

# Difficult (“heartsink”) patients and clinical communication difficulties

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**Abstract:** Managing the difficult patient requires a set of skills or strategies oriented at improving the physician–patient relationship and avoiding conflictive situations. There are different types of difficult patients who should be precisely identified for their management. These patients seek appropriate medical care which is not always provided. However, some may have unrecognized pathological illnesses, especially personality or psychiatry disorders. Clinical communications may be altered by professional and situational factors. In some circumstances, clinical symptoms are medically unexplainable or poorly defined as part of a disease or syndrome. Organic disease should be ruled out before patients are classified as having a somatoform disorder. Diagnosis may be delayed when symptoms are not properly evaluated therefore causing serious health consequences. Clinical competence, empathy, and high quality communication is required to succeed in difficult clinical encounters.

**Keywords:** physician–patient communication, barriers to communication, expert patient

## Introduction

The physician–patient relationship is the central element in the health care system, and includes verbal and nonverbal clinical interactions. Emotions are also components of the physician–patient communication. The ability to manage communication flow can result in improved patient care and adaptation to illness and treatment. In addition, physician communication strategies may decrease stress and help deal with patients’ emotions. The term “difficult patient”, also offensively labeled as “heartsink”, “fat-folder”, “crock”, or “hateful” patient, is a paternalistic denomination that ignores the difficult interplay between patients and physicians in a health care system or context.<sup>1–5</sup> Many physicians consider that these patients consult for unexplainable clinical reasons.<sup>4</sup> In general, care for difficult patients is time consuming, and conditions physicians to feel uncomfortable, frustrated, and sometimes useless.

The term “heartsink” does not denigrate the patient, yet rather acknowledges the understandable unhelpful reaction of the physician. As in many cases one cannot establish if distress is real or fictitious, proper term for these patients should be “persistent applicants”, or patients seeking solutions.<sup>6</sup> However, used labels are sometimes offensive, ignoring the fact that negative feelings are the result of the interaction between two individuals: the patient and the health care professional. Not all difficult encounters can be blamed on the patient side of the interaction. Moreover, difficult relations between physicians and patients originate from the style and personality of both. Therefore, difficult patients create difficult clinical encounters. Approximately

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15% of clinical consultations may be rated as “difficult” by involved physicians.<sup>7,8</sup> Difficult patients elicit negative feelings, stress, and emotional strain that can favor the “burnout” syndrome among professionals.<sup>9–11</sup> However, it is not clear whether difficult clinical encounters contribute to burnout or physicians with burnout syndrome become less tolerant to certain patients. Job satisfaction has decreased among British physicians who display stress and burnout patterns more frequently.<sup>12</sup> The difficult patient approach/management requires a whole set of skills or strategies to improve relations and avoid greater conflicts.

## The patient factor

Difficult patients have very poor ways of dealing with external stressors and complain about everything. They may have unrecognized pathological disorders, especially personality disorders, or have an exaggerated feeling that they deserve more care or attention.<sup>13–16</sup> They are often excessive consumers of medical services. Indeed, their clinical records evidence an increased number of consultations and visits to various medical facilities and free emergency services with poor adherence to both treatment and medical recommendations.<sup>8,13,17</sup> Moreover, these patients feel unsatisfied and threatened before their problems are even exposed. They blame doctors for any administrative issue, quarrel, and in general complain for any reason (with or without cause). Compared to nondifficult patients, difficult ones display worse health outcomes, demand to be prescribed more frequently (sometimes unnecessarily), and receive more prescriptions, visit more often, and undergo more tests.<sup>8</sup> The risk profile of a difficult patient is predominantly a woman, older than 40 years, socially isolated, divorced or with marital problems, low tolerance, low education, and low social class.<sup>18,19</sup> Despite this, there is a great prevalence of antisocial and narcissistic personality disorders among men.<sup>20</sup>

People suffering from anxiety may have many physical symptoms or irritability. They most frequently display cardiac symptoms, gynecological complaints, or general discomfort. Common symptoms among individuals seeking explanations for their anxiety state, alcoholism, drug abuse, and personality disorders include insomnia, back or abdominal pain, headache, or fatigue. Often, when a psychopathological condition is detected explaining consulted symptoms, patients refuse to accept the diagnosis and insist that a somatic (organic) cause be found. Sometimes, patients are too dependent, manipulative, stubborn, and self-destructive.<sup>13,21–25</sup> Types of difficult patients are presented in Table 1.

