Expanding Our Skills for Dealing With Difficult Patient Encounter
Workshop WD04

SGIM
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Objectives:
1. How to be more effective therapeutically and time efficient in dealing with difficult patient situations?
2. How to increase clinical effectiveness when patient’s symptoms are not explained by biomedical possibilities?
3. To enhance participants' skills in addressing the behavioral and psychological aspects of medical encounters.
4. Participants will learn techniques to improve the patient satisfaction level and reduce their stresses in every day practice.
5. To enhance participants’ repertoire of strategies for coping with patients who are “difficult” to deal with.

What Your Patients Think of You—and Vice Versa

From nationwide telephone polls taken for Hippocrates by Roper Starch Worldwide Inc. of 750 patients and 200 physicians in August 1995. Answers do not include “don’t know” responses.

### What behavior in your doctors do you find most difficult to deal with?  

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>They're too rushed</td>
<td>30%</td>
</tr>
<tr>
<td>They're hard to get hold of</td>
<td>19%</td>
</tr>
<tr>
<td>They speak too technically</td>
<td>11%</td>
</tr>
<tr>
<td>They don't give enough guidance</td>
<td>5%</td>
</tr>
<tr>
<td>They're too arrogant</td>
<td>5%</td>
</tr>
<tr>
<td>None</td>
<td>24%</td>
</tr>
</tbody>
</table>

### Who do you find most difficult to deal with? The patient who:  

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>is hostile or angry</td>
<td>49%</td>
</tr>
<tr>
<td>doesn't follow instructions</td>
<td>19%</td>
</tr>
<tr>
<td>is too demanding or needy</td>
<td>19%</td>
</tr>
<tr>
<td>doesn't know how to describe his symptoms</td>
<td>11%</td>
</tr>
<tr>
<td>asks too many questions</td>
<td>2%</td>
</tr>
</tbody>
</table>
Medical school does not train doctors adequately to deal with the emotional needs of patients. How strongly do you agree?

- Agree strongly: 31%
- Agree somewhat: 37%
- Disagree somewhat: 18%
- Disagree strongly: 12%

Model of Clinical Care

Biomedical Model

- Find it
- Fix it

Communication model (The Four Habits of Highly Effective Clinicians)

- Invest in the Beginning
- Elicit the Patient’s Perspective
- Demonstrate Empathy
- Invest in the End
Model of Complete Clinical Care

Opening

Communication Tasks
- Engage
- Empathy
- Educate
- Enlist

Biomedical Task
- Find it
- Fix it

Closing
Outcomes of successful communication

- Agreement on diagnosis
- Informed consent
- Adherence to treatment
- Positive health outcomes
- Mutual satisfaction
- Decrease in malpractice risk

Communication matters

- Improvement in health outcomes
  - Diagnostic accuracy
  - Adherence
  - Biological and psychological measure
  - Beckman & Frankel, 1984
  - Safran et al, 1998; Roter, 1999; Haynes 2002
  - Roter, 2000; Stewart 1999

- Improvement in social outcomes
  - Patient satisfaction
  - Clinician satisfaction
  - Informed consent
  - Malpractice risk
  - Beckman, 1994, Entman, 1994, Levinson 1999
  - Braddock 1997; 1999; Levinson, 1999
  - Pathman et al, 2002
Different situations call for tailored responses

**PROCEDURES**
- Engage
- Empathize
- Educate
- Enlist

**“COMFORT”**
- Acknowledge problems
- Discover meaning
- Opportunities for compassion
- Boundaries

**“CHALLENGE”**
- Extend the System

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The label “difficult” is subjective

- Interpersonal in nature
- Based upon discomfort with:
  - what has happened
  - what might happen
A patient labeled “difficult” by one clinician may not be seen as quite so difficult by another. Differences in expertise and experience account for differences in perception.

“Difficult” is a function of the relationship:
- Two people
- How they interact
Clinicians can have fewer “difficult” relationships by:

- Discovering what factors contribute to the label “difficult”
- Exploring techniques that can lead to more satisfactory relationships
- Experimenting with new skills

Relationship difficulties develop when….

- Success is frustrated
- Expectations are misaligned
- Flexibility is insufficient

A MODEL

Patient

Clinician

“D”

Illness

Systems
**Instructions**

In the spaces below, indicate which situation you believe would be (1) most difficult for you to work with, (2) next most difficult, and (3) least difficult.

Then, in the space provided, jot down your reasons for selecting the situation you did as “most difficult”.

