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ESSAY

# Using Literature to Help Physician–Learners Understand and Manage "Difficult" Patients

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**ABSTRACT**

Despite significant clinical and research efforts aimed at recognizing and managing "difficult" patients, such patients remain a frustrating experience for many clinicians. This is especially true for primary care residents, who are required to see a significant volume of patients with diverse and complex problems, but who may not have adequate training and life experience to enable them to deal with problematic doctor–patient situations. Literature—short stories, poems, and patient narratives—is a little-explored educational tool to help residents in understanding and working with difficult patients. In this report, the authors examine the mechanics of using literature to teach about difficult patients, including structuring the learning environment, establishing learning objectives, identifying teaching resources and appropriate pedagogic methods, and incorporating creative writing assignments. They also present an illustrative progression of a typical literature-based teaching session about a difficult patient.

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There is a large body of literature on recognizing and managing the "difficult" or, in the evocative British term, "heart-sink" patient. But despite the development of useful therapeutic approaches and interventions, for many physicians such patients remain a challenge and a burden. In addition to consuming a disproportionate share of energy and resources, difficult patients also frequently produce feelings of frustration and anger,[1] exasperation and defeat,[2] and even despair[3] in their physicians. These reactions are particularly evident in residents, who, in the midst of ever-increasing responsibility for the care of medically complex patients and the need to satisfy clinic productivity requirements, may not yet have developed successful strategies for managing such patients. Often overworked, fatigued, and frustrated by imperfect care-delivery systems, residents are likely to resort to solutions that enable them to deal with these patients quickly, without ascertaining, and therefore without addressing, the patients' underlying issues and needs. The consequences may include progressive disenchantment for the resident and compromised care for the patient.

One little-explored resource to enable residents to develop greater empathy and generate creative approaches to managing difficult patients is the use of imaginative literature—short stories, poems, and patient narratives—in residency training. It has been claimed that the study of literary works can increase physician empathy, reduce frustration, improve physician–patient communication, and enable physicians to develop new interaction and intervention strategies, with resultant improvements in patient outcomes.[4] In terms of the difficult patient, literature can help residents understand the actual suffering of patients, whose pervasive somatization, psychological disorders, and often intractable medical problems may lead inexperienced providers to feel overwhelmed and resentful.

Below, we describe how a literature-based course on difficult patients can be constructed, based on our own experiences implementing such a course at our institution.

## A Literature-based Course on Difficult Patients

### Time Requirements

Using literature to teach residents about difficult patients can be done in a required 45-minute noon session or a dedicated two-hour session, or in an op-

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*For an article on a related topic, see page 724.*

tional mini-series of informal evening discussions conducted over a two- or three-week period. Each of these structures has advantages and disadvantages; the lunchtime version presents simply a "taste" of the power of literature, but a succession of weekly evening seminars can be difficult to sustain given resident on-call schedules and generally overcommitted lives. When we offer the longer versions of this seminar, we include exercises in creative writing about difficult patients (this is described in more detail below).

### Learning Objectives

As Squier has noted,[5] it is important to develop learning objectives for the medical humanities, despite the "soft" nature of the subject matter. We have set the following objectives for our sessions: by the end of the teaching encounter, residents should be able to (1) show empathy for the difficult patients presented during the session through increased ability to paraphrase the patients' perspectives and model nonjudgmental, compassionate responses; (2) appreciate how point of view, tone, and use of language can express different perspectives and emotional responses in the patients and doctors under discussion; (3) identify a range of emotions evoked in clinicians by difficult patients; and (4) list problem-solving strategies for dealing with these patients. Because residents tend to adopt a "find it and fix it" approach, it is particularly critical that they achieve the first three objectives before moving on to the fourth, so that the management strategies they develop are informed by greater compassion and understanding.

### Teaching Materials

We have used a mixture of short stories, poetry, and excerpts from longer fictional works. Many literary works are especially well suited to the examination of the difficult patient. "Brute"[6] is a well-known story by former Yale surgeon and professor Richard Selzer. In this tale, an older physician warns a young colleague about the dangers of anger and abuse of power in the clinical setting. He recounts an incident from his training in which, confronted by a raging, drug-intoxicated ER patient, he sewed the man's ears to a gurney to subdue him. The story raises provocative questions about decision making and responsibility, the uses and abuses of power, racism, and the "brute" within all of us.

"The Use of Force"[7] is a classic story by the physician–writer William Carlos Williams. Set in the early decades of the 20th century, it presents a doctor's account of his visit to a poor immigrant family that suspects that their daughter has contracted diphtheria. The physician finds a frightened, resistant child who will not allow herself to be examined. Patient and doctor do battle, until the patient is overpowered and the diagnosis made. In this story, the physician is motivated by benevolence, but nevertheless resorts to coercion to overcome the patient's recalcitrance.

