

The “Difficult” Patient Reconceived

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Fiester, A. "What Mediators Can Teach Physicians about Managing 'Difficult' Patients," *American Journal of Medicine*, 2015: 128(3), 215-216.

Fiester, A. "The 'Difficult' Patient Reconceived: An Expanded Moral Mandate for Clinical Ethics," *American Journal of Bioethics*, 2012: 12(5), 2-7.

Overview

- Between 15%-60% of patients are considered “difficult” by their treating physicians
- Literature → challenging clinical encounters are caused by **patient's pathology**
- **My View:** behaviors labelled “difficult” ← responses to problematic interactions or negative experiences related to the delivery or experience of medical care
- “Difficult” patient = reacting to perception of ill treatment, feels morally wronged, frustrated
- Solution/Obligation → employ skills mediators use to understand the grievances of those patients & address them

The Conventional View of the “Difficult” Patient

- Research on the “difficult” patient
 - Defines the problem exclusively from the physician’s perspective
 - Cause → patient’s psychological problems or character flaws
 - Common Hypothesis: “difficult” patient is caused by presence of a psychiatric disorder

Actually: normal reactions

- Some of what is deemed “psychological pathology” in studies of “difficult” patients falls well inside the range of “normal” for individuals faced with significant life-stressors like illness or the perception of being treated unfairly

What Behaviors are “Difficult”

- “patients who make repeated visits without apparent medical benefit, patients who do not seem to want to get well, patients who engage in power struggles, and patients who focus on issues seemingly unrelated to medical care” (Haas 2005)
- “demanding, disruptive, attention-seeking, annoying, and manipulative behavior” (Knesper 2007)
- “time consuming” & “manipulative” (Hahn 2001)

Reconceiving the “Difficult”

- ❖ My focus will be on the WORST manifestations of challenging behavior:
 - raising one’s voice or shouting, using foul language, making accusatory remarks or insulting comments, making racial or ethnic slurs, or using sexist, homophobic, racist, or anti-Semitic epithets

What Behaviors are “Difficult”

■ CLAIM:

If these incontrovertibly inappropriate behaviors lend themselves to a more compelling explanation than **patient-pathology**, then less offensive, more benign behaviors surely will.

Case

- Fred is a 16-year-old with an incomplete C-4 injury to his spinal cord as the result of a gunshot wound. He is currently unable to move his arms or legs, though he does have sensation in his lower extremities. Before his injury, Fred attended school intermittently and was on probation for heroin possession. His mother is unable to visit during the week because of her work schedule and his elderly grandmother is homebound. Since he has come to the rehab hospital, Fred has been verbally abusive to staff, frequently using sexist or homophobic slurs. His cursing, often loud, distresses the other patients, as well as the physicians and other staff. Fred often complains of pain and screams loudly when moved, though his physicians insist he is on the highest dose of narcotics that they feel comfortable prescribing. Because of Fred's language and derogatory comments, both physicians and nurses are starting to refuse to work with him.

Fred is difficult.

Accounting for Fred's Behavior

WHAT MAKES FRED ACT THIS WAY?!

Fred is angry.

Accounting for Fred's Behavior

■ Seven Maxims of Mediation

(Fiester, A. "What Mediators Can Teach Physicians about Managing 'Difficult' Patients," *American Journal of Medicine*)

Seven Maxims of Mediation

1. *“Difficult” people should be viewed as a syndrome, not a species*
2. *Anger is a reactive emotion, so the key is finding its source*
3. *It takes mere seconds to escalate or deescalate a brewing conflict*
4. *Calling someone out for bad behavior will inevitably make matters worse*
5. *Exercising neutrality ups the odds of successful conflict resolution*
6. *UNCOVER INTERESTS: Naming the patient’s concerns demonstrates alliance, avoids creating an adversary, provides a starting point*
7. *A sincere expression of consolation can go a long way in defusing a tense interaction (“I am so sorry that...”)*

Fiester, A. “What Mediators Can Teach Physicians about Managing ‘Difficult’ Patients,” *American Journal of Medicine*

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Revisiting the case from Fred's perspective: What is making Fred angry?

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Accounting for Fred's Behavior

- What is Fred's experience on a daily basis?

How often does Fred feel:

- **Patronized?**
- **Dismissed?**
- **Demeaned?**
- **Humiliated?**
- **Stereotyped?**

Accounting for Fred's Behavior

- ❑ How many indignities has he been subjected to in his stay?
- ❑ Does he feel powerless and emasculated, and, if so, from the injury or the treatment they are giving for it?
- ❑ Does he feel heard, validated, and respected?
- ❑ Does he believe that his care team are treating him as well as they treat all other patients, or does he sincerely believe that their view of him is prejudiced by his past truancy and heroin use?
- ❑ Does he feel victim to being branded “drug-seeking,” “gang member,” “high school drop-out,” or “junkie”?

Accounting for Fred's Behavior

❖ Does he believe that the clinical team *really* cares about him?

DO THEY?

Accounting for Fred's Behavior

- Does Fred feels mistreated, misunderstood, or wronged?
- Those feelings provoke the **Moral Emotions**

Moral Emotions

Moral Emotions =

A category of emotional response that functions as a radar to detect when an individual has a perception of moral offense, wrong-doing, slight or harm

Classic 3 Moral Emotions:

- Anger
- Resentment
- Indignation

Accounting for Fred's Behavior

- Persons who feel indignation, resentment, and anger are susceptible to manifesting their moral grievance in counterproductive ways
- CLAIM: The “difficult” patient is someone reacting inappropriately to the perception that one or more of their interests is being thwarted, negated, dismissed, ignored

Addressing Fred's Concerns

- If the “difficult” patient is someone who has a moral grievance, our obligation is to address that grievance
- What can be done to address Fred's concerns?

What can be done to address Fred's grievances?

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But wait...

- **OBJECTION:** Which came first, his bad behavior or his perception that he is being treated badly?
 - Assume: he treated the staff badly from the moment of admission
 - Not caused by a loss of faith in the medical establishment from his stay at the acute-care hospital
 - Fred is merely angry at the horrific situation he finds himself in:
 - He is merely angry at fate, God, the person who shot him, his family ...

My rejoinder:

- **OBJECTION** : Which came first, his bad behavior or his perception that he is being treated badly?
 - What reactions did he get at the rehab hospital to his understandable feelings of anger and frustration?
 - What stereotypes or bias lie underneath the attitudes or perceptions of his current caregivers?
 - What sources of support did they offer him?
 - How did they reassure him that his mental, spiritual, emotional, and physical well-being would be safeguarded with them?
 - How did they address his grievances?

Ethical Obligations to the “Difficult” Patient

- If “difficult” patients *perceive* themselves as wronged in the medical encounter, then ethical duty to
 - address,
 - validate,
 - repair, or
 - assist in making amends
- (That duty exists whether the ethical harm is perceived or real.)

Summary

- Prevalent view of the “difficult” patient is that the challenging behavior stems from a **patient’s pathology**
- **My Argument:** challenging behaviors are a maladaptive response to a perceived grievance
 - “Difficult” patient = feels morally wronged, affronted
- Obligation → understand and address those grievances
- Need to refocus our attention on the *cause*, not the *effect*