COMMENTARY

Understanding and Engaging the Hostile Patient

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Mr A is a 42-year-old man who presents with substernal chest pain and is found to have had a myocardial infarction. After being evaluated and stabilized in the emergency department, he is admitted to the critical care unit for catheterization. When his medical team enters the room for the first time, Mr A haughtily surveys the group and announces: "Well, if it isn't another white-coat brigade…and this one looks younger than the last group! Don't think you're going to get me to jump through any more hoops…I did that already for those clowns in the emergency room, and I'm done. I'm outta here."

How should a physician respond to such a patient? Frequently, the first reaction is surprise and anger, often mixed with a desire to avoid the patient as much as possible. However, the physician must be flexible enough to move beyond this initial reaction to an attitude conducive to the development of a working relationship, often despite the patient's best efforts to prevent it. As Groves wisely says in his classic paper, "What the behaviors of such patients teach over time is that it is not how one feels about them that is most important in their care. It is how one behaves toward them."[1]

But how *should* the doctor behave with the Mr A's of the world, who seem to be spoiling for a fight? Although patients may be "difficult" for many reasons, such as hostility, psychosis, passivity, help-rejection, denial, entitlement, and rage,[2,3] the final common pathway for the physician's reaction usually involves frustration[4] and dread. A better understanding of what is happening experientially for the patient can provide a basis for more useful responses. What do we know so far about Mr A? It would appear that he can be rude, dismissive, demeaning, and controlling. These are signs; but what are the symptoms—and the human story—behind them? One of the problems with patients like Mr A (and indeed, what helps make them difficult) is that they are unaware of their emotional state, aside, perhaps, from their anger. The task for the clinician is to realize the degree to which fear, anxiety, or other feelings—rather than simple hostility—produce the patient's offensiveness.

Recognition that some degree of fear and anxiety is natural in hospitalized patients can help a physician remain constructively engaged with them. The clinician with a personal or family history of serious illness could more easily see the hospital milieu from the patient's perspective and begin to understand the off-putting behavior. The physician must lose no time in quickly translating the patient's communication into less toxic language. In this case, Mr A has essentially said "I'm mad, I don't take your authority for granted, and I'm doing what *I* want to do." Keeping this translation in mind allows the clinician to avoid the following kinds of potentially inflammatory response:

"I'm Dr B, and this is the team. As you know, you've suffered a significant heart attack and it would not be safe to leave the hospital now;"
"Mr A, I'm afraid I can't talk to you if you make threats and demands;" or
"Pardon me, but we need to know if you're still having chest pain or shortness of breath."

Such responses risk inflaming Mr A because they do not recognize that his hostility is not personally directed but rather serves to keep others at arm's length so that he can avoid feeling fear and anxiety. This is what he *knows how to do* in dangerous situations; his offensiveness is not reserved for physicians alone. The wise clinician deflects the anger and responds first to the fear, recognizing that despite appearances, the anger is not meant personally. The physician needs to *show*, rather than *explain*, that he intends no threat and just wants to help. Three tools are of vital importance here: the handshake, the ID badge, and the chair.

Smiling, Dr B walks up to Mr A's bedside, offers his hand, shows him his hospital ID badge, and says: "I'm Dr B and I hear you were in the emergency department for a long time. Would you mind if I sat down so we can talk a bit about your condition?"

Skeptical readers can be forgiven for thinking that "making nice" with such patients is a waste of time. The attitude exemplified, however, serves 3 useful functions. It communicates respect for the patient's feelings (however unpleasantly expressed), emphasizes the collaborative nature of

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the work to be done, and allows the patient some measure of control over the interaction. Dr B is careful to avoid even subtly taking the bait of Mr A's hostility, invariably a fruitless proposition.

Mr A warily shakes Dr B's hand, glances at the other team members with contempt, but does not object when Dr B sits down next to him. Mr A continues: "I told you, I'm getting out of here. I've had it with needles and [he flings off his nasal oxygen] this stupid tube. My wife is coming to get me. I'm fine."

