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Patients at a polyclinic in January 2020. The writer, a senior consultant psychiatrist, says doctors can be bad at communicating with patients – slipping into medical jargon, not giving enough information, or failing to make consistent eye contact with patients. The latter is made worse by the electronic medical record systems, with doctors typing away at the keyboard while conducting their consults. ST PHOTO: KUA CHEE SIONG

ByInvitation

Being patient with difficult patients

Doctors are people, too. Sometimes it's hard to maintain a professional calm amid patients' demands and strange behaviour. This can cause its own, personal, side effects. What's the cure?

Chong Siow Ann
For The Straits Times

"I did not like those patients. They made me angry, and I found myself irritated to experience them as they seemed so distant from myself and from all that is human. This is an astonishing intolerance which brands me a poor psychiatrist."

Those exasperated words were written by no less than the father of psychoanalysis, Sigmund Freud, on his psychotic patients in a letter to a fellow psychiatrist in 1928.

I'm a psychiatrist and I don't fear my patients with psychosis (a mental disorder where there is a distortion in one's sense of reality with the common occurrence of hallucinations and delusions); I feel that I can understand and accept their occasional challenging behaviour.

It is patients with hypochondriasis, which involves the persistent belief that one has a serious illness despite extensive medical evaluation to the contrary, that I find particularly demanding, and even dread.

These patients would have already made the rounds of numerous specialists about some physical complaints that have inexplicably taken root and utterly dominated their lives.

They would have had an array of blood tests and CT and MRI scans that revealed no abnormality but provided not an iota of reassurance to them. More often than not, it has the opposite effect of convincing them that they are seriously afflicted with some ailment that all the doctors so far have failed to diagnose. And they would come to see me albeit reluctantly but at the vehement insistence of these other specialists.

The desperation of these patients often shrouds me in haplessness, as they want a confirmation that is impossible for me to give.

I often find myself in a bind: expressing concern for their distress only heightens their sense that something is wrong, while any suggestion that the symptoms are psychological upsets them.

Admittedly, there could be another reason for my aversion – they may mirror my own latent feelings of hypochondria(which many doctors are said to have) and remind me of the uncertainty of life.

DEALING WITH 'HATEFUL PATIENTS'

Exactly 50 years after Freud wrote that rueful letter, James E. Groves, a psychiatrist from the General Massachusetts Hospital in Boston, published a paper entitled Taking Care Of The Hateful Patient in the venerable New England Journal of Medicine.

In his article, he described patients who "kindle aversion, fear, despair, and even downright malice in their doctors". Groves proposed four subtypes of such "hateful patients": dependent clingers, entitled demanders, manipulative help-rejecters, and self-destructive deniers.

I read the article with mixed feelings. On the one hand, I was discomfited by the language as Groves growled at the clingers with their "repeated, incarcerating cries for explanation, affection... and all form of attention"; demanders for their bullying tactics of "intimidation, devaluation and guilt-induction"; help-rejecters with their "quenchless need for emotional supplies"; and deniers for their "self-murderous behaviours".

On the other hand, I admired his honesty and felt a sneaking sense of comradely commiseration – after all, I, too, had trying patient encounters that left me feeling depleted, angry, frustrated, and yes, guilty and ashamed for having such feelings. I also felt resentful at these patients for denting my cherished self-image of a humane and empathetic doctor.

The fact of any medical practice is that such "difficult patients" – a less pejorative term that we use these days – are unavoidable in our life as a doctor, regardless of the medical specialty.

In one study of more than 500 patients attending a primary care clinic, the doctors rated more than 15 per cent of their patients as "difficult".

Common situations involved patients who demand certain investigations after researching symptoms and disorders online, who make threats of legal or social media action, express mistrust and dissatisfaction about the doctor's diagnosis; and those who keep harping on about negative outcomes or doggedly fail to adhere to treatment recommendations.

Patients have various avenues through which to pursue their grievances about their doctors. These include departments in hospitals which handle patient complaints, the Singapore Medical Council and the ever-accessible social media.

Doctors, on the other hand, have nowhere to turn to except perhaps the sympathetic ear of a trusted colleague.

Without any relief, doctors can end up feeling helpless, disrespected, demoralised, disillusioned, burned out, abused, or even fearful, if threatened.

DOCTORS SEEN AS SUPERHUMAN

Until Groves published his paper, most medical texts had either ignored this aspect of patient care, or else had provided advice that was more inspirational than of any real practical help.

Despite its acerbic tone, Groves' paper resonates with all doctors as a distress message about the predicament they find themselves in, and the lack of formal training to anticipate and manage difficult patients.

If anything, medical training inculcates the notion that we should mask our inner-most feelings and filter our thoughts to provide effective doctoring.

Talking about our feelings is seen as too touchy-feely. Besides, most patients and their families want their doctor to be preternaturally calm, reassuringly level-headed and always in control, when they feel worried, afraid and uncertain.

But it is impossible for doctors to maintain that professional equanimity all the time and with all their patients.

As with any relationship, the way that parties view each other is coloured by their own emotional baggage. So when things go wrong with our patients, it is almost reflexive that we blame them – many psychiatrists have an unfortunate penchant to label any difficult patient as having a personality disorder.

Patients, in turn, project their repressed fears and insecurities on their doctors which can manifest itself in any variety of aggravating behaviour. However, while this can be due to a mental disorder, especially depressive and anxiety disorders, the majority are not.

SNAPPY DOCTOR SYNDROME

Doctors themselves often contribute to the bad interactions with their patients. They can become angry or defensive because of fatigue, stress, or frustration, which might make them snappish and curt.

Many doctors are overworked with more and more patients crammed into shorter and shorter visits. They can be troubled by personal problems – marital discord, a sick child, financial worries, or a combination of multiple woes.

And doctors can be bad at communicating with patients – slipping into medical jargon, not giving enough information, or failing to make consistent eye contact with patients. The latter is made worse by the electronic medical record systems, with doctors typing away at the keyboard while conducting their consults. (A study has shown that in the consultation room, doctors devoted half of their patient time facing the screen to do electronic tasks which spilled over after hours – some have dubbed this practice as "death by a thousand clicks"). This can give the patient the impression that they are not listened to and they feel slighted.

In his book How Doctors Think, physician and writer Jerome Groopman wrote: "Patients... swim together with physicians in a sea of feelings. Each needs to keep an eye on the neutral shore where flags are planted to warn of perilous emotional currents." This describes how a doctor's feelings about his patient can cause cognitive errors which can cause grievous damage to the patient.

To avoid those treacherous waters, one needs to be more self-aware. This involves a doctor considering not just signs and symptoms that a patient has, but also the underlying feelings and emotions, fears, expectations and hopes. And this, all the while simultaneously monitoring his own emotional responses to the patient and keeping in mind how his own beliefs and biases affect that relationship.

Patients, too, need to be active participants in their care, but in a mutually respectful manner and without expecting the impossible.

But if that is not achievable for whatever reason and the doctor feels that he can't work with the patient to his benefit, then he should do the right thing and transfer the care to another colleague. Likewise, if the patient feels that his doctor dislikes him, then he should find another one.

I still see my patients with hypochondriasis. I'm still trying to figure out how to help them with all those conflicting feelings inside me when I'm with them. I'm not quite there yet with the right feelings towards them, but I'm working on them.

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