**SET ONE**

<table>
<thead>
<tr>
<th>Situation A</th>
<th>Situation B</th>
<th>Situation C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home to Puerto Rico</td>
<td>Prescription for Percocet</td>
<td>Fill my disability form</td>
</tr>
</tbody>
</table>

Reasons for selecting the situation you did as “most difficult” for you

**SET TWO**

<table>
<thead>
<tr>
<th>Situation A</th>
<th>Situation B</th>
<th>Situation C</th>
</tr>
</thead>
<tbody>
<tr>
<td>You don’t care</td>
<td>Fat genes</td>
<td>Heart beats fast</td>
</tr>
</tbody>
</table>

Reasons for selecting the situation you did as “most difficult” for you

**SET THREE**

<table>
<thead>
<tr>
<th>Situation A</th>
<th>Situation B</th>
<th>Situation C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wants results now</td>
<td>You call my daughter</td>
<td>Sees a naturopath</td>
</tr>
</tbody>
</table>

Reasons for selecting the situation you did as “most difficult” for you
Review your selection above paying attention to the reasons for the selection. Then complete the following statement.

“I tend to experience a situation as “difficult” when….”

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Use adjectives or phrases to describe what you need in the clinician-patient relationship.

“Based upon this analysis, I see myself wanting clinician-patient relationship in which…”

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
**Difficult Patient encounter - Differing Role Expectations**

When the doctor and the patient have a different expectation, difficulties may arise that lead to impaired interactions during the medical interview. Some common examples may include:

- The patient expects you to prescribe medications that he or she requests – you expect to perform a history, exam and understand the problem to confirm the medication is safe and appropriate.
- The patient expects you to fill out disability papers – you expect to participate in a discussion of whether the problem merits labeling as a disabling condition.
- The patient expects you to address 10 different problems in a 15-minute interview – you expect to address one or two problems with appropriate level of attention.

**Suggested Approach to Dealing with Differing Role Expectations:**

1. Recognize there is a problem – often feeling discomfort in the interaction is a clue that some boundary has threatened.
2. Begin a discussion of the issue.
3. Avoid blame and name-calling
4. Avoid thinking of yourself as a victim of patient
5. Set limits if rules of communication are dramatically broken
6. Negotiation:
   a. Opening up the disagreement for conversation begins the process of negotiation.
   b. Openness to what your patient is saying, whether you agree or not with his/her theory, is an act of respect. Try to learn how the patient has come to his/her opinion and what is motivating it.
   c. Try to understand the patient and try to let the patient know that you understand.
d. If negotiation fails, you might end gracefully and peacefully despite disagreement.

7. Avoid:
   a. Getting offended and settling into an intransigent position
   b. Repeating yourself, more loudly each time.
   c. Failing to understand your patient’s ideas and values.
   d. Missing an opportunity for empathic communication.

8. Pearls: Ask what leads your patient to think what he or she thinks (patient belief system)
   a. Etiology: ‘What do you think is wrong?’ “What do you consider unlikely, but is your most worrisome concern about what is wrong?”
   b. Pathogenesis: “What do you think has contributed to your illness?”
   c. Diagnosis: “What thought have you had about possible treatment needed for your problems?”
   d. Prognosis: “What thoughts have you had about possible outcomes of your illness?”

**Angry Patient**

Anger in patients is usually obvious, but sometimes anger is expressed in more subtle ways such as discordant message between the verbal expressions and the nonverbal communication.

Physicians frequently avoid addressing anger, most commonly by ignoring it or by changing topic. The two most common reasons given for failure to address anger are for fear of unleashing more anger, or fear of time involvement. This practice may escalate the anger. Responding to patient anger with anger may further escalate the tension, prolong the encounter and visit may be non productive.

Patients’ anger is usually a defense mechanism for dealing with a fear of their own:
- fear of loss of control
- fear of dependence
- fear of rejection
- fear of meaning of illness
- fear of inadequacy
- fear of dying

Following are some of physicians’ responses:
- fear
- Vulnerability
- Confusion
- Reduced empathy
- Resentment
- Sense of being manipulated
- Exhaustion
- Impatience
- Frustration
- Desire to punish
- Anger

**Strategies:**

1. **Active Listening** – Paralanguage skills, position, posture, eye contact, facilitative responses, silence

   *Try talking as little as possible during this time. Listen and paraphrase what you’ve heard.*

2. **Framing** – “Sounds like what you are telling me…”

   “Let’s see if I have this right…”

3. **Reflecting Content** – Factual as well as nature and intensity

4. **Identifying and Calibrating the Anger** – Sometimes content is evident, but nature of anger is unclear

   “That situation really got to you, didn’t it?”

   “I can imagine how angry I’d feel if that happened to me”

5. **Requesting and Accepting the Correction** – “Did I get that right…?”

