

The Difficult Patient

Robert J. Vissers and Norman Kalbfleisch

■ PERSPECTIVE

Certain patients consistently arouse negative reactions in health care providers. These negative reactions may be initiated by a patient's appearance, apparent attitude, interactive style, or presenting complaint. Difficult patients can rapidly disrupt the harmony and efficiency of an emergency department (ED). Such patients have been referred to with a number of pejorative terms, such as *gomer*, *crook*, and other even less complimentary slang terms of disdain. They may receive suboptimal medical care, impede patient flow, and adversely influence the quality of care given to other patients, thus posing a medicolegal risk. Moreover, recurrent exposure to such patients, in the absence of a well-thought-out approach to dealing with them, may lead to escalating frustration for staff, promote unprofessional behaviors, and contribute to eventual burnout.

Historically, the medical literature has largely ignored the possibility of physicians harboring negative feelings toward any type of patient. Anger, hatred, and frustration are traditionally considered feelings that physicians should disown in favor of humor, compassion, and integrity. Although the latter are admirable attributes, to deny the presence of negative reactions is unrealistic. Physicians are as human as the patients they serve. Not until Freud coined the term *countertransference* were the negative reactions that patients can arouse in physicians actually recognized for their potential effect on care and used as diagnostic tools.

Good interpersonal skills are essential to the maintenance of the patient-physician relationship.¹ Although some clinicians have more natural abilities in this area than others, the myth that these skills are intuitive and cannot be taught is erroneous.² Teaching communication and relationship-building skills is now a priority of most medical schools and many primary care specialties.³ The need for guidelines for teaching and evaluating interpersonal skills within emergency medicine residency programs has only recently been addressed.^{2,4,5} The Accreditation Council for Graduate Medical Education (ACGME) has identified professionalism and interpersonal communication skills as two of the six core competencies required in the curriculum of all U.S. residency programs, including emergency medicine, prompting greater interest in research and education in these areas. Although it remains a challenge to measure the effectiveness of these initiatives, innovative curricula on professionalism and communication are being implemented in emergency medicine residencies.⁶⁻⁹

■ DISTINGUISHING PRINCIPLES

Difficult patients are often referred to as “problem patients,” “disruptive medical patients,” “unwanted patients,” and, less diplomatically, “hateful patients.”¹⁰ Patients with personality disorders are commonly included in this group because of their rigid, maladaptive personality traits. Difficult patients, however, do not necessarily have personality disorders and may fall into one of several other familiar patient categories (e.g., drug seekers, hostile patients, malingerers, and ED repeaters).

There is no universally agreed on definition of the difficult patient. We define the difficult patient as *one who interferes with the physician's ability to establish a normal patient-physician relationship*. This impaired patient-physician relationship is often, but not necessarily, associated with negative feelings toward the patient.

■ PATHOLOGY OF THE PATIENT-PHYSICIAN RELATIONSHIP

An understanding of the difficult patient-physician relationship is hampered by a tendency to view it as a consequence of some inherent problem with the patient. Physician characteristics and the ED environment also play a role.^{5,11-13}

Physician Factors

Impaired communication is a common problem in all forms of interpersonal relations and is often exaggerated in the medical setting. Patient satisfaction is highly correlated with patients' beliefs that clinicians listen to them and understand their requests, coupled with the perceived professionalism of the physician.¹⁴ Despite this, physicians continue to focus on their own medical agenda, which may differ from patients' concerns. When confronted with patients who have difficult social situations, physicians exacerbate the problem when they refuse to deviate from their own rigid medical model.

Physicians often have preconceived notions regarding how patients should behave when they are ill and tend to rapidly categorize them as either the acceptable “truly sick” patient type or the “burdensome, difficult” patient type. Patients placed within the former category are excused for their symptoms, but patients in the latter category are not. Patients may also be judged as difficult when cultural differences or language barriers interfere with the develop-

BOX 189-1**GENERAL STRATEGIES FOR DEALING WITH DIFFICULT PATIENTS**

Be supportive.
 Structure the interview.
 Set limits.
 Point out impasses.
 Share your reactions.
 Redirect the interview.
 Take time out.
 Use teamwork.
 Understand the patient's agenda.

Be Supportive

Being supportive is not always the natural response to difficult patients because of the negative feelings they arouse in the physician. Nevertheless, initiating the interaction with a clear and explicit demonstration of concern and empathy may be the single most powerful tool at one's disposal. Some physicians are concerned that seeming to be "soft" with a demanding or entitled patient may exacerbate the situation. To the contrary, expressing a respectful and empathetic concern for their problem effectively disarms many patients who are preparing for a long and arduous battle to be taken seriously. The possible news that there is no immediate solution available is more willingly received by patients who are convinced that they have been heard and believe the physician's desire to help is sincere.