**Table 1** Types of difficult patients as described by 101 physician members at 15 medical schools from the United States<sup>25</sup>

Main type of problems	Category of patient descriptors	Examples of descriptors
Behavior problems	Stay sick behaviors	Worried well Ignoring problems Noncompliant Overly dependent Social visits Abdicates responsibility
	Demanding behaviors	Demand own care Manipulative
	Other patient behaviors	Whiner Unfocused ER abuser Family conflict Hidden agenda Excessively complimentary Slow talkers
Medical problems	Multiple problems Pain, drug problems	Multiple complaints Drug seeking Chronic pain
	Psychiatric problems	Borderline personality Substance abuse Bipolar disorder
	Miscellaneous problems	Difficult diagnoses Workman's compensation Partners' patients

Minuchin et al<sup>26</sup> have emphasized family structure and problems initiated during adolescence as risk factors for an individual to become a difficult patient. Marital problems and hidden conflicts may be expressed by various physical symptoms. Moreover, difficult family relationships, arguing, and stress can alter the immune system and cause the appearance of symptoms.<sup>27–29</sup> In some cases, instead of a difficult patient there is a dysfunctional family, for example, cases of anorexia nervosa or severe menstrual-related symptoms are often associated with family conflicts. Tate<sup>30</sup> distinguishes three types of patients in the general population: the internal controller, the external controller, and the energetic. Internal controller patients believe that they are responsible for their health, and results are consequences of their actions. They eat healthy foods, read health magazines, and run or go to the gym everyday to keep fit. After 20–30 years of healthy life, however, they are disappointed when they have hypercholesterolemia or hyperglycemia. These patients require explanations (although not always rational ones) and a Socratic dialogue regarding their health status. They become involved in decisions and consume alternative medicine due

to some doubts regarding conventional medicine. Despite these doubts, they are willing to comply if convinced appropriately. Contrary to internal controllers, external controller patients do not control their own health in any way, they are fatalistic, question health recommendations, and brag about having obese relatives who live long, drink and smoke, and never go to the doctor. These people do not like the Socratic dialogue (particularly when related to their health issues), and prefer to be told what to do in order to do the contrary or modify recommendations according to their own ideas. Once prescribed one discovers several months later that they had never followed the treatment due to fear or because a friend advised that it was dangerous. Sometimes in a subsequent second or third consultation they tell us “If you say I have to take the medication, I’ll take it. You are the one who knows, you are the specialist”. These individuals have little or no interest in health issues discussed in the media, although they may respond to specific campaigns oriented to encourage patients to avoid risky behavior. Communication methods that are effective on internal controllers are ineffective on external controllers. The third type is the “energetic” patient, different from the two previous archetypes. They are unable to monitor or take any responsible position regarding their health, relying on the physician as their health guardian. When several treatment options are offered they prefer not to make decisions and transfer this responsibility to the physician even if the selected option does not meet their satisfaction and decide finally not to comply.

