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The "problematic patient": what is the problem?

Illustrated by the example of temporomandibular disorders

Problem: When patients report pronounced physical complaints without sufficient somatic findings to substantiate them, practitioners sometimes refer to these patients as being "problem patients" or "difficult patients". When such an attribution is assigned, it usually denotes a difficult interpersonal relationship between practitioners and patients, which can be further exacerbated by deficits related to professional expertise, communication and dental fee schedules.

Discussion/Conclusion: On the basis of examples of persistent temporomandibular disorders/orofacial pain, it is recommended that professionally practicing dentists should live up to their responsibility and trust given to them by patients. For that purpose, dentists must be aware of their limits of competence and be cautious about overestimating their abilities. There are not only "difficult patients"; there are also "difficult dentists".

Keywords: health care provider's role; communication; dentist-patient relationship; pattern recognition; interpretation; clinical decision-making; craniomandibular disorders

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Halden picked up the phone ...
»Yes – – the countess shall then – –, how, – but that can be done without me, sister ...
Good, I'm coming ...«
And to us: »You must excuse me for a few minutes ... It's a somewhat difficult patient ... «

Max Schraut (pseudonym from Walther August Gottfried Kabel [1878–1935]): Harald Harst. Aus meinem Leben [From my life]. Volume 196 of the novel collection "Harald Harst": Doktor Haldens Patient [Doctor Halden's Patient]. Verlag Moderner Lektüre, Berlin 1925.

1. Introduction

According to Donner-Banzhoff [9], four fundamental, stratified medical functions can be distinguished in the relationship between the physician and patient:

- The physician as a healer: the patriarchal-acting expert with exclusive knowledge.
- The physician as a detective: the investigator for seemingly minor findings.
- The physician as a gatekeeper: the identifier of an indication for medically effective measures and justified claims in a solidarity-based health care system.
- The physician as a transparent, patient-oriented therapist: a partner in an equal relationship.

Considering the tasks involved and mutual expectations, it is understandable that not every patient encounter is free of problems. Hoefert [25] remarks: "The 'lucky' case for patients and physicians is always the one in which a certain (organic) cause for a disease is found and the corresponding therapy options are available." This prerequisite is not always a given, however. Particularly in the context of encounters where there is an obvious discrepancy between the disturbed subjective well-being of the patient and no conspicuous clinical and radiological findings, there is a high probability that the buzzword "problem patient" will be used by the dentist/physician. Due to its fuzzy definition and broad meaning, this term can cover a considerable number of people. Since an attribution with the label "problem patient" has a negative connotation, when possible, the term "difficult patient" [34, 40–41, 50] might be the better choice.

Dunkelberg et al. [10] state that patients who are experienced as being difficult by the practitioner are "evidently a problem of considerable extent". Physicians consider that 15 to 18 from 100 patients are "difficult" [27]. Comparable data is not available for dentistry; nevertheless, dental practices are familiar with such patients: based on the results of a nationwide survey in Austria (n = 145), Kreyer [36] reported that, in addition to occupational stress (constant time, scheduling, performance and quality pressure), confrontation with "problem patients" is a particular burden for dental practitioners, and that there is a genuine "fear on the part of dentists of their difficult patients". In any case, the dentists and dental staff involved "remember" [8] these patients for a long time usually. Table 1 summarizes frequent third-party descriptions for such persons.

Patients who are described as being "difficult" are extremely heterogeneous in terms of their complaints, behavior and background. For example, the management of children, anxiety patients and disabled people is often perceived as "difficult" by practitioners [36]. However, when speaking of "difficult patients" in the narrower sense, other persons are generally meant. Hoefert and Härter define "difficult" patient behavior "as a perceived deviation from the image of the 'desirable', or at least, 'normal' patient." As a rule, this involves dealing with insufficiently clarified, or inexplicable physical complaints and symptom evolution, coupled with patients' own behavior-related ("smart aleck" [36]) and other psychosocial peculiarities.

When evaluating this phenomenon, it should be clarified where the fundamental difficulty – or "the problem" – lies, and if, this is not something that needs to be searched for by the patients themselves.

2. The difficult patient?

The characterization of a patient as being "difficult" or "problematic" is an attribution that is assigned on the part of the practitioner [55]. Various authors [10, 40] indicate that such a perception is a relationship and communication problem, or in other

Adjective
pretentious
straining
smart-alecky
disappointed
sensitive
demanding
offended
stubborn
challenging
litigious
troublesome
narcissistic
annoying
nagging
refractory
blathering
recalcitrant
unfair
uncooperative
unsatisfied
reluctant to pay
time-consuming

Table 1 Some (translated) adjective descriptions from the German-language specialist literature (including [28]) for patients who are qualified as "difficult" by dentists/physicians.