Connecting emotionally with the patient can take time. Initially addressing a smaller concern in a caring and respectful manner can build trust and create greater rapport and compliance. For example, a patient who seeks treatment for self-inflicted lacerations but who will not cooperate with a history aimed at assessing suicidal risk is often more candid after the physician has rendered appropriate wound care in a nonjudgmental way.

Structure the Interview

Setting self-imposed time limits for contact with difficult patients helps control the anxiety associated with falling behind in a busy ED.¹ Flexibility in the structure of the assessment may be necessary. It is fair and appropriate to tell the patient of the need to excuse oneself to care for other patients. The fulfilled promise of returning to complete the next element of the assessment helps build trust and rapport.

Set Limits

It is helpful to share the ground rules of reasonable behavior with patients. For example, profane patients should be reminded that they are entitled to treatment but that their language may offend other patients. The physician may suggest they censor their remarks or be escorted from the area.

Point Out Impasses

At times, patient expectations and physician limit setting produces an impasse. When this occurs, it may be necessary to agree to disagree. Some issues can be resolved by pointing out impasses and giving the patient a chance to help solve the problem. Impasses sometimes can be resolved if difficult issues are set aside and returned to later in the interview. This

fundamental approach to negotiations is generally underutilized in the ED.

Share Your Reactions

Pointing out impasses may not be effective if a patient senses annoyance or frustration in the physician. It may be helpful at such times to share one's feelings explicitly with the patient while continuing treatment.

Redirect the Interview

Some patients love to talk about issues unrelated to the problem at hand. Pursuing trivial or chronic complaints should be avoided. Patients often require redirection to focus on issues that have some potential for resolution. Asking them to take a chronologic approach in discussing a specific concern may help keep them on track.

Take Time Out

Physicians occasionally feel unable to contain their frustration. One should feel comfortable retreating from the room and returning when both parties have regained their composure.

Use Teamwork

Individuals who intimidate or split the staff are much more easily treated from the outset with teamwork. This is especially important with violent patients requiring restraint when a show of strength in numbers may defuse potentially dangerous situations. A more subtle, but equally important, application of teamwork is in the treatment and discharge planning of patients with complex problems who require an especially well-organized, multidisciplinary approach involving medical and support services in the community. Occasionally, if available, the benefit of a "second opinion" from an emergency medicine colleague can help identify the difficult patient and allow the treating physician to regain clinical perspective.

Understand the Patient's Agenda

Sometimes physicians ask themselves, "Why is this patient here?"¹ It is often productive to ask the patient the same question in a nonjudgmental fashion. The patient may have an easily satisfied, although unanticipated, agenda. This may be as simple as needing a bus ticket to get home or reassurance that there is no immediate danger of dying from some minor disorder. When the patient's needs are not as easily met, a clear understanding of the purpose of the visit may allow the opportunity to set more realistic goals.²⁰

Dealing with Negative Reactions

Although negative reactions make dealing with difficult patients an unpleasant experience, they can also provide valuable diagnostic information. Physicians should accept these reactions as understandable responses to a patient's unpleasant behavior and use them to their advantage.¹

Physicians typically have similar reactions to certain patient behaviors. The variations in these reactions depend on the individual physician's personality style, previous experiences, and unrecognized prejudices. Physicians must know their own reactions to specific behavioral patterns to use them as diagnostic aids.

Early recognition of these reactions may, in addition to their diagnostic value, allow the physician to analyze them

as the first step in preventing failure in the therapeutic relationship.^{11,13}

Negative Thoughts about the Patient

Negative thoughts about patients have the greatest potential to adversely affect patient care. Patients are often placed into such stereotyped categories as “drug addict,” “malingerer,” or “crock.” These labels may describe individual patients more or less accurately, but the potential exists for physicians to make inaccurate and potentially dangerous assumptions based on the biases linked to these labels.

The process of assigning patients to epidemiologic categories is a normal part of clinical judgment. Certain categories are used to help define the likelihood of encountering diseases in particular patient populations, thereby influencing decisions regarding investigation, treatment, and disposition. The danger in dealing with difficult patients is that this process can result in inaccurate assumptions about patients and compromise patient care.

Inaccurate assumptions about patients based on prejudicial, stereotyped labels are called *cognitive distortions*. The following case exemplifies the effect cognitive distortions can have on clinical decision-making.

