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The Case of the Difficult Patient

Mrs. C was recently hospitalized with a poorly healing foot ulcer; her diagnosis was diabetes mellitus. Her physician worked out a careful regimen of medication, diet, and lifestyle changes to control her diabetes. After three months, the fifty-six-year-old widow was readmitted to the hospital for complications including ketoacidosis and hypoglycemia. Mrs. C's foot ulcer had not improved. Several hospitalizations followed in the next few months, and her physician grew frustrated. Despite his repeated efforts to explain the importance of following the plan of care, Mrs. C's problems persisted. He blamed the recurring medical problems on Mrs. C's unwillingness to participate actively in her care, by not following her medication regimen or diet. He accused her of "not listening to me"; basically, of being a difficult patient.

Patients such as Mrs. C can be frustrating to their caregivers. The label "difficult patient" has long been used to refer to patients who cause problems for the normal flow of healthcare delivery. Unlike "normal" patients, such patients are described as demanding, self-destructive, or hard to get along with. Quite often disagreement builds until the relationship is terminated by one of the disgruntled parties. If these patients behaved differently, providers claim, their medical problems could be dealt

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with efficiently and without undue effort. This common view of patients who don't carefully follow instructions or who seem non-compliant may be too general, but there is no doubt that a patient's failure to comply with his or her medical regimen may well compromise her medical care. What are the limits, if any, on a physician's responsibility in cases such as this one? Is it ever ethical for a physician or other care provider to withdraw from a case? There are several points to keep in mind.¹

First, is Mrs. C not complying intentionally or because something else is going on? What appears to be a lack of cooperation needs to be investigated. There may be the danger of "blaming the victim." Patients' apparent irresponsibility or noncompliance may in fact be due to inadequate education or caregiver support. However, Mrs. C's physician feels that he has conscientiously explained to his patient her medical condition, the reasons for his treatment recommendations, answered her ques-

tions, and obtained her agreement to follow the plan of care. He is frustrated that her condition is not improving.

The problem may be one of decisional capacity. Is the patient capable of making choices and understanding the recommended treatment? If Mrs. C is decisionally capable, and it appears that she is, are there other obstacles that may interfere with her ability to follow recommendations? Patients may fail to comply with instructions because of such factors as irregular routine, adverse effects of medication, complicated regimen, or forgetfulness. Efforts can be made to rectify these concerns.

Second, patients may choose to ignore their regimen because they favor other values more than health. In contemporary understandings of respect for persons in health care, the patient's beliefs, interests, and preferences hold a strong place in the clinical relationship, but they are not sacrosanct. Patients are obligated to help professionals do their jobs: to share, for example, all health or other information needed to provide them with appropriate care. They must also be willing to participate in making decisions about their medical treatment and adhere to the best of their ability to the agreed upon plan of care. If Mrs. C's physician judges that the

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problems are due to her willing persistence in health risks, he should make reasonable efforts to persuade the patient to cooperate with the plan of care, as long as persuasion does not become coercion or other means of unduly forcing the patient to follow a particular course of action.

Third, if external circumstances are the source of the patient's actions, help should be provided to improve these circumstances. Mrs. C is decisionally capable; she appears to understand the doctor's instructions and agrees with the plan, yet her problems continue. Because of her ulcerated foot, the physician makes a referral to a home health agency for a series of in-home follow-ups. When the agency nurse arrives at Mrs. C's home for the intake assessment, she learns that Mrs. C, a widow, cares for her semi-invalid mother. Her unemployed son lives with them. The nurse learns that the son may be stealing his mother's medications to sell on the street. Mrs. C admits to a great deal of stress; it is difficult for her to stick to her regimen while caring for her mother and worrying about her son. When asked by the nurse why she hasn't told her physician about her situation, Mrs. C replies: "I don't want the doctor mad at me, but it's our family's business." This woman is in a bad situation; she won't move into a care facility, abandoning her mother; she doesn't want authorities involved because of her

son. Under these circumstances, it is difficult for this patient to follow her doctor's orders in caring for herself. The patient's apparent noncompliance appears to be a result of her home situation, over which the physician has little direct control but about which he needs to know if he is to be of any help. This may be a case with no easy solution; perhaps all the physician can do is to involve social services, while adjusting therapeutic goals and doing the best he can for his patient under these circumstances. He should work to bolster the trust and confidence in their relationship, so that Mrs. C will feel more comfortable in sharing information.

Finally, physicians may decide that no further treatment is indicated because the patient's persistent behavior is so contrary to the goals of treatment. A physician is not obligated to treat people who persist in actions that counter the goals of that treatment. If, for example, Mrs. C is seen repeatedly in the hospital cafeteria cheating on her diet, or if there is strong evidence of other willful disregard for treatment that undermines the chances for a good medical outcome, it is ethically permissible to withdraw from the case, after advising the patient how to obtain care from other sources.

¹ For a full discussion of noncompliance, see A. Jonsen, M. Siegler, and W. Winslade, *Clinical Ethics* (New York: Macmillan, 1986), pp. 85-94.

e-Ethics provides discussion of important ethical issues in clinical care and organizational life. In specific cases, fuller ethical analysis may be required. The discussions in e-Ethics should not be construed as legal advice and do not necessarily represent official positions of Advocate Health Care.

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