“Difficult” Clinician Patient Relationships

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Through the years, practitioners have attempted to discover more successful and empathic responses to address the needs of what has been referred to as the "difficult" patient. Writers in the past found it useful to define and cull out the distinctions that separated one type of "difficulty" in working with patients from another so as to "handle" some patients more effectively. Recently, it has been recognized and generally accepted that the "difficulty" in caring for patients frequently arises out of an interactive process between the patient and caregiver. This understanding requires practitioner self-awareness as well as reflection about motivations and responses to difficult clinical encounters. Two poems from the medical literature are explored as "clinical" examples that broaden our experience and understanding of the mystery and complexity of all human relationships.


Patient care and management can present a significant source of stress for the practicing dentist. This article presents the various facets and underpinnings of stress, followed by an overview of the physiologic phenomena attending the classic stress response, with an examination of the interplay between the psychologic components of stress and its influences on the development or exacerbation of somatic disorders. In addition, the characteristics that can be attributed to the patient and the practitioner that give rise to difficult encounters are explored, with an eye toward proper professional management. Further, the motivations of select patient personae are examined, including discussions regarding the angry patient, the anxious or demanding patient, and the noncompliant and addicted patient. The article offers suggestions for management of such patients, with short- and long-term stress management techniques.


A student learning experience about managing difficult patients in speech-language pathology is described. In 2006, 40 students participated in a daylong learning experience. The first part of the experience consisted of presentations and discussions of different scenarios of interpersonal difficulty. The theoretical introduction was followed by an active learning experience with simulated patients. A similar experience without the simulated patients was conducted for 45 students in 2010. Both years of students rated the experience with an overall grade and gave qualitative feedback. There was no significant difference between the overall grades given by the students in 2006 and 2010. The qualitative feedback indicated that the students valued the experience and that they felt it added to their learning and professional development. The students in 2006 also provided detailed feedback on the simulation activities. Students endorsed the experience...
and recommended that the learning experience be repeated for future students. However, the students in 2006 also commented that they had felt inadequately prepared for interacting with the simulated patients. A learning experience with simulated patients can add to students' learning. The inclusion of simulated patients can provide a different, but not automatically better, learning experience.


Most pediatricians have experienced uneasy interactions involving patients and/or their parents. The majority of literature on this topic reflects encounters in adult medicine, without providing much information for pediatricians who also face this challenge. Unique to the pediatric approach is the added quotient of the parent/family dynamic. Patients or their parents may have personality disorders or subclinical mental health issues, physicians may be overworked or have a lack of experience, and the health care system may be overburdened, fragmented, and inundated with poor communication. Recognizing the physical or emotional responses triggered by challenging patients/families may allow the provider to effectively partner with, instead of confront, the patient or the family. In this article we review existing literature on this subject and describe possible strategies for the pediatrician to use during a difficult encounter.


The authors describe the philosophy and pedagogical approach of an innovative educational program, grounded in principles of relational learning and designed to improve the preparedness of health care professionals for engaging in challenging conversations with patients and families. The Program to Enhance Relational and Communication Skills (PERCS) is a project of The Institute for Professionalism and Ethical Practice at Children's Hospital Boston, developed in collaboration with Education Development Center, Inc. The one-day workshop is interdisciplinary in its structure, includes practitioners with varying levels of professional experience, uses trained actors to portray patients and family members, and involves learners in improvised case scenarios. The program responds to several developments in contemporary health care: medical education reform, changing definitions of professional competence, and calls for greater attention to qualities of compassion, trust, and respect in practitioners' relationships with patients and families. The program's pedagogy responds to these developments by creating a safe climate for relational learning, by enacting emotionally challenging and ethically salient case scenarios, and by integrating patient and family perspectives in novel and substantive ways. By creating a curriculum and learning environment that explicitly embraces the moral experience of learners, the program's developers aim to exert a countercultural influence on the dehumanizing effects of the hidden curriculum.

Clear and concise recommendations on role definition of clinicians re: two disability processes. Physicians must be aware that disability work involves multiple roles: treating physician, adjudicating physician, certifying physician, expert opinion, etc. Most primary care physicians will simply provide information, not opinions or judgments, in disability cases. Some of the roles are conflicting (you can’t advocate for improved function and total disability at the same time). An opportunity to clarify boundaries with yourself and with patients.


Eight renowned surgeons responded to questions centering on "difficult patients" in facial plastic surgery. Questions ranged from, "How do you manage a postoperative patient who looks 'OK,' if not great, to you but complains about the result?" to "What 'pearl of advice' would you offer a novice surgeon on how to best avoid difficult situations with their patients?" The surgeons taking part in the discussion, from different practices in different parts of the country, provided a lively discussion based on their years of experience.