An injection drug user requests analgesia for severe neck pain after minor trauma. The physician labels the patient a drug seeker and assumes the complaints to be fictitious. After becoming aware of the physician’s assumption, the patient becomes belligerent and aggressive. He is escorted from the ED by security. A few days later, he returns with quadriplegia resulting from a cervical epidural abscess.

The physician assumed the patient was malingering because of past experience with injection drug users and did not consider other legitimate explanations for the patient’s behavior. This phenomenon, known as “all-or-none” thinking, leads to the real disease being overlooked.

Negative Self-Perceptions

Self-directed negative thoughts by physicians often reflect a sense of inadequacy or despair. Some patients contribute to the problem by criticizing their care in ways that reinforce the physician’s feelings of inadequacy. Unreasonable expectations of patients, coupled with their secret conviction that no one can really help, combined with the all too prevalent rescue fantasies of physicians, create a potent recipe for physician frustration, which in the long term can contribute to eventual burnout.

Negative Behaviors

Physician behaviors can be the most obvious manifestations of negative feelings and thoughts. Examples include rudeness, sarcasm, and indifference toward patients. A patient may receive an incomplete clinical evaluation, and unnecessary ancillary tests may be performed, as an attempt to compensate. Physical or chemical restraint use, administration of naloxone, or the performance of other procedures may be used inappropriately or punitively. Analgesics may be withheld or used sparingly. Faulty communication may result in misunderstood discharge instructions and poor compliance. Impaired patient-physician relationships may lead to a refusal of care, forcing treatment against patients’ wishes, or resulting in them leaving against medical advice.²¹

Although patients can suffer at the hands of physicians, the potential exists for the reverse to occur. Dissatisfied patients with incorrect diagnoses and poor follow-up instructions are

prone to initiate successful malpractice suits against physicians.¹ The physician may become the victim of patient violence.²² Negative physician behaviors can also have an effect on the rest of the ED staff. Actions viewed by colleagues as inappropriate can compromise team morale and functioning. Physicians who are feeling angry, demoralized, and stressed may vent their frustrations on team members or consulting services, resulting in a further deterioration of the immediate situation and potential damage to long-term working relationships.

Strategies for Managing Negative Reactions

Six strategies are helpful in managing physicians’ negative reactions toward patients.

Maintain Appropriate Emotional Distance

Physicians should avoid reciprocating hostile reactions offered by patients. This may be difficult to resist and is best accomplished by maintaining sufficient emotional distance so as to avoid taking the patient’s behavior personally. This “detached concern” must be balanced with sufficient emotional investment to convey a sense of caring and empathy for the patient.¹¹

Generate Alternatives to Negative Reactions

Instead of applying negative labels, physicians should attempt to view the patient as a victim of circumstance. Patients do not choose the social and genetic pool into which they are born. They do not choose to be abused children, to suffer from psychiatric disorders, or to experience many of the life events that lead to an ED visit. They are entitled to high-quality care, delivered with courtesy and empathy, despite their behavior.

Attempt to Understand the Patient’s Behavior as a Symptom

The second step in managing negative reactions is to recognize that patients relate to the world in a particular way because of their condition, culture, and circumstances. The condition may include a variety of medical and psychiatric problems, intoxication, cognitive impairment, or personality disorders or traits. The behaviors that one finds so disturbing should be recognized as the symptoms resulting from these conditions. Cultural differences and social circumstances can result in behaviors that seem irrational or difficult if the underlying issues are not understood. When attempting to maintain a compassionate approach to a particularly troubled and troubling patient, it is sometimes helpful to imagine how difficult one would find it to *be* that patient.

Look for the Cognitive Distortion

Cognitive distortions are best identified by looking for evidence that patients or situations are being stereotyped. Physicians should be aware of the effects on clinical judgment that arbitrary inferences and all-or-none thinking have on interactions with patients.²³

Find a Rational Response to Cognitive Distortions

The initial reaction to the elderly schizophrenic patient presenting with chest pain might be to discount the symptoms as delusional. Psychosis, however, is not protective against ischemic heart disease, and the principle of first considering the

most potentially life-threatening diagnosis serves both the patient and physician well in the ED.

Place Negative Reactions in Perspective by Viewing Them in Context

The ED is a stressful work environment. An expectation exists that emergency physicians will deal with problems quickly and effectively. Patients who thwart physicians' attempts to perform accordingly may be identified as undesirable. Such patients are difficult to view objectively when one is feeling overwhelmed. The frustration resulting from dealing with such difficult situations may produce an exaggerated response to a patient's behavior. Recognizing this may help reduce the loss of objectivity that leads to problems with patient care.

