Perspective

Duty, Empathy, and Hierarchy: Healing "Difficult Patients"

DANISH ZAIDI

Setting the Stage

Anthony is a fourth-year medical student, currently on service during an away surgery rotation. He is rounding with a first-year intern, Dr. Lovett, and the attending, Dr. Todd. They stop outside the room of Mr. Turpin, a 54-year-old male who has recently had a toe amputation due to uncontrolled diabetes mellitus. His chart lists him as a drug-seeker managed for chronic pain. As such, his analgesics are being closely monitored. Before entering the room, Dr. Lovett mentions that the patient had been irritated the night prior, complaining of uncontrolled pain, and upset at staff for refusing increased pain medication. Dr. Todd knows this, remarking that Mr. Turpin has a history of being a "difficult patient."

In the room, Mr. Turpin offers only curt responses. As Dr. Lovett removes the patient's bandages, he begins to groan, telling her to stop. Dr. Todd interjects, "I understand that you're in pain. Let's just take a look at this, and we will get you more meds for the pain afterward." Dr. Todd then directs Anthony to replace Mr. Turpin's dressings; as Anthony opens a packet of gauze, Mr. Turpin cries out: "Don't touch me! None of you understand that I'm in serious pain!" Dr. Todd calmly responds, "Sir, we're trying to treat you."

As Anthony again moves forward, bandage in hand, Mr. Turpin yells, "I don't want any of you touching me!" The room is silent but for Mr. Turpin's moaning. Dr. Todd looks at Mr. Turpin for a moment, then turns to his team: "Come on. It's useless right now. Forget about the bandage." As Dr. Todd walks out of the room, Anthony is left wondering what to do with the gauze in his hand and the whimpering patient in front of him. How does he respond?

Response

Knowing something is wrong is easier than figuring out how to make it right. Reading Beauchamp and Childress is a start; but actually applying prima-facie principles in the real world—with patients in pain, and physicians under pressure—is the real challenge.[1] In dealing with "difficult patients," the onus is on physicians to not just consider duties to autonomy or beneficence, but also to cultivate an empathetic and open space where such principles can be put into practice. This is no simple task, and it calls into question how empathy is used in clinical care, taught to trainees, and safeguarded from burnout.

Both Mr. Turpin's outburst and Dr. Todd's dispassionate response are symptoms of a broken patient-physician relationship that is lacking in empathy. To Dr. Todd, the patient has "always been difficult"; and to Mr. Turpin, the

Acknowledgements: This paper was adapted from a 2016 submission to the AMA Conley Ethics Essay Contest.

Cambridge Quarterly of Healthcare Ethics (2019), **28**, 378–382.

doi:10.1017/S0963180119000215

doctor does not listen. Moving away from a provider-centric viewpoint, one can appreciate that these statements result from squandered opportunities for communication between patient and physician.[2] In the context of this particular case, there is a responsibility on Dr. Todd to repair this patient-physician relationship, as it not only has direct impact on Mr. Turpin's wellbeing, but also on the training of Dr. Lovett and Anthony.[3]

Redefining the "Difficult Patient"

Knowing that Mr. Turpin has always been difficult, as Dr. Todd claims, is not as valuable as knowing why he has been so. Most research defining "the difficult patient" does so solely through a physician-focused lens.[4,5] Patients are labeled difficult when they elicit negative emotions in physicians, often as a result of the patient's noncompliance or behavior, or from frustration with poor communication between provider and patient. This conventional view of the difficult patient is challenged when considering the normal spectrum of human behavior in the face of pain, and is further called into question when providers consider the level of compassion and time they have given said patient.[6] It should be relatable that a person in pain—one who feels wronged and unheard—is scared, frustrated, and angry.

A principlist framework may misleadingly suggest that Dr. Todd has done right by leaving Mr. Turpin, overruling beneficence with respect for autonomy (to some, the first principle among equals).[7] This is where empathy necessarily supersedes bioethical theory, as without it, proper application of theoretical principles is not possible. For does Mr. Turpin actually wish to be left alone? Does he not want his dressings replaced? Or does he simply want to be heard?

An alternative approach to such cases relies on understanding where the patient actually is—not just physically, but socially and emotionally as well. Using that information, one can recontextualize the patient's struggle, distress and helplessness, giving new meaning to the idea of "difficult" patient. Through this empathy-based framework, a damaged patient-physician relationship has greater potential for repair by way of exhibiting compassion and understanding through improved communication and reflective listening.