Is this really a competency issue? Does Mr A not understand that he has had a myocardial infarction? Is he about to leave against medical advice? These questions can be answered only after someone asks Mr A what *he* thinks is going on. Unless a few minutes are immediately invested in allowing the patient to tell his story, convey his view of the situation, and vent his emotions, the possibility for collaborative understanding could be lost. A common tactical error is to address competency (more accurately, "capacity") issues before some minimal solidification of the therapeutic relationship. Dr B sidesteps the discharge issue, recognizing that it is not yet ripe; he first needs to know more about how the situation looks from Mr A's perspective.

Dr B, avoiding the temptation to remind Mr A of the gravity of his situation, says to him: "I understand you were in a bar with some friends when you began having some pain in your chest. How do you feel now?"

Even the well-adjusted patient can hear the question "What brought you to the hospital?" only so many times in the course of a day without becoming irritated. For the angry and demanding patient, twice can be too often. The prepared clinician already has some idea of what brought the patient in; communicating this knowledge to the patient staves off the "Don't you idiots *talk* to each other?" reply that often greets the clinician who asks *first* to be told the whole story again. Dr B leads his inquiry *not* with a request to be told the chief complaint, *not* with an attempt to determine Mr A's capacity to sign out against medical advice, and *not* with an attempt to maintain authority by making it clear who's the boss. Instead, he prioritizes the patient's discomfort and asks about it.

"Goddamn lousy," replies Mr A. "I still can't breathe right, I'm black and blue from where some moron stuck me 10 times looking for a vein, and now little Miss Barbie over there [he points to his nurse] says I'll need a 6-foot wire up my crotch for the next test? You're dreaming. My wife's taking me out of here."

Mr A makes nothing easy. Yet like a rock climber searching for the tiniest handhold, the clinician in these circumstances must look for any opportunity to have a nonvolatile exchange with the patient. For the moment, Mr A seems too upset to discuss the medical specifics of his situation; a different tack should be tried.

Dr B (having noted that Mr A has mentioned his wife twice) says: "How is your wife doing with all this?" Mr A answers: "She was goddamn hysterical on the phone when they told her I had had *a heart attack. That's how my old man died, and he was younger than me. Jesus—first we find out last week that our kid has been using cocaine, and now this."*

Now things have started to open up a little bit. By consistently refusing to verbally retaliate, Dr B has efficiently uncovered other stresses burdening Mr A, who has, probably without being aware of it, confided in his physician. Physicians often feel that they lack both the time and the skill with which to uncover such matters. In fact, it may only take a few minutes; what matters is that the physician approaches the patient with curiosity about his activities and relationships.[5,6] Common sense is more useful than expertise here. Once physician and patient have had a conversation *on any topic,* it will be easier to get down to business. (Dr B makes note of another important point: Mr A knows that he has had a heart attack, and that heart attacks kill people. These will be important data if the AMA discharge issue comes to a head.)

Is Dr B losing valuable time by not focusing on the medical facts? In reality, the scenario played out thus far would likely take less than a minute or two, and this small investment of time could make the difference in developing a working rather than an adversarial relationship. Just as the typical operative note indicates that before an incision was made the patient had been "prepped and draped in the usual sterile fashion," so with the contentious patient some preparatory alliance-building must be done if the patient is to decide to collaborate—rather than fight—with his caregivers. Often this involves talking about anything *but* the disease process itself; physicians must resist the temptation to think that their job is only to manage disease.

Dr B decides to stick with Mr A's family situation briefly and asks: "Will your wife be OK?" Mr A replies: "She's already frantic about our kid, and I'm the breadwinner. If I kick off, she's sunk. Am I gonna die, Doc?"

Now Mr A is starting to sound less like a difficult patient. This is the opening for which Dr B has been preparing.

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Here is the chance to begin a dialogue about the medical aspects of the case.

Dr B replies: "Well, things could have been much worse. It looks as if you're going to pull through fine, as long as we can work together. Can I explain what our game plan should be?"

