

# A Challenging Patient, An Innovative Solution

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## ABSTRACT

This report of the management of a 28-year-old patient over 2 and a half years illustrates how interaction between psychosocial issues and physical symptoms complicates diagnosis and management. The case also highlights the challenges inherent in a large health care system with multiple health care professionals, clinics, and available resources. A “team model” approach is outlined as a useful strategy in such cases. Once problem areas are defined, a partnership agreement (contract) is recommended, which applies structure and limits to the physician-patient relationship. This contract calls for mutual trust, communication, and accountability while preventing excessive use of the health care system. Our patient and hospital system greatly benefited by this approach as evidenced by (1) a 60% decrease in medication costs, (2) markedly decreased ED visits and telephone calls, (3) successful treatment of depression and anxiety, and (4) a positive outcome on the patient’s health.

## INTRODUCTION

Patients present with a wide variety of problems both fascinating and frustrating to the primary care physician. Some problems involve a complex interplay of biomedical and psychosocial issues that are not easily recognized in the medical setting. Psychiatric comorbidity is associated with personal suffering, reduced psychosocial functioning, and increased health care costs. Patients with depression often present with a complex set of overlapping symptoms including emotional and unexplained physical complaints that complicate diag-

nosis. This case illustrates how comorbid conditions play a significant role in clinical outcome and the need for clinical predictors to assist in diagnosis.

## CASE HISTORY

### *Patient Profile*

A 28-year-old woman presented with the chief complaint of “I feel lousy, Doctor.” Her primary complaints were congestion, rhinorrhea, shortness of breath, cough, fever, and chills, which persisted over the next 3 years. Her past medical history was significant for allergic rhinitis, a clinical diagnosis of asthma, and recently diagnosed hypertension. Social history was significant for a recent divorce as well as polysubstance abuse including alcohol, tobacco, marijuana, amphetamine, and cocaine. She had been drug- and alcohol-free for the past 5 years, attended Alcoholics Anonymous meetings regularly, and held a part-time job in sales. Family history was unremarkable, and her medications on initial presentation included albuterol and triamcinolone acetonide inhalers and nifedipine XL 30 mg. Review of systems was remarkable only for URI symptoms, a dry cough, and normal effort tolerance.

Physical examination revealed an anxious woman with a blood pressure of 140/86 mm Hg, pulse 86/minute and weight of 192 lbs. Positive findings included erythema of the nasal turbinates, and diffuse end expiratory wheezes in both lung fields. Laboratory studies revealed a normal blood count and basic metabolic panel, normal pulmonary function tests, and a negative methacholine challenge test. Further evaluation revealed normal chest radiograph and CT of the sinuses, prompting referrals to pulmonary and allergy consultants. These consultants concurred that the patient did not have asthma and diagnosed her with allergic rhinitis.

We assumed the patient’s care in September 1996, and over time it became apparent that she used the health care system extensively, especially the emergency department (ED) and urgent care clinic. Her complaints were always centered around asthma exacerbations and sinusitis, with repeated requests for antibiotics and prednisone. On fur-

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ther questioning, the patient affirmed increased physical symptoms and anxiety with psychosocial stressors and disturbing life events. By June 1997 the patient had developed steroid-induced diabetes. Further chart review and pharmacy records confirmed the overuse of the health care system and revealed the magnitude of the problem. Her working diagnoses at this time included steroid and antibiotic abuse, steroid-induced diabetes and hypertension, anxiety, depression, and allergic rhinitis.