The Fiduciary Duty To Repair Relationships

Given that dedicated time to exhibit empathy can improve the relationship between patient and physician, Dr. Todd bears the brunt of responsibility for repairing the broken communication channel with Mr. Turpin. More importantly, his fiduciary (rather than contractual) duty to treat Mr. Turpin demands that he does what he can to remove any roadblocks in the way of optimal treatment.[8]

Dr. Todd's fiduciary duty entails understanding the needs that Mr. Turpin has, and doing his best to address them. This does not simply mean replacing dressings; spiritual and social needs may have to be met through collaborations with social work or chaplaincy. As mentioned earlier, with an empathetic framework, Dr. Todd could potentially get Mr. Turpin to more properly communicate his grievances. Since these unvoiced grievances are directly playing a role in impeding Mr. Turpin's treatment, it is Dr. Todd's responsibility as a physician to do all he can to hear and appreciate them.

This dynamic can change, depending on circumstances. For example, it is more difficult to communicate with a patient lacking capacity. And in

psychiatric and critical care settings, there are numerous instances of patients endangering other patients or hospital staff.[9] In such cases, it is difficult to empathize with the patient; and even if one has done so, respecting autonomy remains challenging.

Behavioral Modeling and Empathy Decline

The patient-physician relationship influences more than just the two named parties. Research shows that the actions of attending physicians, residents, and other role models influence the learned behaviors of medical trainees within the "hidden curriculum."[10,11] As such, the stakes are even higher than Mr. Turpin's wellbeing, because the behaviors that Dr. Lovett and Anthony could potentially model after working with Dr. Todd could detrimentally impact patients for years to come. Therefore, as a teacher and role model, Dr. Todd again has a greater responsibility in improving the patient-physician relationship than does Mr. Turpin.

Knowing this, why does Dr. Todd act the way he does? One reason: he was taught to. Medical culture has long championed technical skill over one's capacity for empathy.[12] Research shows that empathy can decline during medical training, where emotionality and empathy are not prioritized, and in some instances, admonished. Jack Coulehan and Peter Williams poignantly wrote that in medical practice, "The emotional aspects of human experience are distanced and diminished."[13]

Only recently has medicine begun to appreciate the "psychosomatic" aspects of care, from spiritual distress to emotional neglect. Medical schools and residency programs are now beginning to push back against the "no emotion" mentality, stressing the importance of caring for the whole person. But it will take sustained effort on part of administrators and institutions to keep afloat educational initiatives that teach and maintain empathy.[14]

A second reason for empathy decline is rooted in the work that physicians do. It is not easy working with those who are ill, explaining to patients and families why their lives will be different or how certain treatments have failed. That the work of doctors is hard and emotionally taxing is a relevant factor when thinking about the patient-physician relationship. What if Dr. Todd had just lost a patient earlier on his rounds? What if he was nervous about a surgery that he had to perform later in the day? Simply put, physicians deserve empathy as well. This does not excuse Dr. Todd's behavior, but it is enough to call into question whether institutions are offering the necessary resources for doctors to deal with the emotional toll of their work.[15] Research shows that while some mental health and spiritual resources are offered to physicians, barriers like work hours and professional stigma keep them from practicing self-care.[16] Appreciating these barriers and the stresses of medical practice may offer some insight into to why physicians like Dr. Todd behave the way they do—and what can be done to help them.

Power Imbalance and The Trainee's Role

The reality of the hidden curriculum speaks to an inherent power imbalance in medical training. Such dynamics further complicate the case when considering the roles of Dr. Lovett and Anthony, both under the supervision of Dr. Todd. Empathy—however fundamental—remains too abstract to gain real traction to help future "Anthony M3s" and "Dr. Lovett PG1s"

who are dealing with similar experiences. How does a medical trainee take up such a case successfully in an institutional hierarchy without being self-righteous?

An analysis of data between 2000 and 2012 from the Association of American Medical Colleges found that 12-20% of medical student graduates had reported mistreatment during their education from people of power, mainly clinical faculty, residents, and interns.[17] While much of this mistreatment entailed sexist behavior, ethnically offensive remarks, or requests to perform personal services, there is a running relationship between mistreatment and supervisor evaluations. In a hierarchy where trainees are expected to comply with an attending or resident, there is legitimate fear of lowered grades and evaluations for challenging one's superior. A pattern develops where trainees compromise professional ethics for the "right" answer rather than the "best" answer, at times misleading patients, compromising confidentiality, or complying with unethical commands like Dr. Todd's.[18]

Recognizing this power imbalance is the first step in addressing Mr. Turpin's case. Depending on his relationship with Dr. Todd, Anthony may look to approach the chief resident privately, and in a nonaccusatory tone convey his nagging unease. As a member of Mr. Turpin's medical team, Anthony may mention how he feels responsible for his patient's care, and as such, wants to help repair the broken patient-physician relationship. If Anthony fears potential repercussions for reaching out to Dr. Todd (e.g., poor evaluations and lowered grades), he should be aware of reporting channels for improper supervisor behavior.[19] Institutions should meanwhile be committed to improving the accessibility and effectiveness of such reporting channels, and to developing guidance programs to help trainees navigate such cases within a medical hierarchy.

