EDITORIAL

The Myth of the Demanding Patient

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In this issue of *JAMA Oncology*, Gogineni and colleagues report on their empirical inquiry into patient demands,[1] a nemesis that proves to be more mythical than real. The study hypothesis—that patient demands for treatments and scans drove unnecessary costs—was spectacularly unconfirmed when using data collected from physicians themselves. Only 8% of the patient-physician encounters at 3 cancer centers in Philadelphia involved a patient "demand," and the majority of those "demands" were viewed by the physician as "clinically appropriate." Suddenly, the demanding cancer patient looks less like a budget buster and more like an urban myth.

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In the wake of these findings, the question now deserving of our attention is why does the myth of the demanding patient have so much traction? Surprisingly (as the authors note), no prior empirical study exists to tally patient demands in cancer care, which makes the existence of the demanding patient myth even more curious. My new hypothesis is that these findings say more about our own clinical sensibilities than what they reveal about our patients. We clinicians often, in my own experience, view patients who make a request that is surprising, unjustified, or forceful (eg, a "demand") as (1) hard to deal with; (2) memorable despite their infrequent appearance; and (3) a convenient target for the bigger, complex, seemingly unsolvable problems we face.

When patients make requests forcefully, it is easy for an unskilled clinician to be pushed off balance. A forceful request often carries an undercurrent of hostility that throws oncologists who are used to being treated with deference. We do not like this, and consequently, hostility from the patient tends to provoke hostility from the clinician. For clinicians who have not been trained to detect and respond to emotion as a core communication skill, it is easy to fall into the trap of responding defensively or angrily. From the outside, this skill can look like magic because it is subtle—it starts with self-monitoring.[2] The key skill is to notice when you are irritated, and rather than blurt out your defense, pause and step back for a moment. You will then recognize that your patient who is demanding something is actually upset and hurting in a way that is overwhelming their coping skills or, much less often, has a personality such that they deal with everyone in their lives by making demands. A skilled clinician, after the pause, would start with an empathic remark ("Hmm, sounds like this is really important to you") and modulate accordingly.[3] For a patient who is really upset, the emotionally intelligent oncologist might offer more empathy ("I get the feeling you are worried…") and uncover the real issue ("Yes doctor, I'm just scared"); and when the emotional tone fades, try the information again ("Could I step back—I'll try to do a better job explaining my recommendations").

Although demanding patients are not common, they often figure prominently in our memories because our cognitive biases tend to spotlight outliers.[4] One reason for this is that a demanding, dissatisfied, unhappy patient can tap into our own unhappiness about not being perfect, our own disappointment about not saving the day, and our own dismay about not being appreciated. If we do not have our own skills to emotionally self-regulate and recharge, we tend to give these cognitive biases more influence than they merit. And we have started our day with stress, multitasking, and inadequate sleep—all very common. It is even easier to let our cognitive biases run rampant. A common cognitive bias, misattribution bias, is particularly relevant for this discussion. The demanding patient leaves us with vivid memories, and it is an easy move to pin them (unjustly) with the blame for runaway costs.

The real point of the study by Gogineni et al,[1] however, is this: we have to stop blaming patients for being demanding. In reality, it is hardly happening. The myth of the demanding patient is more about our own responses and how lackluster communication skills can contribute to difficult situations that stick in our throats and our memories. And when we have calmed down enough to look up, we see that what is really happening between patients and physicians these days is something quite different.

The demanding patient myth reflects an old paradigm of patient-clinician interactions: the paternalistic physician told the patient what to do, and the patient who did not like it had to resort to a demand to cut through the physician's cloak of authority.[5] But that old posturing is receding in the face of a new dynamic.

We are witnessing a tectonic shift in the dynamics between patients and physicians around cancer.[6] Patients used to come to oncologists seeking information about their cancer and recommendations for treatment. Before the Internet, they did not have any other sources. But now in the age of Wikipedia, patients and their families usually come prepared. Patients and families seek and absorb information from websites, textbooks, their own medical records, or other patients, all unmediated by clinicians, and they come to visits to verify what they have heard, ask questions, and gain from the physician's clinical experience. Patients now begin shaping their preferences and decision making before they set foot in the oncologist's office.

The new dynamic is reflected in a fresh view of interactions from other empirical studies. What patients value from physicians is being guided to the information they need and want; being given that information at a pace they can absorb;

having access to the physician's clinical experience; and feeling that the physician recognizes their situation, their individuality, and humanness.[7] This dynamic builds trust between patient and physician so that when they need to face the tough decisions, the medical decision making reflects the patient's real values and not just their fear.

It is possible that what the study by Gogineni et al[1] documents is a point in the evolution of the patient-physician relationship when both sides recognize that the complexity of cancer care belies a simple fix. Perhaps this "negative" study is pointing to an important truth: that we need to redirect our attention from the myths that are distracting us.

ARTICLE INFORMATION

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Published Online: February 12, 2015. doi:10.1001/jamaoncol.2014.185.

Conflict of Interest Disclosures: None reported.

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