Although dealing with negative reactions is not the panacea for dealing with difficult patients, it provides the foundation for restructuring one's interactions with them in a way that will ultimately benefit the patient clinically and the physician emotionally.

Crisis Intervention

Some presenting complaints such as "can't sleep," "nervous stomach," "anxiety," and "can't cope" are especially likely to produce a sense of frustration and dread among caregivers. Attempts to deal with such complaints directly often prove unfruitful, partly because the patient's seemingly exaggerated affect interferes with effective communication. These are, however, all signs of a patient presenting in crisis.²⁴

Anatomy of a Crisis

A crisis occurs when a hazardous event is encountered and customary problem-solving strategies prove ineffective.²⁴ People experience crises of various intensities many times in their lives; common examples include the death of a loved one, the loss of a job, serious illness, and domestic violence. The usual response of an individual to such stress is to experience an inner tension that mobilizes coping skills. Different problem-solving behaviors are then tried based on previous experience.

If an effective means of resolving the crisis is chosen, the person returns to a more organized state. If a resolution to the crisis is not easily found, a period of disorganization follows. During this time, the person experiences intense emotions such as confusion, anxiety, fear, anger, and despair. It is during the state of emotionally charged disorganization that a person may seek help at the ED.

Patients in crisis will, by the nature of their complaints and behavior, fall into the category of "the difficult patient" whether or not they actually are a "difficult person." It is important to be able to apply certain techniques of crisis intervention when dealing with such patients.

Dealing with the Crisis

Recognizing the Crisis. The presenting complaint of a patient in crisis may be a description of an event, situation, emotion, or physical symptom that can be vague or specific (domestic violence, inability to cope, anxiety, unwell, headache). Patients who present with crisis-related symptoms are a heterogeneous group. At one end of the spectrum are patients who have chief complaints that describe some type of emotional suffering and who do not require a traditional "medical" workup. At the other extreme are patients who need to be reassured in absolute terms about the absence of serious disease before their

BOX 189-2 FIVE BASIC STEPS IN CRISIS INTERVENTION

- Recognizing the crisis
- Gathering basic information
- Understanding the development of the crisis
- Reproducing the peak tension of the crisis
- Finding the solution

anxiety is alleviated. Between these two extremes are patients who partially understand how their circumstances might be contributing to their suffering. They can accept the idea that "the effect of stress often produces these kinds of physical symptoms." Many patients, however, are justifiably unwilling to accept this explanation until they believe their medical complaint has been adequately assessed. This usually requires no more than a careful history and physical examination followed by reassuring communication from the physician, and the patients' perception that the complaint is taken seriously. Some patients who are in severe crisis need to be taken through the steps of formal crisis intervention. The complex nature and considerable time required for this are often beyond the scope of practice of a busy emergency physician. The unfortunate increase in the length of stay for psychiatric patients in the ED, due to diminishing resources for these patients, may provide an opportunity for social workers, psychiatrists, or psychiatric nurse practitioners to employ this technique. A recognition of the patient in crisis is critical to creating a functional patient-physician relationship, addressing their underlying illness, and beginning the process of intervention (Box 189-2).

Gathering Basic Information. The first step in crisis intervention, after recognition of the crisis, involves gathering general information about the patient's home environment, work situation, personal relationships, and social involvements. The purpose of basic information gathering is to place the patient and the crisis into context before exploring the crisis itself. This step is time-consuming and cannot be rushed, and it needs to be performed by providers other than the emergency physician.

Understanding the Development of the Crisis. A structured interview is performed to obtain information about the sequence of events leading up to the crisis and the nature of the crisis itself. The objective is to understand the situation while keeping the interview organized and directed so that the patient can describe events without being overwhelmed by the emotion attached to them.

Reproducing the Peak Tension of the Crisis. Once the crux of the crisis is identified, the care provider should proceed to help the patient express the intense emotions associated with the situation. Through empathetic, active listening, the person in crisis is allowed to experience the previously overwhelming emotions in a safe context. This places the care provider in a position of trust and sets the stage for problem solving.

