COMMENTARY

Difficult to Treat Patients: Why Do We Label Them as Such?

J. Coll Verd
Palma de Mallorca, Spain.

Is it not true, that on reading the list of patients before starting the clinic, we make an initial classification and we put difficult to treat patients into a category (due to not mentioning other possible more descriptive labels) of those which we assume are going to make the consultation difficult?

Do we not stop to think that surely we are conditioning the subsequent development of the consultation, on letting ourselves be influenced by what we may call, prejudices, pre-conceived ideas?

Why we not take time to try to establish and analyse the possible causes of a difficult relationship with a patient that we label as "difficult"?

Is it true that we believe that these patients are generally more discontent with the health system and care received?

All doctor-patient relationships, as far as human interaction is concerned, have an inevitable emotional content but, why should this emotional component be even more powerful in relationships with these difficult to treat patients?

If we look at the different definition criteria of these patients we can see that they are disparate, although what they will have in common is the capacity to cause distress in the health professionals who care for them. In these times when there is more professional discontent and burnout than is desirable, it could be thought that these difficult to treat patients are one of the possible causes, as has been suggested by some authors.[1]

It is good news, therefore, that the study by Mas et al,[2] in which they did not find this supposed dissatisfaction in these patients and instead demonstrated a good degree of satisfaction, which even exceeded that obtained in a sample of the general population in some sections. Although it is true that other studies have shown a greater dissatis-

Key Points

- Patients labelled as difficult to treat represent a considerable percentage in the daily clinic.
- The criteria of those who are included in this category are normally subjective to a certain extent, and with a significant emotional burden.
- The idea that these patients are more discontent with the care they receive appears to be misconceived.
- To try to understand these patients better and our attitude against them can be a good way to decrease the perception of difficulty in treating them.
- It would be more appropriate to talk of "difficult encounters," where the patient as well as the professional should have their share of responsibility.
- There are efficient strategies to modify our communication skills and thus improve the ability to face up to these types of relationships.

faction in these patients, but with doubtful methodologies. In one of these studies,[3] a higher level of discontent in those patients is shown in some aspects, such as explanations received, the perception of the competence of the staff and the time dedicated to the consultation. More time? Would that be able to stop there being difficult to treat patients, if we could dedicate more time to them?

We might say a nihilistic attitude should be adopted with these patients, that is, to consider them as an inevitable load that we have no other option than to accept it ("the sooner and quicker the visit is over, the better"), or perhaps try and analyse the possible causes with the aim of designing mechanisms to improve the relationship. This latter would be a much more suitable and possibly effective strategy, particularly taking into account that the proportion of this type of patient in the clinic is not insignificant (between 15% and 30% according to different authors). An evaluative attitude, as pointed out by Blay,[4] might enable us to adopt a series of treatment measures for these patients that could improve our relationship with them, at the same time as decreasing the professional burnout inherent in these difficult relationships. In any case, this evaluation should not only be limited to the patients, but also to the professionals themselves. It is not enough to ask: why is this patient acting in this way? without the need to look into our own behaviour: why do I adopt this attitude with this patient?

If there are difficult to treat patients, can we not also have difficult to treat doctors?

And this placing of the label "difficult" on a patient could sometimes be the result of the inability of the doctors themselves to manage the situations that certain patients create.

Perhaps, as other authors advise, it would be more appropriate and realistic to talk of "difficult encounters" more than difficult to treat patients. It would be in those cases where the patient or the professional experience the encounter with displeasure, for many and different reasons which should be analysed. This continuous evaluation and in both directions, without a doubt, requires a real effort and great capacity for self-criticism, as there does not appear to be many alternatives.

The study by Mas et al surely makes us see these patients with other eyes, on knowing that their satisfaction and confidence in our services is not less than the rest of the patients.

As the authors mention, a factor which possibly contributes to this satisfaction is the continuous care, unlike that observed in other studies where visits carried out by any professional and not necessarily by the family doctor.

Therefore, continuity plays an important role in the increase in satisfaction, although we could ask ourselves if it may simply be a mutual adaptation mechanism over time which contributes to smooth out differences and difficulties.

A great virtue of this study, is that it approaches the point of view of the patient in our setting, and does not just contemplate the professional point of view, like the majority of studies on this subject.

It seems obvious that it is fundamental to obtain more information and attempt a better understanding, both of the patient and our own mechanisms, as well as improving our communication skills, if we want to decrease the perception of difficult to treat. It is not an easy task and no doubt requires time (which is already so scarce), but is surely a good investment if we consider, as has already been mentioned, the percentage of patients who we put into this category and the emotional burden that usually comes with treating them.

References

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