6. **Empathy** – Three implications

   - **Cognitive** – enter patients’ perspective but don’t loose your own
   - **Affective** – put yourself in patient’s place
   - **Action** – verify emotion so patient can correct and/or feel listened to.

   *If you’d like to show empathy without saying “I’m sorry” which might imply responsibility for the situation, consider using a statement with the words “I wish”, for example, “I wish you didn’t have to wait as long as you did.”*

   * Empathy is not the same as agreeing with patient. Empathizing is expressing understanding of how the patient feels.

7. **Sorry** - I you made a mistake that lead to anger, admit it and apologize.

   Do not try to excuse, explain or discuss specifics at first… the patient will need to have his or her feelings validated first before they are willing to listen if they are angry. Trying to excuse the problem may lead him or her to feel as if their feeling is not valid and lead to more anger.

8. **Consider Motivation** – Secondary gain? Hidden agenda

9. **Recognizing Physician Limitations.**

**Dealing with Patient Emotions**

Dealing with a patients’ anger or any such strong emotion could be a challenging task during the medical consultation/interviewing. The strong emotion could affect the interview process in many ways including the ability for the physician to obtain necessary information during the interview, to negotiate a plan of care with patient and to have a long-term relationship for continued partnership in care.

It is important to address and diffuse the emotions otherwise it will create barrier to effective and efficient communication during the encounter.
Following is a suggested algorithm providing strategies for dealing with difficult emotions. (Mnemonic: NURS the emotion)

1. **Name** – name the emotion
   a. I can see that you are frustrated…”
   b. If you’re not sure of the emotion or you “guess” wrong… the patient will correct you…”I’m not frustrated, I’m angry”
   c. Move forward and name the correct emotion, “I can see that you are angry…”

2. **Understand** – show the understanding of the reason for the emotion
   a. “I can understand how you would be angry if you had to wait as long as you did…”
   B. Or ask the patient the reason for his emotion

3. **Respect** – Provide recognition for the helpful behaviors the patient is exhibiting
   a. “I appreciate the fact that you choose to wait to see me even if you were upset about…..”
   b. Respect their reason with out judgmental comments.

4. **Support** – Provide a statement of ongoing support and partnership
   a. “I’d like to know that I am going to do my best to help you with the time we have today..”

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**Motivational Interviewing Skills**

Developing Discrepancy by Eliciting Change Talk:

1) Evocative Questions for all 4 types of change talk
   - Disadvantage of status quo -- What worries you about your condition?
     -- What difficulties have you experienced?
   - Advantage of change -- If your condition magically went away, how might your life be better?
     -- What would be good about quitting?
- Optimism about change -- When have you changed in the past?
  -- Who might support you in this change?
- Intent to change -- What do you think you might do?
  -- What do you want to happen?

2) Importance Ruler – “On a scale of 0 to 10, how important is change right now?”
  follow up w/ “What would it take for you to go from (answer) to (higher #)
  and “Why are you not at 0?”

3) Exploring both sides of the decisional balance – don’t just focus on the negatives of behavior and the positives of change, help the pt to explore both sides of the ambivalence, keeps you from arguing against pt

4) Elaboration – once a pt starts change talk, keep them talking about it by asking
  - “In what way? How much? When?”
  - for an example
  - “What else?”

5) Query extremes – “What is the worst thing that could happen to you if things stay the same?”
  “If the best came of your change, what would that be like?”

6) Exploring values – Find out what is important to patient. Is this affected by condition?

**Rolling with resistance:**

1) Simple reflection – acknowledge pt’s concern, without being defensive
  “It’s hard to imagine how I could understand”

2) Amplified reflection – take pt’s statement farther than intended “My wife is always exaggerating. I haven’t ever been that bad.” Response “It seems to you that she has no reason for concern.”

3) Double sided reflection – “You are experiencing a lot of pain and at the same time you think that exercise will help in the long run.

4) Shifting focus – “Ok, the judge said I have to be here, tell me what I have to do.” Response “I don’t know you well enough for us to even start talking about what makes sense for you to do, instead, let’s…”

5) Reframing – offer new meaning to pt’s observations (after validating) ex. Pt is disappointed at multiple failed attempts to change, reframe to emphasize perseverance and learning from set backs

6) Agreeing with a twist “Nobody can tell me how to raise my kids. You don’t live there or know how it is.” Response “The truth is that it really is up to you how your kids
are raised. You’re in the best position to know which ideas are likely to work or not. It really is important that you are a full partner in this.”

7) Emphasize personal choice and freedom – helps to diminish “No one tells me what to do” response. e.g. “I can give you information, but the choice is up to you.”

8) Paradox - “It may just be worth it to you to keep on drinking as you have, even though it causes some problems. It’s worth the cost.” “It’s possible that after giving it another try, you still won’t be any better off, so it might be better not to try at all. What do you think?”

