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On Clinicians' Professional Difficulties

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A clinician's life is rewarding but difficult. The rewards are easy to see and are enjoyed by nearly all of us. Being a physician is, after all, a service profession, a helping profession. Being of service is inherently rewarding, all the more so because we clinicians are called in when the stakes are high, when life and limb are on the line, when pain or loss or incapacity threatens harm. Our part is sometimes decisively important in the lives of those we serve. This extraordinary service is, to be sure, extraordinarily rewarding.

Our line of work carries yet another dimension of reward beyond service that is inherent in many professions. Patients present to us with deep and complex problems, the management of which requires in each instance the creative use of hard-earned knowledge, measured judgment, refined interpersonal skills, and other professional assets to produce for our patients a plausible explanation and a personalized plan that is acceptable and effective in returning them to health, or keeping them there, or at least interfering with their decline or demise. This kind of problem solving is just plain fun.

But difficulties arise, and not just because it is hard work. Sometimes our encounters with patients do not produce these vaunted benefits; sometimes the appreciation of our efforts does not materialize; sometimes the problems we are asked to solve do not fit our internal maps and paradigms; sometimes our ministrations simply do not work. This is hard for us. For obvious reasons, we should study these difficulties closely, and strive to understand and manage them better. It turns out that many of the difficulties of primary care clinicians can be assigned to the same 2 categories as the rewards: those having to do with the relationships we make with our patients and those having to do with our success (or lack thereof) at understanding and resolving the problems they bring to us. (An important set of professional difficulties having to do with the business of medicine—remuneration, documentation, and so on—is not addressed here.)

Medically unexplained physical symptoms can be thought of as problems that have been inadequately characterized and remain unsolved; by definition, they have not yielded to our usual clinical investigations. Patients who exhibit such symptoms can be said to be somatizing and may qualify for one of the somatoform diagnoses. Lynch et al.[1] report in this issue that in their sample of 165 primary care patients, the number of somatization symptoms from the PRIME-MD correlates significantly with physician perception of difficulty. Both are related to utilization of medical services. This finding is important and corroborates the findings reported with the validation of the Difficult Doctor-Patient Relationship Questionnaire[2] (DDPRQ) and with the validation of the PRIME-MD Patient Questionnaire,[3] both of which are instruments used in the present study. The PRIME-MD validation study showed that the level of perceived difficulty was directly proportional to the number of medically unexplained symptoms, which was in turn related to utilization, and the patients meeting criteria for multisomatoform disorder were more than 12 times as likely to be considered difficult as those not meeting the multisomatoform threshold. More than 12 times as likely! Lynch and colleagues' study[1] and the earlier instrument validation studies[2,3] showed no such association of perceived difficulty with chronic medical conditions such as diabetes or congestive heart failure, although the (usually undetected) presence of other mental disorders has been, like somatization, associated with a difficult relationship.

What should we make of this? Why would patients have multiple unexplained symptoms in the first place, and what is it about our relationships with these patients that we regard as so difficult? Most important, what can we do about it? Is it possible to alter our clinical approach so as to lower the likelihood that our patient relationships will be viewed as difficult? The somatization literature and the literature on difficult clinical relationships both contain research that helps inform speculation about these questions, but to my knowledge, the answers are not known. In other words, many of us have ideas about how to deal with the difficulty associated with somatization or with certain patient-clinician relationships, but I have been unable to find in my literature review or in conversation with colleagues anyone who has tested whether these ideas actually reduce perceived difficulty to a significant degree. Research here would be most welcome.