The “expert” patient usually has a chronic illness, subject to periodic follow-up. They are very meticulous in seeking information regarding their illness. For some physicians, “expert patients” are disturbing, whereas for others they may be considered a relief as the patient’s expert knowledge can aid doctor – patient communication. The description of an expert patient is presented in Tolstoy’s novel *War and Peace*, when the main character Natasha Rostova insisted to the fact that doctors could not understand her illness and she was the only one capable of so. Some conditions lead patients to develop knowledge related to diabetes, human immunodeficiency virus infection, cancer, endometriosis, the menopause, premenstrual syndrome, polycystic ovary syndrome, and so on. Specific programs aiming at training patients on how to overcome their ailments have been implemented in some US hospitals with good results, improving quality of life, and reducing health care expenditure.<sup>31,32</sup>

Another type of difficult patient that can be identified is the “treated badly” or “abused” by the physician or the health care system. These patients have received little treatment

(unsuccessful or with complications), been excluded from decision-making and poorly informed or incompletely understood. Profound knowledge of patients’ rights should encourage respectful, nondiscriminatory, confidential, and effective use of health care resources. In many countries regulations state that patients or their legal representative must decide on all aspects relating to their condition. If this is not the case, then physicians are committing patient abuse.

## The professional factor

In a difficult patient–physician relationship, the patient’s perspective is usually opposite of the physicians’. Patients feel they are dealing with a “difficult” physician, and lack confidence (ie, reluctant to share information), and display negative feelings toward them. Physicians with lower job satisfaction, less experience, and poorer psychosocial attitudes have more difficult patient encounters.<sup>5,9,33,34</sup> Indeed, this may be the case among young physicians at the beginning of their careers due to work overload, bad working conditions, and a higher number of difficult consultations. Inexperienced physicians may be considered as difficult professionals especially when patients present with vague symptoms and complaints that persist after therapy, or failed clinical management.<sup>5,17</sup> Patients receiving inappropriate treatment or feeling ignored, tend to repeat visits which causes increased friction in the patient–physician relationship. In these circumstances, the professional has probably not identified the emotional background and individual needs of the patient.

Physician and patient gender may influence the clinical communication style. Indeed, one experimental study reported that the degree of satisfaction among users of computer-generated medical consultations depended on physician and patient gender. Female and male patients harbor different expectations regarding the consultation and satisfaction is higher when patient–physician gender is the same.<sup>35</sup> In the United States, female physicians seem to have less difficult patient encounters,<sup>8</sup> probably because patients who have more psychosocial concerns may consider a woman doctor as being more understanding. Other possibilities include the so-called women’s greater sensitivity to the patient’s suffering. However, there are no gender differences in perception of suffering; it is more likely a problem of training deficiencies in the ability to detect and manage suffering.<sup>36,37</sup>

Nurses may also be the target of difficult patients, who display negative attitudes to certain treatments or diagnostic procedures.<sup>38,39</sup> In different European countries, violence against nurses has increased in recent years. In the United Kingdom, harassment may affect up to 40% of nurses.<sup>40</sup>

Some patients do not consider the great amount of responsibility they have, the knowledge they possess, or the physical and emotional demands that are required to do their jobs. Nurses should know how to relax the patient and assure them they are in good hands, to gently answer all questions and to explain care and hospital procedures.

Untrained and amateur paramedical and hospital reception staff may cause problems to the national health service when they are undertrained and incapable of managing patients wisely, favoring negative and temperamental attitudes among patients.<sup>41,42</sup> Patients may sometimes confuse the health care provider with an authoritarian personality of his/her past (mother, father, or guardian). In these cases the patient usually argues all physician's proposals and finally accepts them in a skeptical or bad-humored way.

## Situational factors

Workplace and working conditions are also determinants of a successful patient–physician relationship. Overloaded outpatient clinics, isolation or psychosocial marginalization of the health care provider, underutilization of human resources, among other factors, may damage this relationship.<sup>11,43–46</sup> The traditional perception of the physician devoted to the care of their patients has been replaced by the image of a health care manager with business objectives, which has caused a decrease in trust among patients and relatives. At the same time, the pressure to reduce health care costs and increase physician productivity have limited the time for friendly and personalized communications.<sup>47–50</sup> These conditions have lead patients to express their dissatisfaction towards health care providers and systems that do not meet their expectations. Dissatisfied patients claim their rights for good professional care, therefore problems within the health care system seem to shift to the personal sphere and deteriorate patient–physician relationships. In this context, patient and physician factors mutually potentiate and favor poor communication.