Finding the Solution. In the final phase of crisis intervention, the physician reframes the circumstances in objective, realistic, and understandable terms for all those concerned in order to facilitate a solution to the problem. Possible solutions to the crisis are then suggested, with participation from the involved parties, and the best plan for resolution is implemented. It is important that this be a joint effort and that the patient have some ownership of the solution.²⁴

■ SPECIFIC APPROACHES FOR DEALING WITH DIFFICULT PATIENTS: PUTTING IT ALL TOGETHER

The various management strategies described here can be consolidated to formulate a practical approach to dealing with

difficult patients. The first step is the recognition of specific behavior types, rather than traditional diagnoses. These behavior types describe the most difficult patients seen in the ED. Patients displaying some, but not all, characteristics of a certain behavioral type may still be amenable to the management strategies for that type.

Behavioral Classification

Individuals with personality disorders frequently present as difficult patients. Although reliably establishing the diagnosis of a personality disorder during the typical brief ED encounter is difficult, an awareness of those personality disorders having a high prevalence in the ED helps ease communication with colleagues when the diagnosis has been previously established (Box 189-3).

An alternative to the traditional diagnostic categories for classifying difficult patients is based on four specific behavioral

presentations and the negative reactions they produce.²⁵ We have adapted this classification system, using more neutral terms. The behavioral categories are *dependent patients*, *entitled patients*, *intractable patients*, and *self-destructive patients*. Through recognition of the difficult patient's maladaptive behavior and identification of the physician's subsequent negative reactions, patients can be placed into one of these behavioral categories. The behavioral categories in turn suggest effective treatment strategies for each patient type (Table 189-1).

Dependent Patients

Dependent patients see physicians as inexhaustible sources of compassion and understanding. Their initially reasonable requests rapidly escalate into repeated demands for reassurance, affection, analgesia, or other forms of attention. They are excessive in their gratitude; however, the more care they receive, the more their needs multiply. Initially, the physician

BOX 189-3 COMMONLY ENCOUNTERED PERSONALITY DISORDERS

Borderline Personality Disorder

Pattern of instability of interpersonal relationships, self-image, and affect that is accompanied by marked impulsiveness beginning by early adulthood and present in a variety of contexts. It may be indicated by five or more of the following:

1. Frantic efforts to avoid real or imagined abandonment
2. A pattern of unstable and intense interpersonal relationships characterized by alternating extremes of idealization and devaluation
3. Identity disturbance: markedly and persistently unstable self-image or sense of self
4. Impulsiveness in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating)
5. Recurrent suicidal behavior, gestures, threats, or self-mutilating behavior
6. Affective instability caused by a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)
7. Chronic feelings of emptiness
8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)
9. Transient, stress-related paranoid ideation or severe dissociative symptoms

Antisocial Personality Disorder

Pattern of disregard for and violation of the rights of others since the age of 15 years as indicated by three or more of the following:

1. Failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest
2. Deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure
3. Impulsiveness or failure to plan ahead
4. Irritability and aggressiveness, as indicated by repeated physical fights or assaults
5. Reckless disregard for safety of self or others
6. Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations

7. Lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another

Dependent Personality Disorder

Pattern of pervasive and excessive need to be taken care of that leads to submissive and clinging behavior and fears of separation beginning by early adulthood. It may be indicated by five or more of the following:

1. Has difficulty making everyday decisions without an excessive amount of advice and reassurance from others
2. Needs others to assume responsibility for most major areas of his or her life
3. Has difficulty expressing disagreement with others because of fear of loss of support or approval
4. Has difficulty self-starting projects or doing things (because of a lack of self-confidence in judgment or abilities rather than a lack of motivation or energy)
5. Goes to excessive lengths to obtain nurturing and support from others, to the point of volunteering to do things that are unpleasant
6. Feels uncomfortable or helpless when alone because of exaggerated fears of being unable to care for self
7. Urgently seeks another relationship as a source of care and support when a close relationship ends
8. Is unrealistically preoccupied with fears of being abandoned

Paranoid Personality Disorder

Pattern of distrust and suspiciousness of others, such that their motives are interpreted as malevolent, beginning in early adulthood as indicated by four or more of the following:

1. Suspects, without sufficient basis, that others are being exploitive, harmful, or deceitful
2. Is preoccupied with unjustified doubts about the loyalty or trustworthiness of friends or associates
3. Is reluctant to confide in others because of unwarranted fear that the information will be used maliciously against him or her
4. Reads hidden demeaning or threatening meanings into benign remarks or events
5. Persistently bears grudges (i.e., is unforgiving of insults, injuries, or slights)

BOX 189-3 COMMONLY ENCOUNTERED PERSONALITY DISORDERS—cont'd

6. Perceives attacks on character or reputation that are not apparent to others and is quick to react angrily or to counterattack
7. Has recurrent suspicions, without justification, regarding the fidelity of spouse or sexual partner

