Diagnosis and management of problem patients in general practice

WHO are our problem patients? Although many small group discussions involving general practitioners concern the management of this group of patients, little has been published to help doctors look after them.

Whitenack and McGoughie[1] attempted to provide quantitative measures of problem patients by comparing 26 people identified as 'problem patients' with 'non problem patients'. Not surprisingly, the former group scored higher on scales relating to adverse health beliefs and psychological dysfunction.

Groves classified and defined four categories of difficult patients:[2] (1) the 'dependent clinger' who expresses excessive thanks and gratitude for actions taken by the doctor but who also seeks repeated reassurance about minor problems; (2) the 'entitled demander' who appears to view the doctor as a barrier to receiving services and who frequently complains to health authorities about imagined shortcomings in the services received; (3) the 'manipulative help rejector' who presents a series of symptoms which the doctor is powerless to improve; and (4) the 'self destructive denier', for example the patient with severe peripheral vascular disease who refuses even to consider reducing his cigarette intake.

General practitioners will know of patients in each of the above categories and could probably invent more of their own. Problem patients provoke a variety of responses in doctors which vary from mild dislike to aversion and rejection. What is it about these patients which makes us dislike them? Is it their repeated requests for our attention and their subsequent rejection of our advice? Much of general practice is concerned not with curative medicine but in helping people come to terms with illness, disability or problems with relationships. We expect patients to at least consider and possibly comply with the advice we give them. Problem patients do not comply with our advice as we would wish. In addition, their repeated consultations are a reminder of our ineffectiveness.

While doctors may wish to 'know all, love all and help all',[3] Campbell[4] argues that all the caring professions modify their compassion when dealing with problem patients and describes the ways in which the different professions do this. However, the literature on the conflicts which occur in therapists who are seeking to help difficult patients is sparse for general practitioners compared with psychiatrists. We need to recognize that there may be unconscious punishment of the patient, self-punishment by the doctor and even attempts to exclude the patient from the health care system[5-7] when the doctor–patient relationship is under stress.

The first step in managing difficult patients is to accept our own feelings about them. In the consultation we cannot avoid negative feelings towards some patients nor pretend that they are unimportant. Without recognition of these feelings, needless, unpleasant and unnecessary investigations may be ordered and referrals to specialists may take place because of a need by the doctor to escape for a time from contact with the patient rather then a real need for a second opinion.

What sources of help do general practitioners have in dealing with difficult patients? Many practices now have access to marriage guidance counsellors and clinical psychologists. As well as helping patients directly, counsellors and psychologists can assist general practitioners in dealing with their own feelings about particular patients. Other sources of help for patients also exist. Self-help groups, the extended family network, and religious organizations are just some of the resources which are directly available to patients. Similarly it is important to recognize that not all problems require solutions. To deprive someone of a reason for seeking help may not be desirable.

Recognition of negative feelings towards patients and the constructive use of these feelings may help the doctor and consequently help the problem patient. The work of Balint and his colleagues not only gave new insights into the behaviour of doctors and patients but also led to the setting up of Balint groups which are a practical way of assisting doctors to help patients whom they find difficult.

Although in thinking about problem patients we tend to think of extreme examples, we all have the potential to be difficult either as doctors or as patients. Further examination of how doctors deal with problem patients may provide insight into the nature of all consultations.

JOHN COHEN
Senior Lecturer in General Practice, Middlesex Hospital Medical School

References

1. Whitenack DD, McGoughie WC. Towards an empirical description of problem patients. *Fam Med* 1984; **16:** 13-16.
2. Groves JE. Taking care of the hateful patient. *N Engl J Med* 1951; **298:** 883-885.
3. Maltsberger JT, Bull DH. Countertransference hate in the treatment of suicidal patients. *Arch Gen Psychiatry* 1974; **30:** 625-633.
4. Campbell AV. *Moderated love: a theology of professional care.* London: SPCK, 1984.
5. Hackett TP. Patients which turn you off — it's worth analysing. *Med Econ* 1969; **46:** 94-99.
6. Adler G, Buie DH. The misuses of confrontation with borderline patients. *Int J Psychoanal Psychother* 1972; **1:** 109-120.
7. Groves JE. Management of the borderline patient on a medical or surgical ward: the psychiatric consultant's role. *Int J Psychiatry Med* 1975; **6:** 337-348.

THE IRISH COLLEGE OF GENERAL PRACTITIONERS

FOUNDATION MEMBERSHIP

The College was established in 1984. Membership now stands at 80% of general practitioners practising in Ireland, and some 300 doctors practising overseas. The foundation period for membership comes to an end on 27 March 1987. Thereafter membership will be by way of examination only.

If you are interested in becoming a member of the Irish College of General Practitioners, for further details write to:

The Administrative Secretary
Irish College of General Practitioners
Corrigan House
Fenian Street
Dublin 2
Ireland
Telephone: 763705