On occasions physicians display negative attitudes toward their work, which reflect a sense of disenchantment, frustration, and anger. These attitudes are not directed toward their patients yet to the responsible insurance companies or government agencies. These tensions are particularly strong in the American health care system. Almost one-third of US physicians work outside hospital practice alone or in groups of less than five physicians. Internet-related communities are creating virtual spaces to support physicians working under difficult conditions, especially among those who have difficulties in keeping up to date with scientific progress.<sup>51,52</sup>

Although these aspects are related to the health care frame, and political factors, they may indeed alter the physician–patient relationship.<sup>53–55</sup>

Another scenario may be the particular national health system of some countries, for instance Spain.<sup>56</sup> The Spanish health system has achieved high technological levels yet reducing time for reflection and the study of the complexity of problems seen among certain patients. Therefore, there is a discrepancy between the organizational model and patient's expectations. Physicians and nurses train at assessing symptoms or processes (especially biological ones) rather than managing the psychological components of diseases. Patients, however, want more than just clinical care, they desire comprehension, to be able to transmit their emotional preoccupations and most of all be heard. Sometimes these desires are not fulfilled and may explain their high degree of dissatisfaction. The majority of claims for medical errors are in fact due to poor communication and information. Thus, there is a bias between what patients expect and what physicians offer.<sup>15</sup> The economical crisis of recent years has increased unemployment, reaching up to 20% in some European populations.<sup>57</sup> This situation has created a certain degree of anxiety and unhappiness. This general situation is extrapolated to the clinical practice in the form of pessimism, aggressiveness, and frustration during patient–physician clinical encounters.

A Spanish study of family practitioners found that physicians who had been in their job for at least 5 years had between 12 and 19 difficult patients each. Although numbers do not seem high, these patients still generated a lot of work and anxiety.<sup>58,59</sup> In some medical circumstances, continuity of care by the same physician cannot be guaranteed, which reduces patient satisfaction.<sup>60</sup> Malpractice is a consequence of bad clinical communication. Any degree of malpractice is always too much not only in terms of injuries yet also suffering and patient dissatisfaction.<sup>61</sup> Defensive medicine is also a consequence of bad communication which increases the number of unnecessary explorations and tests. However, scientific guidelines may be an alternative in reducing malpractice risk.<sup>62</sup>

## Medically unexplainable physical symptoms

The 20th century has created the “medicalization” of common human conditions.<sup>63</sup> Under this scenario, the population has boundless faith in preventive medicine and expects to live in a permanent state of happiness and good health. At the same time, the industry provides the therapy for new “conditions” more related with lifestyle than with diseases,

using subtle (or gross) incentive mechanisms to address risks or conditions.<sup>64,65</sup> As a consequence, physicians have become guardians of minor symptoms or discomforts whereas medical organizations have become a major threat to health due to iatrogenic situations. In an editorial, Ogden<sup>66</sup> wondered why patients with symptoms feel concerned enough to visit the physician, whereas others do not? Why do symptoms increase in people who have more free time, but are unusual in individuals who have a rewarding job? Why do certain types of people frequently go to consultations for any reason and are constantly unhappy?

Western traditional medical education is based on the “disease theory”, whereas most recent medicine is centered on promoting health and disease prevention. However, clinical practice is not always clearly black or white. On some occasions, physicians are not prepared to manage bizarre clinical cases (ie, patients with partial symptoms of a disease), causing a difficult patient–physician interaction. On the other hand, the biological medicine model recognizes that injuries begin at the cellular level, progressing to tissue damage and then consequently producing symptoms and signs. In most cases, there is a link between symptoms and clinical diagnosis, but sometimes relationships between symptoms and a disease are questionable. Both physicians and patients should assume that numerous symptoms have no organic basis or cannot be linked to a disease by the available methods. When there is no physical cause for the complaints, they are too often justified as a manifestation of depression, anxiety, or a somatoform disorder.