Histrionic Personality Disorder

Pattern of excessive emotionality and attention seeking beginning by early adulthood as indicated by five or more of the following:

1. Is uncomfortable in situations in which the center of attention is someone else
2. Interaction with others is often characterized by inappropriate sexually seductive or provocative behavior
3. Displays rapidly shifting and shallow expression of emotions
4. Consistently uses physical appearance to draw attention to self
5. Has style of speech that is excessively impressionistic and lacking in detail
6. Shows self-dramatization, theatricality, and exaggerated expression of emotion
7. Is suggestible (i.e., easily influenced by others or circumstances)
8. Considers relationships to be more intimate than they actually are

Narcissistic Personality Disorder

Pattern of grandiosity, need for admiration, and lack of empathy beginning by early adulthood as indicated by five or more of the following:

1. Has a grandiose sense of self-importance (e.g., exaggerates achievements and talents, expects to be recognized as superior without commensurate achievements)
2. Is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love
3. Believes self to be “special” and unique and can only be understood by, or should associate with, other special or high-status people (or institutions)
4. Requires excessive admiration
5. Has a sense of entitlement (i.e., unreasonable expectations of especially favorable treatment or automatic compliance with their expressed expectations)
6. Is interpersonally exploitive (i.e., takes advantage of others to achieve personal ends)
7. Lacks empathy, is unwilling to recognize or identify with the feelings and needs of others
8. Is often envious of others or believes that others are envious of him or her
9. Shows arrogant, haughty behaviors or attitudes

Adapted from American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 4th ed. Washington, DC, American Psychiatric Association, 2000.

may feel powerful and unique. Dependent patients give the message “You’re the only doctor who cares” and the physician often believes it. As the demands escalate, the physician’s patience diminishes and initial feelings of inflated self-esteem are replaced with feelings of frustration, exhaustion, and failure. This leads to a natural desire to discharge or refer these patients, along with their demands, to another unfortunate physician. The patient leaves feeling rejected and then begins the same vicious cycle with the next physician. Patients with certain personality disorders (dependent, borderline, and histrionic), somatoform disorders, malingering, and chronic psychiatric disorders often fall into this behavior category.^{1,26}

Dependent patients are best treated early in the relationship before the help-rejection cycle is fully established. Some of their earliest identifying features are the negative reactions they produce in physicians. The replacement of physicians’ strong feelings of self-esteem by frustration and failure is a diagnostic clue to this type of patient. Although it is important to be supportive with such patients, it is imperative to set limits as tactfully and firmly as possible. Physicians should point out their own limited time and resources. Reasonable expectations for the patient must be established while giving assurances that one will try to help. After appropriate management, disposition should be arranged, and written discharge instructions with defined criteria for return visits to the ED should be provided. The need for follow-up visits with the appropriate primary care provider should be emphasized.

Dependent patients are especially likely to seek solutions to their problems at the ED in times of crisis. Looking for the underlying issues and structuring the interview along the lines of crisis intervention can assist in finding a satisfactory resolution to the patient’s problem.

Entitled Patients

Very important persons (VIPs) are often well-informed, independent professionals who may be knowledgeable in medical matters. They spend their professional lives in a position of authority and control. The traits that make them successful in the workplace, however, can cause them to be demanding, fault-finding, and self-entitled patients.

Entitled patients also seem to have endless needs, but instead of helplessness or seduction, they use intimidation, hostility, and threats to attain their often unreasonable demands. Entitled patients fear being helpless and dependent on physicians. They use a shield of entitlement to protect themselves. An example is the lawyer who, in his refusal to accept his illness, roams from physician to physician demanding repeated tests and opinions, while threatening to sue the previous physician who had tried to help him. Physicians experience the natural responses of disgust, anger, and antagonism when faced with such patients. There may be an urge to enter into a power struggle with the patient. The other common temptation is to accept the patient’s terms at the price of compromising his or her care. Occasionally, the physician may even experience shame at being unable to meet the patient’s unrealistic demands. The maladaptive behaviors of entitled patients are commonly seen in people with paranoid and narcissistic personality disorders, as well as in addicted patients and VIPs.²⁶

Because the behavior of the entitled patient stems from insecurity, it is important to be supportive. While reassuring patients that they are entitled to good medical care, physicians must set limits that unreasonable demands will not be met. Prolonged debates with the patient about diagnostic and therapeutic options should be avoided. Recommendations about management options should be offered and patients left to