Now Dr B can begin to discuss more traditional medical subjects such as diagnosis and treatment. Keeping in mind the fact that Mr A is obviously not someone who likes feeling dictated to, Dr B emphasizes the *collaborative* nature of medical care and is careful to again ask Mr A's permission to explain how they might work together. As a general rule, discussions with challenging patients should make copious use of the pronouns *we*, *us*, and *our* rather than *I*, *you* and, *your*. A helpful model here is that of "doing business" with a patient. This implies a need to recognize the patient's position and to be willing to *negotiate, rather than dictate* a plan with which each party feels reasonably satisfied.

Does this approach sound like indulging or caving in to the needs of a demanding person? Should the physician not take a firm line to ensure best medical practice and to keep the patient from running the show? Obviously, the goal is not to cater to all the whims of the demanding patient. Neither physicians nor other staff members should be the objects of ongoing harassment. Yet by bending a little at the beginning of the interview, by giving the patient a *limited* opportunity to be difficult, physicians will find that, as in the case of Mr A, they are soon able to move forward.

Mr A replies: "OK, but I'm not staying for a week…I have to get back to work. And what about this business with that wire up my crotch? You can forget about that. Isn't there some other test you can do?"

Mr A is trading hostility for curiosity, a sure sign of a patient who is feeling less threatened and more listened to. Now that Mr A is more receptive, Dr B can carefully begin to communicate more medical information:

"If we can be on the same page and there are no complications, I think you'll be out of here in a few days. Here's the deal with that wire: the bad news is that we do need to put it in to see what shape your heart's blood vessels are in; the good news is that we can give you some numbing medicine first, and it's not usually too bad."

Once again, Dr B emphasizes the fact that medical treatment involves *working together*, not *being done to*. Some standard clarification regarding length of stay and the nature of cardiac catheterization begins to defuse those subjects as opportunities for struggle. Dr B is careful to respond concretely and specifically to Mr A's fears; once the patient knows that the physician knows how he feels, he has less need to get his point across by making threats.[7]

Mr A visibly relaxes a bit and replies: "Doc, I'll be honest with you…don't take this personal…I hate doctors and hospitals…always have since my old man kicked. I was only 8 when that happened. When my chest started to hurt I kind of knew what it was, and it freaked me out."

This is a frequent outcome: by remaining engaged while refusing to retaliate, Dr B has discovered a clearer view of the reasons behind Mr A's behavior. What is hard, especially for doctors in training, is "not taking it personally." Like all clinical skills, this can be practiced.

However, we still know very little about Mr A's formal psychiatric diagnosis, or if he has one. In the heat of the moment, such information is often a luxury; the physician must "aim high" in his attitude to the patient, treating the patient *as if* he could respond positively to being treated as a more adaptive person. Conversely, if Mr A were to be treated as an "entitled demander,"[1] he would likely be only too happy to oblige, to the frustration of all involved.

Does a soft answer turneth away the wrath of all difficult patients? Unfortunately not. Such an approach works with many—but by no means all—patients such as Mr A, who lead with controlling, angry threats. The wide variety of difficult patients demands a wide variety of responses. What I have tried to show here is that the doctor—by taking a moment to see the situation through the patient's eyes—can turn a potential impasse into a productive collaboration.

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REFERENCES

1. Groves JE. Taking care of the hateful patient. *N Engl J Med.* 1978;298(16):883-887.
2. Schafer S, Nowlis DP. Personality disorders among difficult patients. *Arch Fam Med.* 1998;7(2):126-129.
3. Koekkoek B, van Meijel B, Hutschemaekers G. "Difficult patients" in mental health care: a review. *Psychiatr Serv.* 2006;57(6):795-802.
4. Lipsitt DR. The challenge of the "difficult patient" (deja vu all over again—only more so) [editorial]. *Gen Hosp Psychiatry.* 1997;19(5):313-314.
5. Fitzgerald FT. Curiosity. *Ann Intern Med.* 1999;130(1):70-72.
6. Barondess JA. Viewpoint: on wondering. *Acad Med.* 2005;80(1):62-65.
7. Kahn MW. Emergency psychiatry: tools of engagement: avoiding pitfalls in collaborating with patients. *Psychiatr Serv.* 2001;52(12):1571-1572.

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