9) Active paradox – set up a role play where you argue against change and the pt has to try to convince you otherwise

Bibliography of Difficult Patient Interactions
12. Martyn C. Field guide to the difficult patient interview BMJ. 1999 Sep 18;319

Bibliography for How to Break Bad News

9. Maynard, D. W., On clinicians co-implicating recipients' perspective in the delivery of diagnostic news, Talk and Social Structure: Studies in Ethnomethodology and

References for Patients Refusing Medical Treatment:

Questions

QUESTION # 1
The Four Habits of Highly Effective Clinicians include all of the followings except.

A. Invest in the Beginning
B. Elicit the Patient’s Perspective
C. Finding and fixing the problem
D. Demonstrate Empathy
E. Invest in the End

QUESTION # 2
Outcomes of successful communication will include all of the following except.

A. Agreement on diagnosis
B. Better adherence
C. Mutual satisfaction
D. Positive health outcomes
E. Increase in malpractice
QUESTION # 3
Last year you found that your patient, an active 56yo carpenter who also serves in city government, had diabetes. He dieted and walked more and lost 15 pounds, reducing his Hgb A1C from 8.5 to 6.0. This year, his weight slowly increased and his A1C is 8.5. His wife reveals his liking for Girl Scout cookies. Patient complains of worsening hip pain, which you previously successfully treated with NSAIDS. After discussion, you advise him to lose 15 pounds again, and he says, "Oh doctor, with my hips, I just can't walk enough!" His wife again interrupted and complained about his sweet tooth.

Which of these POSSIBLE RESPONSES do you prefer?

A. Perhaps stopping cookies will get the weight off.
B. I think I can ease your hip pain.
C. You lost weight before; can you do it again?
D. You may have to start a diabetes medication.
E. You want to manage the diabetes, but are concerned you can't lose weight because of your hip pain and your wife is worried about your eating habits.

QUESTION # 4
You are doing an initial complete history & physical examination on a new patient who is a 42-year-old construction worker. Two days prior to the visit his spouse called you and made you aware of the fact that she is very worried about his heavy drinking and that she wanted you to be sure to address it in the context of the visit, but not to divulge the fact that she called. During the history taking the patient reveals that he has 3-4 beers "on the way home with the boys" then usually another three or four each evening. He made it clear that he sees this as a modest intake as it is "only beer." He denied having his drinking ever interfere with his interactions at home, his work situation or his driving, although he reveals he had one "close call" for a DWI.

Which one of these POSSIBLE COMMENTS regarding this patient's drinking do you prefer?

A. Your alcohol intake is clearly excessive and will likely get you into medical trouble down the line.
B. I understand from your wife that your drinking has been a problem at home.
C. You are drinking the equivalent of six or eight shots of liquor each evening.
D. I am concerned about your drinking.
E. It is only a matter of time until you get caught for a DWI.

QUESTION # 5
About 25-305 patients in practice are considered “difficult to deal with”. ADOBE model is a good mnemonic for strategies to deal with these patients. All of the following are part of the ADOBE model except.

A. Acknowledge the problem  
B. Discover meaning  
C. Opportunities for compassion  
D. Adjust boundaries  
E. Educate the patient

**Answers:**

**Question # 1: C**  
**Explanation:** Finding and fixing should be part of complete care model but it is not the part of communication model.

**Question # 2: E**  
**Explanation:** Research has shown that clinicians could reduce the malpractice risks by using communication model.

**Question # 3: E**  
**Explanation:** Research shows that engagement and commitment are enhanced when doctors paraphrase patient's thoughts, particularly when the patient's initial response is qualified or negative. This strategy is called "reflective listening". It demonstrates your attention and gives the patient freedom to suggest a plan, to ask a question, or to name additional concerns. Letting him have the lead ((as well as his wife)) will boost your efficiency at finding successful solutions.  
Giving orders (C) or simple fixes (A, B) to complex lifestyle problems often fails. People will succeed only when they make a considered decision.
Threats (D) leave him hanging and stifle dialog, as would emphasis on his admitted transgression (A).

**Question # 4: D**
**Explanation:** Personal ("I") statements reflecting sincere concern on the part of an empathic physician are very powerful tools in building a relationship and gaining trust. In a patient who is still in denial, accusatory statements such as A or E often only result in further alienation from the clinician. An educational statement such as C, to help with the reality check can be helpful, but perhaps not as an initial offering. Certainly statement B, which betrays trust in three directions will only serve to make the patient suspicious and likely not return.

**Question # 5: E**
**Explanation:** The correct answer is Extending the system

**Notes**