"Doc in a Box"[8] is excerpted from a novel of the same name by a practicing neurologist in the San Francisco Bay area. The excerpt we use describes the visit to a walk-in clinic of a patient with a longstanding complaint of headache and his belligerent wife. Although the doctor on duty has just resolved to behave more compassionately toward his patients, he is defeated by this couple's dysfunctional dynamics and his inability, in his own judgment, to render them any real assistance.

Excellent poems relevant to the topic of the difficult patient (many written by physicians or nurses) describe variously a prejudiced, racist patient (Danny Abse's "Case History"); the "worried well" (Mark Ziloski's "Free Health Care"); an unlikable dying patient (Christine Parkhurst's "Case Study"); an irritating geriatric patient (Cortney Davis's "Old Lady Patient"); a noncompliant diabetic patient (James Dickey's "Diabetes"); somatizing patients (Tillman Farley's "Second Thoughts"); a neglectful, drug-abusing mother (Rafael Campo's "Jamal"); a dying, angry AIDS patient (Rafael Campo's "F.P."); and a non–English-speaking pregnant patient with no prenatal care (Rafael Campo's "Maria"). These poems illustrate a range of the problems and frustrations frequently encountered in the clinical setting, and can be sampled from depending on the needs and priorities of the residents.

### Teaching Methods

In the sessions we offer, all teaching is conducted in relatively small groups of six to 20 residents. After a brief introduction to how literature can help residents work with difficult patients, appropriate selections are read aloud. The initial reading is performed by an instructor, to model inflection, tone, and phrasing. Volunteer residents render subsequent readings. While no one is compelled to read aloud, it is stressed that oral reading provides an opportunity to identify with the narrator because the reader is literally assuming the narrator's voice.

After the reading is completed, certain foundational questions are addressed (see List 1). These basic questions are designed to ensure that all learners are on an equal footing and have a basic understanding of the selection. Experience has shown that such questions also instill confidence in residents, who, despite their many years of education, may be uncertain about discussing a literary work.

Next, residents' reactions to the characters (including patients and physicians) are examined. In discussing difficult patients, this phase is particularly important, because it usually elicits some admissions of frustration or irritation, as well as puzzlement about how such a patient could be managed. These disclosures can be followed by questions eliciting alternative views of the patient ("Does anyone see this patient differ-

**List 1**

**Useful Questions for Discussing Literature about "Difficult" Patients**

1. Basic orientation questions

   Who is the speaker?
   What is the point of view?
   What is happening?
   What is the tone of the work?

2. Thematic questions

   What is the selection saying?
   What is the basic idea of the selection?
   How would you interpret the message or point of this selection? Do you agree or disagree?

3. Emotional response/empathy questions

   What is the narrator (and other characters) feeling about his/her/their situation?
   How did you feel about the narrator, other characters, and/or opinions expressed in the selection?
   If you did not like the narrator, other characters, etc., are there any circumstances under which you could feel more sympathetic to him/her/them?
   What would this story be like from the point of view of one of the other characters?
   Did you like or dislike the selection? Why?

4. Credibility questions

   Is the passage true to human experience?
   Is it credible? Does it make sense?

5. Clinical implications

   What message can you take back to clinical practice from this selection?
   What did it teach you that might be relevant to dealing with difficult patients?
   How would you feel about being this person's physician?
   If you were this person's physician, how would you try to act? What might you say and do?
   What have you learned about yourself as a physician from reading this selection?

ently?" "What might be other ways of thinking about this patient?").

In the next phase of discussion, issues of point of view predominate. Questions such as "How does the world look from the patient's perspective?" and "What might explain (although not necessarily justify) the patient's behavior?" are used to help residents enter into the patient's reality and speak in the patient's voice. This phase of the discussion is particularly useful in creating greater empathy for the patient. Having residents practice "speaking in the patient's voice" (i.e., using "I" instead of "she") greatly facilitates this exercise.

By this point, residents are usually ready to consider what emotional engagement or connection with the patient might mean. They still may not "like" the patient, but they have developed more understanding, insight, and sympathy for the patient's experience. They frequently begin to express increased caring about the outcome of the encounter, and greater interest in exploring various possibilities for improving the patient's care.