Earlier, I pointed out why clinical problem solving was rewarding. At first, somatoform complaints are ap-

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proached like all other presenting symptoms, with the same expectations that they will yield to our problem-solving skills. But they do not—they are medically unexplained. We are frustrated when our "hard-earned knowledge, measured judgment, refined interpersonal skills, and other professional assets" produce for our patients no plausible medical explanation, and therefore no effective plan. We know what to do when someone's chest pain turns out to be caused by gastroesophageal reflux disease, angina pectoris, or costochondritis—our interventions usually work and usually engender great appreciation. But when no such explanation is discovered, our hopes for a resolution are dashed. Frustration and disappointment are multiplied as the number of medically unexplained symptoms grows. At a certain point, the phenomenon of many unexplained symptoms must be recognized as a problem in its own right, as a sort of metadiagnosis, and managed as such. For the interested reader, Kurt Kroenke has produced an elegant algorithm for dealing with patients who present with medically unexplained symptoms.[4] A number of interventions have been shown effective in some ways for the somatizing patient, including

- a 6-point consultation letter that contains encouragement for regular brief visits, limited laboratory workups and surgeries, reassurance about the nonlethal nature of the disorder, and other recommendations along those lines[5–7];
- antidepressants[8];
- cognitive-behavioral therapy[9];
- short-term group therapy[10];
- dynamic psychotherapy[11];
- massage therapy[12]; and even
- St. John's wort.[13]

Powerful testimonials notwithstanding, it should be repeated that improvement in perceived difficulty has not been among the benefits demonstrated for these interventions.

As shown by Lynch et al.,[1] somatization does not account for all or even most of the variance in perceived difficulty. I mentioned previously that undetected mental disorders were found to be associated with perceived difficulty in the PRIME-MD validation study.[3] One might plausibly hypothesize that patients with an undetected, untreated, disabling problem might be experienced as difficult on the basis of their unattended suffering alone, but it simply is unknown whether recognition and treatment would reduce the perceived difficulty. This could be studied rather easily and certainly should be.

I endorse the recommendation of Lynch and colleagues that we should seek explanations for perceived difficulty beyond those explored in this or any other studies, e.g., gender concordance, length of continuity relationship, and type of practice. Moreover, I recommend that we pay particularly close attention to 2 elements of the clinician-patient relationship that can affect the perception of difficulty. The first is our own behavior as clinicians. Remember that patients enter into a relationship with us for specific reasons—usually to seek information, clarification, advice, and treatment for a health problem. It is our professional responsibility to behave according to our patients' needs, expectations, and requests (if they are reasonable and ethical), but sometimes we do not. McDaniel et al.[14] found that in one third of primary care clinical encounters, physicians spent part of the encounter talking about themselves, and sometimes this self-disclosure was grossly inappropriate. Patients will sometimes take this negatively, and certain difficulties in the relationship may follow. We can forestall this unfortunate sequence by remembering the reasons patients have chosen to consult with us, reviewing the ways we can best serve them, and behaving strictly according to standards of professional service.

Finally, there is the delicate business of relationship difficulties that are related to the patient's personality, role, and agenda—in other words, patient factors. While I agree with Lynch and colleagues that patient-centered orientations to this problem can be blaming and biased, I believe there is much value in examining these factors closely and adjusting our own approach accordingly. In 1978, Groves published an illuminating paper in the *New England Journal of Medicine* with the unfortunate title of "Taking Care of the Hateful Patient."[15] The negative connotations of the title notwithstanding, this paper offers an extremely valuable typology of abrasive personality types and how a clinician can respond constructively. In 2002, Hahn wrote an absolutely brilliant chapter in which he elaborated this typology, offered a compassionate explanation for the reasons underlying such patients' behavior, and provided clear and utterly compelling suggestions for the ways clinicians can respond to difficult encounters in a kind, cooperative, and constructive manner.[16] (This chapter would benefit any clinician wishing to better understand and manage difficult patient-clinician relationships.)

Yet again, such recommendations, compelling though they may be, have not been put through the rigors of proper clinical trials to see whether they actually improve relationships or merely reduce our perception of difficulty. We must do this research. Most successful medical research is aimed at discovering better treatments. Medical research aimed at making our clinical encounters less difficult, more rewarding, and more effective is just as important. I believe that a fully engaged clinician who is working for patients whom they like and look forward to helping is a clinician who will do better work and enjoy their profession more. Let's test that hypothesis.

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