Patient's side
Description of diverse, vague, unclear, partially variable somatic complaints
Excessive preoccupation with the (sometimes minor) symptoms
Lengthy medical history
High degree of concern
Increased psychosocial stress, presence of social pressure or conspicuous biographical events (e.g. separation conflicts, family members in need of care)
High prevalence of mental disorders or psychiatric diagnoses
Elaborate explanations
Strong, but unfavorable causal beliefs
Exact knowledge what is missing, what the cause is and how best to proceed, sometimes written down meticulously on a piece of paper, envelope or the like (*la maladie du petit papier* [5, 49])
Increased use of health care services (heavy user)
Attention-seeking, clinging, manipulative, demanding behavior towards the dentist/physician
Pre-informed (often misinformed) via the Internet
Unrealistic expectations regarding the health care providers and the therapy
Uncooperative behavior, lack of trust in the therapy (unwillingness to be treated), resistance to medical/dental recommendations
Frequent switching of dentists/physicians ("doctor shopping", "doctor hopping", "hospital hopping") [7]
Poor or no response to common therapeutic methods
Dissatisfaction
Ongoing procedures with other practitioners
Physician's side
Considerable time requirement (until shortage of time)
Difficult communication with the patient
Exclusive focus on somatic medical aspects
Dismissing, dominant communication behavior
Strong emphasis on visualization procedures
No consideration of psychosocial factors in diagnostics and therapy
Poor or unexplainable symptoms of the patient: despite great efforts, no causes for the complaints can be identified (discrepancy between subjective state of health and clinical/imaging findings)
In conflict with own professional standards

Table 2 Characteristics of a difficult physician-patient relationship (expanded after [10, 15, 27, 34, 40, 63]).

Overestimation of own knowledge and skills
Problems with decision-making when facing uncertainty
Disappointing therapeutic results (cave: iatrogenic damage due to overtreatment and incorrect therapy [39, 59, 61])
High strain, feeling of hopelessness, helplessness, disappointment, anger, frustration, aversion
Feeling of being taken advantage of by patients
Dissatisfaction, helplessness, disillusionment, self-doubt about your own competence
Patient-physician relationship
Strong differences between the "individual realities" (disease theories) of patient and physician/dentist [8, 26]
Absence of an explanatory model (disease theory) for the complaints from both sides [46]
Lack of a common basis for the initiation of meaningful diagnostic and therapeutic steps, expectation discrepancy regarding the ways and goals of therapy
Appearance of new problems at the end of the consultation
Patient as "expert killer" [36–37, 47]

Table 2 Continuation Characteristics of a difficult physician-patient relationship (expanded after [10, 15, 27, 34, 40, 63]).

words, a difficult *interaction* between the physician/dentist and patient. This assertion is supported by the realization that dealing with "problem patients" in dentistry is associated with a disturbed physician-patient relationship; it can take on the form of personal antipathy, emotional involvement and expressions of aggressiveness, for instance [36]. Kowarowsky [35] thus states: "The difficult patient does not exist. It takes two to tango." (Figure 1). Accordingly, Kreyer [38] suggests the following definition: "Problem patients, whose therapy can become a psychological, and sometimes, even physical burden for the dentist, are primarily those patients in whom it proves impossible to build a sustainable physician-patient relationship."

Langewitz [40] cautions that "the communication skills of physicians play a decisive role in the perception of a consultation as being difficult". Communication is not only a matter of concern between physicians/dentists and patients [11–12, 22, 53, 54, 67], but also between the treatment providers themselves [7]. Characteristics of the interpersonal relationship between patients and (dental) practitioners are summarized in Table 2.

3. Dealing with difficult patients

Especially those patients who are described as being "difficult" expect their practitioners to provide emotional support; for instance, this means responding to their complaints to a greater extent than is usually the case in patients with somatic problems [52]. The patients – many of whom have previously turned to other doctors without success – are primarily seeking for advice. The practitioners are thus faced with a special responsibility. This is the establishment and maintenance of a trust-based relationship, which is of critical importance. In order to achieve this, patients should be given sufficient time (not only during the first consultation) to talk about their complaints, concerns, expectations, and explanatory models of illness [14, 17]. This is rather unusual in a profession, in which (well-paid) doing dominates over (hardly-paid) listening, speaking and explaining [43]. Some strategies for dealing with patients who are usually perceived as being difficult are found in Table 3.