The concept of medically unexplained physical symptoms (MUPS) was introduced by Melville<sup>67</sup> to differentiate somatization disorders and other psychosomatic diseases that are characterized by the perception of symptoms of mental origin. Approximately one-fifth of patients (mostly women) seen in the general consultation have MUPS.<sup>13,17–19,68</sup> A lower rate may be seen among medical specialists. MUPS refer to symptoms of undetermined cause that may have somatic, physical, or environmental origin. However, MUPS overlap with somatization and somatic functional symptoms.<sup>69</sup> Lacking a specific etiology, MUPS can cause patient–physician conflicts that may cause physical attacks and/or litigations. Several validated questionnaires (eg, the Patient Health Questionnaire, the Whitely Index, the Four-Dimensional Symptom Questionnaire, and the Short-Form 36 Health Survey) have been designed to recognize severe MUPS and help manage affected patients.<sup>70</sup>

Differential diagnosis includes somatization resulting from loneliness, marital conflicts, some forms of hypothyroidism, atypical personality, adjustment difficulties, and unrealistic expectations toward the physician–patient relationship. Organic disease must be ruled among patients exhibiting many symptoms. Even hypochondriacs can have an organic disease at a given time, and some degree of caution is advisable.<sup>5,71–73</sup> The *Diagnostic and Statistical Manual of Mental Disorders* in its third edition (DSM-III) introduced the somatoform disorders category as a group of unexplained somatic symptoms not related to a general medical condition.<sup>74</sup> This category has been expanded in the fourth edition of the DSM and although it has been expanded,<sup>75</sup> it has been criticized (by health care professionals and patients) and proposed to be removed or be replaced to “functional somatic symptoms and syndromes”. This change would allow to study their etiology and to specifically treat them.<sup>76</sup> Differential diagnosis of somatoform disorders should include general organic disease, depression with somatic complaints (masked depression), domestic violence, different types of anxiety and panic disorders with maladjustment, and schizophrenia.<sup>77–79</sup> On occasions, the diagnosis of an organic disease is not made because the patient has an illness that does not alter their overall health or the physician does not request a diagnostic test due to its cost, the filling out of long and cumbersome forms, or because it was not contemplated within the institutional protocol. Appropriate tests should not be omitted in any given case before considering a psychiatric diagnosis. Logically, excessive testing should not be generalized to people who enjoy feeling sick and be subjected to permanent medical care.

We may all recall cases in which the results of tests were not sufficiently analyzed; however, upon retrospective analysis one realizes that data for the diagnosis was in fact there. Although many cases with pain upon pelvic examination may suggest vascular problems, endometriosis, adhesions or surgical sequelae, laparoscopy is required to confirm diagnosis. Medical conditions may remain undiagnosed if the physician is not opened minded or just relies on a particular test or complementary exploration. All diseases and syndromes were once medically unexplained. It is easier to blame the patient for unexplained symptoms or those supposedly made up, rather than honestly admit their lack of knowledge regarding with what is happening to the patient and refer the case to other specialists. Patients who repeatedly seek clinical aid waste physician’s time and yet still do not feel completely satisfied. Furthermore, the patient may seek diagnosis and treatment outside conventional medicine.