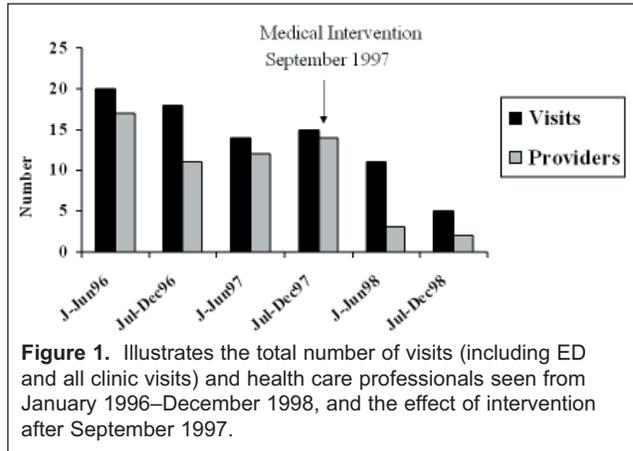
### Chart review

Retrospective review of the clinic, ED, and pharmacy records were done starting from January 1996. This revealed that by early 1997 the patient was receiving care from multiple locations and multiple health care professionals, including Urgent Care, the ED, the medicine clinic, and the after-hours answering service. It was not easy for these various groups and locations to access medical records. During a 6-month period from January to June 1996, the patient had 20 visits (14 to the clinic and 6 to the ED), and saw 17 different health care professionals (Figure 1). The patient's medication profile reflected this discontinuity. Her complaints included URI symptoms, dyspnea, and nasal congestion. She was prescribed steroids and antibiotics on every visit and had the recommendation to follow up with psychiatric care (which she did not follow). She received 18 courses of antibiotics and 20 separate courses of prednisone during this time period (Figure 2). Her medication costs were substantial, averaging over \$750 per month (Figure 3).

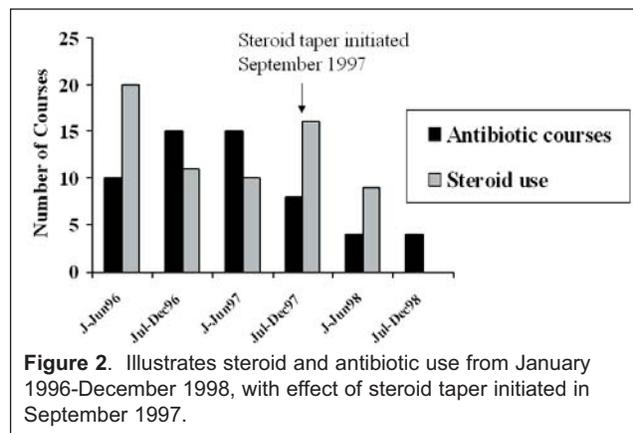
### Medical Intervention

The enormous burden to the health care system and the seriousness of the patient's health problem was recognized. We implemented a contractual approach to managing the patient's care. The contract agreement was implemented in September 1997. This required open communication and a multi-disciplinary team approach. The language of the contract included:

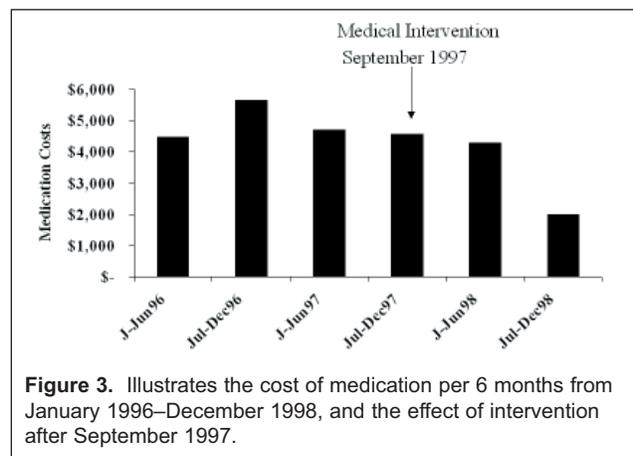
1. Limitation of health care professionals to 2 physicians within the General Internal Medicine Clinic for her medical care and prescriptions.
2. Non-symptom-dependent visits scheduled regularly.
3. Medications written only by her health care professionals and filled at a single pharmacy.
4. Initiation of prednisone taper.
5. Requirement to obtain psychological evaluations and treatment.
6. All urgent visits and telephone calls to be directed to her primary care physician (PCP).
7. Encouragement of open lines of communication



**Figure 1.** Illustrates the total number of visits (including ED and all clinic visits) and health care professionals seen from January 1996–December 1998, and the effect of intervention after September 1997.



**Figure 2.** Illustrates steroid and antibiotic use from January 1996–December 1998, with effect of steroid taper initiated in September 1997.



**Figure 3.** Illustrates the cost of medication per 6 months from January 1996–December 1998, and the effect of intervention after September 1997.

between patient, pharmacy, all health care professionals, clinic staff, and ED.

## RESULTS

The patient was monitored from September 1997 to December 1998. The post-intervention condition revealed a gradual decline in both the patient's symptom complaints and in the frequency of her contacts within the health care system. The number of clinic visits did

initially increase secondary to her scheduled biweekly appointments, but by the end of 1998 her clinic visits declined from 14 over a 6-month period, to only 4 (Figure 1). ED visits declined after the contract was instituted, with only 2 visits for the entire year of 1998. The patient routinely kept her psychiatry appointments, which were scheduled monthly. Shortly after institution of the contract, the number of phone calls from the patient doubled, but then decreased significantly as mutual trust developed. The primary content of the calls involved complaints of increasing upper respiratory symptoms and congestion, along with non-specific symptoms of weakness and fatigue. Prednisone taper was initiated, and within 3 months her prednisone use declined by 50%. By 10 months she was weaned off prednisone completely without change in pulmonary status (Figure 2). Her medication costs decreased by 60%, despite the added cost of treating diabetes and hypertension (Figure 3). The patient was diagnosed and received psychiatric care for dysthymia and anxiety. Her overall health improved, with better control of the steroid-induced diabetes and hypertension. Metformin was initially required to treat steroid-induced diabetes, but was not needed with the discontinuation of prednisone. In addition to these objective measures of improvement, psychiatric treatment subjectively improved her mood and affect. She maintained a job intermittently, participated in computer courses at a local college, and remained drug-free.