Finally, time is spent considering clinical implications. We begin by discussing how the physician in the selection (if there is one) responded to the patient, and what the strengths and shortcomings of this effort were. Next we engage in creative, imaginative, and empathic problem solving to explore the following questions: "What might be alternative approaches to this patient?" "What might happen if this were said, or that?" "Suppose you stopped arguing with this patient about diabetic management and talked to him about fishing instead?" In response to "Doc In a Box," for example, residents generated such interaction strategies as pairing with the belligerent spouse and acknowledging the difficulties of her role in the marriage; reframing her behavior toward both physician and husband in a more positive light; disclosing personal frustration at not being able to do more for the patient; compassionately setting limits on inappropriate behavior; and interviewing the patient without the wife present to create a therapeutic alliance.

Finally, we ask residents to relate the problems presented fictionally to real patient situations. Sometimes the situations in the readings are entirely new to our residents. For example, most state they have never encountered an overtly racist patient. However, other literary examples lead residents to recall numerous associations from their own clinical exposures. Residents often refer to particular patients and comment on how the reading has given them a new perspective on these patients. Others disclose how they have successfully handled such a patient in a clinical situation. Sometimes emotional insights from the reading may illuminate ignored or repressed feelings about a real patient.

### Creative Writing about "Difficult" Patients

As has been noted by other scholars,[9] creative writing requires the same balance of emotional distance and engagement that is needed for optimal patient care. Specifically, the discipline of writing about a patient provides emotional ballast, an anchor or "steadiness" to prevent being overwhelmed by the patient, an especially frequent problem for resi-

dents with difficult patients. At the same time, creative writing encourages a certain empathy or tenderness because it requires a willingness to enter unreservedly—if only in one's imagination—into the patient's world.

Writing about difficult patients is an excellent way to shift residents' perspectives about them. Writing, like reading, can heal feelings of frustration, irritation, anger, and helplessness about difficult patients. It can make residents more sensitive and empathic, and can even give them new insights into the meaning of their patients' illness experiences. Informal comments from residents who have participated in this exercise suggest that creative writing leads to both greater appreciation for difficult patients and even new ideas about how to communicate with them or about how to manage these cases.

Creative writing assignments can occur either during a 20-minute break during a long (i.e., two-hour) teaching session, or, in sessions that are conducted over time, as homework. In our course, we ask the residents to be brief (i.e., write no more than one to two paragraphs or a brief poem) and to spend no more than 20–30 minutes on the task. We emphasize that literary skill or writing ability is not necessary to derive benefit from the writing assignment. We also make it clear that there will be no literary critique of these efforts. A sample of a resident's writing, "I Don't Want to Go Upstairs Yet," is included in a box within this article.

## I Don't Want to Go Upstairs Yet

NOTE: *This imaginative piece was written about a 51-year-old white man who drives a truck for a living and was found to have NIDDM five years ago. Despite attempts at diabetic education, he has been unable to control his diabetes. He has had several diabetes-related complications, including most recently a scrotal abscess.*

Okay, doc, I know you and me don't always see eye to eye. You keep on nagging me about how I got to take more responsibility for this diabetes. I won't argue with you—you're right, I know you're right. But sometimes you sound like my mother or something. You're always saying stuff like, "Your diabetes is poorly controlled, Robert" and "I really need to see a little more commitment on your part, Robert." Geez, I'm a grown man, you know? You just got to see things my way. For one thing, I'm in pain, I'm in so much damn pain. If it's not one thing, it's another. Right now this sore on my—well, my private parts—it's driving me crazy. And now I've got blurry vision and sometimes I get real dizzy. I feel like I'm coming apart. Me and the wife ain't so hot right now either. And I've got a two-year-old—a damn *two*-year-old!—at home, top of everything else. So worrying about what I eat is the least of my problems. Anyway, whoever heard of a long-distance trucker keeping to a diet? It just don't make sense, and that dietician you sent me to didn't have any bright ideas either, couldn't figure out what the hell to do when I told her I drive nights, sleep days. Look, doc, I'm so sorry I've been screwing up. I want to stick around, believe me. I don't want to go upstairs yet. But you got to see what I'm up against.

—written by a third-year family practice resident
August 1999

## Conclusion

The stories of difficult patients are the stories to which residents are least likely to listen, the ones they are most likely to dismiss and find unsatisfying. But it is by entering into these stories, for a moment suspending irritation, suspicion, anger, and disbelief, that residents can learn to develop a different relationship with these patients. In response to a written story, they can explore how the story might be modified to make it more hopeful or more empowering.[10] They can consider what responses on their part would be most helpful and most supportive to the patient. Perhaps the most important lesson to be learned from the study of difficult patients in literature is that the perception of difficulty has as much to do with the resident as with the patient.

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