Conclusions

Ultimately, the onus of repairing the patient-physician relationship lies on the physician. A rigorous debate of principles does not do justice to this case of Mr. Turpin and Dr. Todd. Such a scenario requires empathy from the physician to help understand why a patient may be acting "difficult," and subsequent effort to address relevant challenges. Beyond the obvious fact that the patient-physician relationship impacts the care Mr. Turpin receives, Dr. Todd's behavior directly influences his intern and medical student.

For trainees, repairing the damage done by a superior is difficult, particularly because of the inherent power imbalance within institutional hierarchies. Luckily, should Anthony fear repercussions for challenging his supervisor, channels for reporting bad behavior are in place. But what if Dr. Todd is a great clinician and caring teacher just having a terrible day? This reinforces the importance of knowing why someone is acting "difficult"—patient or physician. Knowing this, Anthony should withhold judgment, trust in his capacity for empathy, and ask Dr. Todd the same question that should have been asked of Mr. Turpin: "How can I help?"

Notes

1. Beauchamp T, Childress J. *Principles of Biomedical Ethics*. 5th edition. New York: Oxford University Press; 2001.
2. Berger Z. Understanding communication to repair difficult patient-doctor relationships from within. *American Journal of Bioethics* 2012;12(5):15–6.
3. Neumann M, Edelhäuser F, Tauschel D, et al. Empathy decline and its reasons: A systematic review of studies with medical students and

residents. *Academic Medicine* 2011;86(8): 996–1009.
4. Wasan AD, Wootton J, Jamison RN. Dealing with difficult patients in your pain practice. *Regional Anesthesia and Pain Medicine* 2005; 30(2):184–92.
5. Miksanek T. On caring for 'difficult' patients. *Health Affairs* 2008;27(5):1422–8.
6. Fiester A. The "difficult" patient reconceived: An expanded moral mandate for clinical ethics. *American Journal of Bioethics* 2012; 12(5):2–7.
7. Gillon R. Ethics needs principles—four can encompass the rest—and respect for autonomy should be "first among equals." *Journal of Medical Ethics* 2003;29(5):307–12.
8. Margolis JD. Professionalism, fiduciary duty, and health-related business leadership. *JAMA* 2015;313(18):1819–20.
9. Tischler CL, Reiss NS, Dundas J. The assessment and management of the violent patient in critical care hospital settings. *General Hospital Psychiatry* 2013;35(2):181–5.
10. Bandini J, Mitchell C, Epstein-Peterson ZD, et al. Student and faculty reflections of the hidden curriculum: How does the hidden curriculum shape students' medical training and professionalization? *American Journal of Hospital Palliative Care* 2015 [Epub ahead of print].
11. Karnieli-Miller O, Vu TR, Frankel RM, et al. 2011. Which experiences in the hidden curriculum teach students about professionalism? *Academic Medicine* 86(3): 369–77.
12. Kerasidou A, Horn R. Making space for empathy: Supporting doctors in the emotional labour of clinical care. *BMC Medical Ethics* 2016;17:8.
13. Coulehan J, Williams PC. Conflicting professional values in medical education. *Cambridge Quarterly of Healthcare Ethics* 2003;12(1): 7–20.
14. Batt-Rawden SA, Chisolm MS, Anton B, et al. Teaching empathy to medical students: an updated, systematic review. *Academic Medicine* 2013;88(8):1171–7.
15. Hu YY, Fix ML, Hevelone ND, et al. Physicians' needs in coping with emotional stressors: The case for peer support. *Archives of Surgery* 2012;147(3):212–7.
16. Guille C, Speller H, Laff R. Utilization and barriers to mental health services among depressed medical interns: A prospective multisite study. *Journal of Graduate Medical Education* 2010;2(2):210–4.
17. Mavis B, Sousa A, Lipscomb W, et al. Learning about medical student mistreatment from responses to the medical school graduation questionnaire. *Academic Medicine* 2014;89(5): 705–711.
18. Brainard AH, Brislen HC. Viewpoint: learning professionalism: A view from the trenches. *Academic Medicine* 2007;82(11): 1010-4.
19. Angoff NR, Duncan L, Roxas N, et al. Power day: Addressing the use and abuse of power in medical training. *Journal of Bioethical Inquiry* 2016;13(2):203–13.