4. Interpretation

Clinically and radiologically, practitioners can reliably recognize only what they have learned before. Based on single or multiple previous experiences, the brain stores patterns which are used in comparable future situations (pattern recognition [18, 33]). Practitioners with many years of professional experience have developed this ability to a particular degree [13]. Consequently, they feel secure in their professional field. In spite of this, the acquired skills cannot be transferred to other fields in which one has only little expertise. Forgetting this principle can put patients at risk just as much as ignoring the progress in one's own field of expertise.

Pattern recognition (i.e. detection), as the first step in an interpretation, is followed by explanation and evaluation, and (if necessary) standardization [4]. Changes in the scientific evaluation of clinical findings, such as the question "a variation of normality or pathology?" (e.g. in the

Strategies
Confirmation of the credibility of the complaints: they are neither imagined nor deliberately pretended
Respecting and striving for openness, empathy, and appreciation towards the patient
Objectivity; avoidance of emotional reactions
Making personal expectations more realistic
Use of proven communication techniques: – patient, non-judgmental listening – creation of a clear time frame and structure for the consultation – directness; avoidance of misleading statements – using humor as a tool in conversations – targeted exploration of the patients' subjective concepts of the disease (disease theories), their beliefs regarding the causes and their preferences – involving patients in the decision-making process (shared decision-making)
Atmosphere- or situation-specific strategy when receiving vague feedback without justification [40], such as: – "Obviously, we're not going further past this point." – "I realize that I do not know how I can help you further on at this point."
Personalizing the relationship through self-revelation, e.g. "Thank you for telling me so clearly." [41]
Setting limits and organizing further help: – Addressing difficulties, confronting patients when their behavior is inappropriate – Referral of the patient – In hopeless cases: seeking advice from colleagues, recommending a change of dentist/physician
Avoidance of using trivial and random findings as an explanation for the complaints
Avoidance of unnecessary and redundant examinations
Waiving of non-indicated therapies
Up-to-date, trustworthy and reliable information [1]
Consideration of current therapeutic recommendations (guidelines etc.)

Table 3 Some strategies for dealing with patients who are perceived as being difficult (based on [7, 10, 40]).

case of an anterior disc displacement [58]) start at the level of explanation; this is then followed by, for example, clinical, ethical/moral or esthetic judgment of the observed phenomenon, for which, especially when it occurs frequently, action-oriented suggestions or recommendations (e.g. guidelines from specialist societies) are usually developed, if they do not already exist (standardization).

Valid interpretations of clinical phenomena must always be based on the current state of scientific knowledge. In this sense, regularly remaining up-to-date with developments in one's field of experise is indispensible. Failure to do so increases the likelihood that a clinical situation and the patients involved will be considered "difficult" or "problematic".

5. Are patients with temporomandibular disorders "difficult"?

Patients affected by temporomandibular disorders (TMDs) and/or orofacial pain (OFP) are at particular risk of being perceived as "difficult" as they are fundamentally different from those persons who are usually seen during routine dental practice [62]. By resorting to the traditional "craftsman's model" [23] in patients with OFP or impaired mandibular function, the practitioner's limits will quickly be reached. On the other hand, the introduction of a biopsychosocial view [11] within the framework of diagnosis and therapy [64] continues to pose considerable challenges [56]. Unfortunately, it can repeatedly be observed that dentists with little experience in the field of functional disorders tend to describe TMD and OFP patients as "psychosomatic", "psychologically disturbed" or "psychologically altered". Such an ad hoc assessment not only reveals a lack of professional expertise, but also violates the fundamental ethical and moral principles of the (dental) profession [cf. 17, 44]. The over-

Curriculum provider	Continuing education
Dental Academy Karlsruhe	Curriculum "Function and pain" [URL: https://www.za-karlsruhe.de/de/akademie/fortbildungsangebot/curriculum.html?curriculum=Funktion_und_Schmerz_2021.html]
Academy for Practice and Science (APW)	Curriculum "Bruxism" [URL: https://www.apw.de/iw/curricula/curriculum-bruxismus]
Academy for Practice and Science/ German Society of Craniomandibular Function and Disorders	Curriculum "Function, functional disorders, temporomandibular disorders, and pain" [URL: https://www.apw.de/curricula/curriculum-funktionsdiagnostik-und-therapie]
Academy for Practice and Science (APW)	Curriculum "Basic competency in psychosomatics" [URL: https://www.apw.de/curricula/curriculum-psychosomatische-grundkompetenz]
University of Greifswald	Master's program "Dental functional analysis and therapy" [URL: http://www2.medizin.uni-greifswald.de/dental/master/index.php?id=451]
Scientific society	**Working group**
German Pain Society	Interdisciplinary working group for orofacial pain [URL: https://www.schmerzgesellschaft.de/topnavi/die-gesellschaft/arbeitskreise/mund-und-gesichtsschmerzen]
German Society for Dental and Oral Medicine (DGZMK)	Working Group for Psychology and Psychosomatics [URL: https://www.akpp-online.de/]

