An Encounter with "the Difficult Patient"

Rabia Iqbal, MD

On morning pre-rounds during my Methodist rotation, I was rushing to see all the patients in anticipation of the bolus of admissions that would be coming in soon. I spotted the gray and yellow cart near my patient's door and opened the cart door while simultaneously trying to fit my handoff into a scrub pocket. I was about to knock on the door with my gown and gloves on, but my flimsy gown was falling so I ended up opening the door with my leg as I was retying it around my neck. The nurse down the hall briefly looked at me and smiled as if I was doing a whimsical dance. "And we don't knock on doors anymore?" said Mr. W in his resounding voice and skeptical tone. Frozen in the doorway, my hand was still clinging to the doorknob as I straightened my back and offered a sincere apology. No reply from Mr. W except an annoyed gaze as he put his cereal spoon down. I let go of the doorknob and approached him. I asked him how he was feeling now but he looked away and gave no response. "What about your shortness of breath? Is it better now?" I asked. He finally responded, "Just wait until you see me walk down the hallway then you'll see how short of breath I get." I asked him if he had gotten a chance to walk the hallways yet and he hadn't. He then asked me to leave his room and I obeyed.

My initial reaction was feeling a sense of guilt and frustration at not being able to get through to this patient on one hand and resentment towards his behavior on the other. But Mr. W was infamous for being "difficult" as my intern warned me earlier that week, so I took a step back to reassess the situation. His medical record had other instances of negative interactions with providers in the past, the definition of the so-called "difficult" patient. Was it simply a result of his personality, as suggested by an initial glance at the encounter? Perhaps his chronic conditions included a bad temper and angry disposition that led to deflection of any meaningful engagement with providers. Were a few problematic encounters enough for me to impart such a judgement on him, especially knowing they would forever put a label on him during his future visits? The answer was no, of course, and besides Mr. W appeared cheerful when speaking with his family members over the phone.

Mr. W questioned each test, lab, or medication offered to him as to whether it was actually going to help him get better. At one point, he wanted to speak to representatives from patient relations and hospital administration, but even a great amount of explanation couldn't lessen his skepticism toward medical treatment. What made him "difficult" was not simply a result of his personality but seemed to stem more from his perception of suboptimal, or worse, ill-intentioned treatment. Being an African American male potentially contributed to this perception for historical reasons. Furthermore in Mr. W's case, he told us he felt dismayed at being discharged before a "full medical recovery" or at least his expectation of such a recovery. He lived with the idea that he could somehow get better enough for his sickness to leave him altogether. Repeated explanations of the pathophysiology of heart failure and lymphedema of the legs could not reassure him. But instead of focusing on Mr. W's seemingly counterproductive behavior, I decided to use my role as his provider to try to change the pattern of our encounters.

In part, what had made me perceive Mr. W as a "difficult" patient had to do with my own experience with patients who would not open up to me for help on their own accord. My first reaction of feeling frustrated at not being able to talk to him meant that it was actually the conversation that was the difficult part. I had to find a way to have a meaningful conversation, so I thought back to the time in medical school when I was taught to begin medical interviews with an open-ended question followed by a period of reflective listening. This is where I would reiterate back to the patients their narratives in my own words in order to make them feel heard. Another strategy would be to reflect the feelings they were conveying through their narrative or body language if they decided to keep silent. Although it seemed archaic when I learned it as a student, I now felt it was a tool I could use to help this patient, so I decided to give it a try.

I was once again met with silence when I entered his room. "It must be really hard having to live like this," I said as I approached him. "You have no idea," he replied with a weak smile for the first time. He had a look of helplessness and shame on his face and was starting to cover himself with a blanket. Living with huge legs was not easy and he deserved some empathy. Finally, after days of refusing to be discharged from the hospital, he came around to it. I brought a computer to his room and showed him his lab results and follow-up appointments per his request. He let me explain to him the importance of taking his medications and keeping his appointments. As I was leaving the room, he thanked me but also said that he was planning to come back to the hospital next week in his usual sarcastic tone. This time, however, he seemed to be in good spirits and even sounded friendly. "You're welcome to if needed" I said, "and we'll take good care of you each time." He was still smiling as I left the room.