## DISCUSSION

This case emphasizes that the early recognition of psychosocial issues is of utmost importance in caring for patients presenting with difficult-to-document physical complaints. It is lamentable that this patient's health care had progressed to such a degree of unnecessary excess, proving deleterious to both her physical and psychological health. The development of steroid-induced diabetes and hypertension, as well as physical and psychological dependence to prescribed medication, combined to complicate her pre-existing health conditions. While patients must assume some degree of responsibility for their health, several underlying factors in the health care system and in physician practices allowed this situation to progress. Once defined, an appropriate approach to her health care was begun.

In reviewing the asthma literature, patient characteristics found to influence asthma outcomes include age, gender, poverty, psychosocial factors, psychiatric disorders, and ethnicity.<sup>1</sup> In addition, co-existing medical conditions such as allergic rhinitis and sinusitis have been shown to play a role in determining asthma out-

comes in adolescents and adults.<sup>2</sup> However, the effect of comorbid psychiatric conditions have received relatively little attention.

Psychiatric comorbidity, of which depressive and anxiety symptoms are most common, is present in about one-third of medical outpatients. Despite its important clinical significance, only 30%-50% of cases are identified in the clinic setting.<sup>3</sup> In addition to personal suffering, psychiatric comorbidity is associated with increased health care costs and elevated risk of mortality. However, studies have shown that if treatment is initiated, patient outcome improves significantly with regard to clinical outcome, satisfaction with care, and health services cost.<sup>4</sup> Efficient pharmacological treatments are available especially for depressive disorders. Additionally, physicians must contend with other disincentives such as limited time, inadequate access to mental health care, and other competing demands.<sup>5</sup> Hence, simple clinical indicators are needed to improve recognition and treatment in the primary care setting. Lowe et al<sup>6</sup> identified 4 important predictors of psychiatric comorbidity for diagnostic use in busy medical settings: (1) a screening question for nervousness, anxiety, or worries; (2) a screening question for depressed mood; (3) self report of 3 or more bothersome physical symptoms; and (4) distress due to partner difficulties. Information about these 4 predictors can identify as many as 86% of cases with psychiatric comorbidity.<sup>6</sup>

This case also illustrates that a written care plan (contract) can be successfully instituted for non-narcotic medications in the care of a difficult patient. The use of contract agreements is well known for patients using long-term opioids.<sup>7</sup> This approach is mutually beneficial, sets limits, and reduces the liabilities that contribute to the excessive use of the health care system by a susceptible patient. A contract is defined as an "explicit bilateral commitment to a well-defined course of action."<sup>8</sup> A contractual approach forms a partnership between the physician and patient. It is guided by the 4 basic contractual assumptions: (1) both the doctor and the patient have unique responsibilities; (2) the relationship is consensual, not obligatory; (3) both people must be willing to negotiate; and (4) each must gain something in the encounters. These interactions allow both participants to share the responsibility for care. In addition, a contract between the doctor and patient is a dynamic multidimensional agreement that evolves over time. As the medical condition evolves, so must the therapeutic agreement.<sup>9</sup> This agreement places structure and limits within the patient-physician relationship, unifying previously fragmented care.

The development of mutual trust and communication is essential to successful management in this partnership.<sup>9</sup> This trust is built by working together as a team with defined rules and expectations. Clear communication between the patient and all members of the team is essential. Communication can be difficult and fragmented in large academic centers with multiple trainees and providers. A team approach limits this fragmentation and improves care. Our patient was willing to trust her health care team and became actively involved in her own health. This, in turn, allayed the patient's anxiety, met her needs, and resulted in a positive outcome for her overall health. Health care system overuse was avoided and patient care was unified.

In conclusion, we believe that in the care of the difficult patient, one should recognize the precise nature of the patient's problem, clinical predictors of psychiatric comorbidity, and possible fragmentation of care and overuse of the health care system. Improved structure, communication, and accessibility coupled with strong patient effort form the backbone of success.

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