Table 4 Training opportunities and working groups in the fields of functional disorders, orofacial pain, and psychosomatics in Germany. (Tab. 1–4: J.C. Türp)

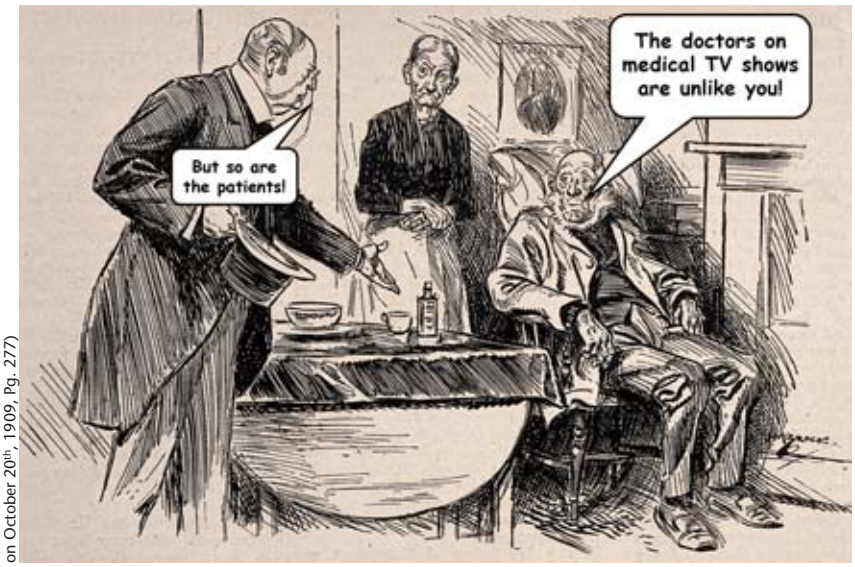
whelming majority of patients are not "more difficult" than people who wish to be treated for the purpose of preserving, replacing or repositioning their teeth. When the patient is haphazardly put into the "psychological corner", the "difficulty" – or more appropriately: the problem – is on the part of the dentist. Practitioners must be conscious of their professional limits and express themselves with due caution regarding issues that are outside their area of acquired expertise.

A particular challenge is posed by patients with *persistent/chronic* OFP which goes beyond ordinary toothaches, especially when the pain cannot be detected and explained by structural lesions, as is almost regularly the case in dentistry. Non-specific complaints associated with a feeling of suffering and functional impairments occur relatively frequently in medicine (e.g. globe sensation; chronic fatigue syndrome) [57] and are collectively referred to as "functional body complaints" [51].

In the presence of pronounced pain syndromes (e.g. fibromyalgia syndrome; irritable bowel syndrome), one refers to "functional somatic pain syndromes" [21, 24]. Patients with chronic TMDs fall into this grouping [21]. When contacting these patients, the dentist is sometimes exposed to situations that are well known in medicine. For example, one may be encountering patients

- who appear at the initial consultation with (*fat folder)* [16, 32] that are filled with written documents (findings reports, results from imaging examinations, correspondence with reimbursers, etc.);
- who like to appear at their appointments with (usually small) pieces of paper [42] on which they have meticulously noted down new questions about their symptoms; these must be patiently worked through at first (*la maladie du petit papier*) [5, 49];
- whose (dental) medical documentation is disproportionately detailed – and the patient's medical/dental history record is correspondingly thick (*thick-file case*) [14].

Meetings in this very extreme form are the exception, even in university settings or special consultation facilities, where patients with functional disorders of the masticatory systems are exclusively attended to. Colleagues working in private practices should thus decide on how they would like to deal with such patients from early on. In cases where one's professional expertise is surpassed, early referral to appropriate centers, such as university dental facilities or specialized colleagues, is recommended. Yet, depending on the lo-



(Fig. 1: published in the satirical magazine "Punch, or The London Charivari" on October 20th, 1909, Pg. 277)

Figure 1 Difficult patient or difficult physician? Different expectations on the part of the patient and physician coupled with unfavorable communication.
(Based on a wood engraving by Henry Matthew Brock, published in the satirical magazine *Punch, or the London Charivari* on October 20th, 1909, Pg. 277: A doctor angry with his patient for trying quack medicine as well as his own prescription. URL: <A doctor angry with his patient for trying quack medicine as Wellcome V0011480.jpg> [last accessed on: January 4, 2021])

cation, it may not be easy to find a competent center for making a referral. This even applies to university dental clinics. The TMD field is not a domain in which an overwhelming number of dentists show interest. This is also reflected in the dental school curriculum. A survey conducted by Hugger et al. about 10 years ago [29] showed that only 2 of the 30 dental schools in Germany offered lectures on the subject of TMDs. To date, this situation has not changed significantly.