Table 189-1 Management Strategies: Putting It All Together

BEHAVIORAL CLASSIFICATIONS	ASSOCIATED TRADITIONAL DIAGNOSTIC CATEGORIES	SUGGESTED MANAGEMENT STRATEGIES
Dependent Patients		
Excessive needs for attention, reassurance, analgesia.	Personality disorders: dependent, histrionic, borderline	Try to view the patient's neediness as a symptom. Be supportive while setting limits on patient expectations.
Uses helplessness and seduction.	Malingering, chronic psychiatric patients	May need crisis intervention.
Physician initially feels special, then drained and frustrated.		Follow-up with appropriate, consistent physician.
Patient increases needs when ultimately rejected.		
Entitled Patients		
Fear of loss of power causes entitled behavior.	Personality disorders: paranoid, narcissistic	Be supportive of entitlement to good care while setting limits on unreasonable demands.
Uses intimidation, name dropping, hostility, and threats.	Substance abusers	Allow patients to choose between reasonable treatment options.
Physician feels intimidated, angry, sometimes inadequate.	VIPs	Avoid power struggles.
Potential for litigation.		
Intractable Patients		
Excessive needs for attention met by having unsolvable problems with multiple visits, doctor shopping, poor compliance, and no hope for successful treatment.	Personality disorders: antisocial, borderline Malingering	Distinguish from other complicated patients, and manage appropriately.
Physician feels frustrated, angry, but fears "sharing" pessimism and missing significant illness.		Beware of cognitive distortions that may obscure significant illness.
Cycle of "help me, but nothing helps."		Be supportive while setting reasonable expectations.
Self-Destructive Patients		
Disregard for own health and repeated visits for serious illness.	Borderline personality disorder Substance abusers	Provide appropriate medical care.
Often overtly self-destructive, denying of illness.	Chronically suicidal patients	Learn to deal with own negative and nihilistic reactions to patients.
Physicians feel frustrated, helpless, angry, and guilty for wishing the patient success.		Look for signs of depression and consider psychiatric referral as needed.

VIPs, very important persons.

exercise their autonomy in choosing their preferred course. At the same time, physicians must communicate their acceptance of the patients' rights to exercise this control and that their decision will not jeopardize subsequent access to appropriate care.

Intractable Patients

Intractable patients, like dependent and entitled patients, have insatiable needs for emotional support. They are, however, neither seductive nor dependent in their behaviors. They present the antithesis of entitlement; they believe nothing will help. Intractable patients desperately seek help despite the failure of all previous medical assistance. Their history is punctuated by multiple emergency visits and behaviors that are self-defeating, covert, and manipulative. These negative behaviors undermine treatment and antagonize physicians, creating feelings of anger, self-doubt, and frustration. Patients with borderline and antisocial personality disorders and malingering often fall into this behavioral category.²⁶

Malingering are among the most difficult patients presenting to the ED. Malingering is the intentional production of false

or grossly exaggerated physical or psychiatric symptoms, motivated by external incentives that are unrelated to illness.²⁷ These patients may be seeking narcotics, shelter, or monetary compensation; may be attempting to avoid work or criminal prosecution; or may simply be lonely.

Malingering represents deceptive, manipulative behavior and is coded in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM-IV), as a "problem" rather than a mental disorder.²⁶ This contrived behavior must be distinguished from the psychiatric illness of somatoform disorders. Somatization is the involuntary production of symptoms without the patient's awareness. Unlike malingering, somatizers are not motivated by any conscious desire for secondary gain.

Repeaters are patients who frequent the ED excessively to the point that most staff know them by name. Although chronic schizophrenics often fall into this category, this behavior can occur in any patient with poor coping skills and maladaptive responses to psychosocial stressors. The easy accessibility of the ED often makes it the only support system immediately available to chronically decompensated patients. Despite the perception that "frequent flyers" are often inappropriate in their ED utilization, studies demonstrate that frequent users

are in poor health and require medical attention more often than less frequent users.^{28,29}

Geriatric patients with multiple medical problems and those abandoned in the ED by caretakers who are no longer willing or able to meet their needs are also patient types that deserve special attention. Although these patients have problems that are often difficult to solve, the patients themselves are not necessarily difficult people.³⁰

Intractable patients elicit strong negative reactions from physicians and are sometimes identified by the feelings of futility that they produce in their caregivers. Their multiple, vague complaints that defy diagnosis and successful treatment often cause them to be labeled as “crocks,” along with dependent patients.