## Delayed diagnosis

The “itinerant” patient runs through many consultations and specialized clinics without finding a solution to his/her problem. Although this type of patient is not difficult in essence, he/she deserves to be cared for, especially if health care was not adequately provided. Not taking into account any act of bad faith, in general, these are patients in which the basic principles of good practice have not been followed, evidence has been used inaccurately, and prompt diagnosis and treatment was not provided earlier. These errors are particularly relevant when it comes to malignant tumors.<sup>80–82</sup> Gandhi et al<sup>82</sup> studied 307 cases of malpractice associated with adverse outcomes due to delayed diagnosis. A 59% of cases were delays in cancer diagnosis (mostly due to inappropriate testing), 45% inappropriate follow-up, and 42% lacked detailed and proper anamnesis and examination. All evidence and previous actions must be carefully reviewed when a new or abused patient is being attended and the consultation must be carried out without bias or influence from any previous treatment. Clinical practice has not changed in centuries: a proper clinical history, thorough examination, individualized care, and the appropriate use of complementary tests to confirm or deny the initial diagnostic impression. In the US, lawsuits are mostly due to professional malpractice in which patients, lawyers, and insurance companies have usually received benefits.<sup>83</sup> For example, in the state of Massachusetts over 38% of gynecologists have received complaints in recent years, especially among general gynecologists rather than those practitioners working in a specialized field such as gynecologic oncology (10% of reports), perinatal medicine (3.7%), and reproductive endocrinology (11.9%). Sums paid to patients in the US due to lawsuits are significantly high.<sup>84</sup> The number of claims in Europe is lower than in the US, however there is a significant increasing trend.<sup>85</sup> The recommendation for all specialists is to manage difficult patients appropriately and respectfully to decrease friction in the patient–physician relationship. If necessary, certain cases should be reassessed for possible organic causes.

## Managing communication problems

Currently evidence-based medicine is the main goal in clinical learning. The clinical relevance of evidence-based medicine should be extrapolated to the everyday clinical situations with focus on patients’ needs. One must bear in mind that technological advances cannot override good communication tools. Studies have shown the importance of good patient–physician communication. The style of communication

(verbal and nonverbal) influences patient satisfaction and the compliance to medical recommendations.<sup>86–88</sup> Medical students should receive appropriate training on how to manage patients in order to prevent difficult clinical encounters and to gain empathetic culture. Earning trust and credibility among patients is essential to enable effective communication and patient confidence in the physician. Most complaints related to medical practice involve poor communicational skills, clinical incompetence, or other factors (eg, waiting time).<sup>89–92</sup>

Physicians should exercise self-control mechanisms in order to neutralize the emotional responses caused by the difficult patient.<sup>93,94</sup> On occasions patients come to the health care provider with a long list of symptoms (sometimes even written down). These patients should be given the opportunity to express themselves; nevertheless they should be warned that the physician has limited time for their medical consultation and that the patient must focus on the most relevant issues.<sup>95,96</sup> These patients may display components or symptoms of depression or inadequate adaptation to life problems. In any case, physicians should assess symptoms adequately. One must bear in mind that a negative emotional reaction from the patient to any given physician could be due to a personality disorder.<sup>97</sup> Sometimes difficult patients with undiagnosed and untreated alterations require appropriate assessment of their problems with open questions such as “what is happening or which are your concerns?” This will invite the patient to initiate communication more fluently. Another possibility is to ask the patient “what difficulties have you had in performing daily activities? Do you know why this is happening?” Specific questionnaires have also been designed to identify patients with subclinical psychiatric problems.<sup>98</sup> Psychiatric problems are highly prevalent in patients with multiple unexplainable symptoms<sup>99</sup> and hence require special management. Despite this, many of these patients have no definite psychological illness.<sup>100</sup> Mauksch et al<sup>101</sup> have updated models intended to increase efficiency within medical encounters, including rapport building, agenda setting, and acknowledging social and emotional components.

Psychological research shows that physicians need a framework of broad knowledge in sincerity, emotion detection, and have the capacity to express genuine interest in patients’ complaints.<sup>102,103</sup> Empathy and appropriate listening and discussion are key issues in the management of difficult patients. Thus, patient-tailored communication skills are the best tools for managing difficult patients, including empathy, tolerance, and nonjudgmental listening. Difficult

patients should not be treated badly, on the contrary health care providers should attempt to increase among patients knowledge regarding their illnesses. Whenever needed, physicians should seek appropriate counseling or collaboration with psychiatrists. Physicians who have difficulty in managing difficult patients should seek help from other professionals, colleagues of the same specialty, or psychotherapy support groups.

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