Given the fact that

- the field of TMDs/OFP thematically differs from other dental specialties in fundamental ways [56];
- this field is obviously not sufficiently integrated into dental education [29];
- new scientific evidence [66] grows annually in the form of high-quality articles [30] reporting, for example, on results from randomized controlled trials [65];
- the acquisition of profound expertise can only be achieved through
  - (a) continuing education and ongoing professional training;
  - (b) reading contemporary and relevant literature on the topic [60],
  - (c) regularly attending high-quality training events, and
  - (d) maintaining regular (daily) contact with affected patients over many years[1],

it can be concluded that a large proportion of TMD/OFP patients characterized as "difficult" are given this description only because there is often a lack of expertise on the part of the treating dentist [56]. Consequently, the patients are not appropriately diagnosed and managed. This point of view is confirmed by data from Kreyer [36]: according to the author, one of the main reasons for dentists' fear of patients who are deemed "difficult" lies in the dentists' perceived lack of their own professional competence. During face-to-face conversations, many colleagues openly admit their limited knowledge in the field of TMDs. It is simply not possible to have a sufficient level of knowledge regarding all types of complaints in the oral and maxillofacial area. However, dentists who are primarily handicraft- and surgically-oriented are not recommended destinations for these patients [50].

Moreover, it is difficult to perform a lege artis assessment of TMD/OFP patients due to billing-related restrictions, especially given the considerable amount of time that is sometimes required for taking a thorough patient history. Insufficient payment for the collection of this important data is a serious problem worldwide and this is disadvantageous for patients. A praiseworthy exception can be found in the tariff regulations of the Swiss Dental Association (SSO): it permits payment for the TMD-related patient history based on 5-minute intervals. This, however, is the only means for ensuring that the patient is given an adequate opportunity to speak. In both general medicine [19] and pain medicine [48], the medical history plays a key role in the evaluation of a clinical case. The combination of

- inadequate dental education and continuing education,
- anamnestically incomplete patient information and
- possible communication deficits

makes complex cases not only "difficult" and "problematic", but also inevitably leads to failure (even if the practitioner is not always aware of it)[2].

6. Discussion

For some dentists, the label "problem patient" may have the function of "relieving" them of a part of their responsibilities. However, with such a strategy, dentists rob themselves of one of the most valuable assets available to them in their dealings with patients: trust, which, as the Freiburg medical ethicist Giovanni Maio noted, is the "binding agent" in the relationship between the patient and

[1] The Canadian physician Sir William Osler (1849–1919) remarked: "To study the phenomena of disease without books is to sail an uncharted sea, while to study books without patients is not to go to sea at all." [2].
[2] Relevant postgraduate continuing education and training opportunities are summarized in Table 4.

the physician/dentist: "The need for trust comes into play [...] when the patient can no longer judge whether what the physician recommends is really good advice or not". [45].

For years, representative surveys in Germany have shown that, after firefighters (2019: 94 %), physicians (2019: 87 %) are the most highly regarded professional group in the population [6]. This indicates that being a dentist means to pursue a profession of trust [45]. This advance of trust must not be jeopardized by unprofessional, unscientific and/or unethical actions. By the simple use of terms like "problem patient", this can already be happening in clinical situations that are beyond the practitioner's usual patient cases.

Boland [3] advises: "Before we label a patient as a problem, we should analyze ourselves and our reactions to the patient and consider why we have this reaction." The characterization of people as "difficult patients" is an interpretation that, in some cases, is misleading and reveals professional and communicative deficits on the part of the dentist. There are also "difficult" (dental) practitioners [31].

7. Conclusion

Knowing the current status in his field of expertise, and at the same time the limits of his professional and communicative competence is a quality that distinguishes a dentist who acts professionally and practices "good dentistry" [20]. The overestimation of one's abilities is one of the greatest dangers for professional failure and a risk factor for creating "difficult" patients.

Conflicts of interest

The author declares that there is no conflict of interest as defined by the guidelines of the International Committee of Medical Journal Editors.

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