Intractable patients pose a particular risk of missed diagnosis or premature discharge. Physicians must avoid the temptation to overreact with cognitive distortions and dismiss the possibility of genuine illness in the patient. Intractable patients should be distinguished from other complicated patients, evaluated for conditions that require immediate intervention, and provided appropriate management and disposition. Alternatively, there may be a tendency to inappropriately launch into extensive investigations if the behavior type is not recognized. Collateral information from previous medical records and other caregivers is valuable in providing diagnostic guidance.

Because this type of behavior stems from a need for a relationship and fear of rejection, it is important for physicians to be supportive. The belief that showing empathy only encourages maladaptive behavior is generally untrue. To the contrary, an escalation of symptoms usually follows when these patients interpret a physician’s lack of concern as rejection.

Nevertheless, limits should be set regarding patients’ expectations. Physicians should use this strategy while acknowledging the difficulty of the patients’ problems and sharing their deep concern, and perhaps even pessimism, regarding the outcome of the investigations and treatment. It is helpful to make statements such as, “You know, Mr. Jones, you obviously have a very difficult problem here. You’ve seen lots of doctors and had lots of tests and treatments that don’t seem to be helping much. There is no way, given the limited resources available in the ED at 11 o’clock on a Friday night, that we are going to be able to get to the bottom of this. What I can do is examine you and do some tests to make sure that there is no new, serious problem going on tonight. Then you will be able to follow up with your regular doctor on Monday.” In this way the physician can communicate both an interest in the patient and empathy for his condition while setting limits on expectations. Both the physician and patient then understand the “contract” and have a way of terminating the encounter satisfactorily.²⁰

Self-Destructive Patients

Self-destructive patients are particularly difficult to treat. Unlike intractable patients, they do not seek help. Rather, they are repeatedly brought to the ED because of their neglectful and self-destructive behaviors. Their ability to deny their problems is profound and sets up the maladaptive cycle of “nothing is wrong and nothing will help.” Yet their behaviors often require repeated heroic efforts to save their lives. Their

chronic self-destructive behaviors may temporarily meet their immediate needs of shelter and food and perhaps, paradoxically, some of the attention they outwardly reject. This lethal cycle usually leads to a premature death. The *substance abuser*, the *violent patient*, and the *suicidal patient* are included in this category of difficult patient.¹⁰

It is not surprising that ED staff respond to such patients negatively, feel frustrated and helpless, and may even secretly wish them success in their self-destructive efforts. These are among the most difficult patients to treat. In reality, physicians can do little apart from providing appropriate care for the multiple presentations characteristic of this type of patient. The greatest obstacle for physicians may be to come to terms with their own complacency about the survival or demise of such patients. The lack of real concern about whether they live or die or, worse, actually wishing that they would die, is repugnant and produces feelings of self-recrimination. Our inability to relate to the self-destructive decisions made by these individuals contributes to our complacency about their plight. Remembering our own human weaknesses or risk-taking behaviors and viewing their seemingly incomprehensible behavior as a difference in degree rather than in kind may help us to have more empathy for them.¹¹ Being supportive is important. Signs of depression in the patient may indicate the need for psychiatric referral. These patients should be screened for risk of suicide and, when appropriate, held for psychiatric evaluation following medical stabilization.

■ SUMMARY

Dealing with difficult patients is a common problem in the ED. The impaired patient-physician relationships associated with them have multiple negative implications for both patients and physicians. Their treatment may be optimized by using the general principles discussed in this chapter, by dealing realistically with one’s own negative reactions, and by using techniques of crisis intervention where appropriate. These strategies are best applied within the context of a behavioral classification that avoids pejorative terms and stereotypes, labels that differentiate them from “worthier” patients.¹¹ Although this approach is not a panacea for dealing with difficult patients, the framework may help physicians render appropriate care while minimizing personal frustration, medicolegal exposure, and eventual physician burnout.

One of the great challenges of medical practice is to maintain humanity when caring for these difficult and highly vulnerable individuals. By focusing on their humanity, we have the best chance of preserving our own.¹¹ It is easy to care for patients who generate sympathy and noble to care for those who do not.¹³

In the end, the ability to accept distressing behavior as a symptom and to treat even the most irritating individuals with compassion and kindness may be the key to surviving them. When asked how he had avoided burnout after decades in emergency medicine, one well-known patriarch of the specialty simply responded, “You’ve got to love the patients.”³¹ This is a tall order, and not meant in the literal sense. But the degree to which we can show caring and empathy, even to the unlovable, may be the key to maintaining the quality of our care, our satisfaction with the specialty, and our long-term survival in practice.