Virtually every physician has had patient encounters that are frustrating and dissatisfying for doctor and patient alike. Rather than label such patients "difficult," it may be more appropriate to call the patient-physician relationship itself difficult. By identifying possible sources of friction in these encounters--the patient care system or environment, illness, patient, or physician--and sharpening your communication skills, you may deflect potential unpleasantness, enhance rapport, and ensure greater patient satisfaction.


Two articles that review the rationale and techniques for eliciting the patient’s “explanatory model” of illness. Smith’s article suggests pausing after the agenda for the visit is set and asking, “Before we talk about these problems, how are you doing? DelBanco describes a more systematic approach, like a psychosocial review of systems, regarding the illness experience. These two articles describe the importance of discovering the meaning of the illness for the patient and suggest practical ways for going about it.

BACKGROUND: Nearly all family physicians have patients that engender a sense of frustration or dislike, often described as "difficult." Most research in this area focuses on describing these patients and their physicians, not management or coping.

OBJECTIVE: To describe how respected family physicians identify, manage, and cope with difficult patient encounters.

METHODS: Qualitative semi-structured interview study. Participant physicians described as "excellent" were recommended by medical school family medicine faculty around the county. Interview questions included "describe the patient you least like seeing," and "how do you keep sane but still assure adequate care for the patient?"

Interviews were analyzed using the editing method, looking for common categories and themes.

RESULTS: 102 physicians were interviewed. Physicians described both patient behaviors (stay sick and demanding) as well as medical problems (multiple, chronic pain, drug seeking, psychiatric) that they found frustrating. Difficult encounters occurred when these patient behaviors and medical problems clashed with physicians' personal and practice traits. Their management strategies to return the encounter to success incorporated collaboration, appropriate use of power and empathy.

CONCLUSIONS: We propose a model where clashes between patient behaviors and physicians' traits turn a successful encounter of collaboration, appropriate use of power and empathy into a difficult encounter of opposition, misuse of power and compassion fatigue. Management strategies used by our participants aim to return success to the encounter and may serve as a guide for practicing physicians and for future research.


This article provides a background for understanding and managing maladaptive personality traits and personality disorders in neurology practice. These characteristics are commonplace in neurology patients and may cause diagnostic confusion, increased functional impairment, and complications in the doctor-patient relationship. Maladaptive personality traits and personality disorders may precede neurological illness, may contribute to circumstances that lead to neurological injury, and may be caused by neurological illness, or some combination of these factors. Maladaptive personality traits associated with key neurological illnesses are reviewed, as are the major personality disorders, maladaptive defense mechanisms, countertransference reactions, and how these combine to contribute to difficulty in patient management. Finally, basic clinical management strategies are suggested.


Between 15 and 60% of patients are considered "difficult" by their treating physicians. Patient psychiatric pathology is the conventional explanation for why patients are deemed
"difficult." But the prevalence of the problem suggests the possibility of a less pathological cause. I argue that the phenomenon can be better explained as a response to problematic interactions related to health care delivery. If there are grounds to reconceive the "difficult" patient as reacting to the perception of ill treatment, then there is an ethical obligation to address this perception of harm. Resolution of such conflicts currently lies with the provider and patient. But the ethical stakes place these conflicts into the province of the ethics consult service. As the resource for addressing ethical dilemmas, there is a moral mandate to offer assistance in the resolution of these ethically charged conflicts that is no less pressing than the more familiar terrain of clinical ethics consultation


Five problematic statements by patients to their physicians are presented, and response are suggested based on current communication literature. Issues discussed include too many problems/too little time, requesting a test that is not indicated, changing doctors and health plans, and requests to bend the rules.


The challenges in managing the more complicated headache patients are discussed and reviewed in this article. These patients often have chronic daily headache or high-frequency disabling headache. Some of these patients have problems adhering to treatment regimens, which may reduce treatment efficacy and sometimes lead to medication overuse. Medication overuse itself may induce a transformation of headache to daily by reducing the effectiveness of acute and preventive therapies. Biobehavioral factors are important in the assessment and treatment of headache patients. Also the biobehavioral aspects involved in headache patients will provide a model for integration of behavioural therapies into clinical practice. The purpose of this article is to highlight behavioural/psychological factors important to consider for clinicians managing this particular category of patients.


All physicians must care for some patients who are perceived as difficult because of behavioral or emotional aspects that affect their care. Difficulties may be traced to patient, physician, or health care system factors. Patient factors include psychiatric disorders, personality disorders, and subclinical behavior traits. Physician factors include overwork, poor communication skills, low level of experience, and discomfort with uncertainty. Health care system factors include productivity pressures, changes in health care financing, fragmentation of visits, and the availability of outside information sources that challenge the physician's authority. Patients should be assessed carefully for untreated psychopathology. Physicians should seek professional care or support from
peers. Specific communication techniques and greater patient involvement in the process of care may enhance the relationship.


BACKGROUND: Previous studies have found that up to 15% of clinical encounters are experienced as difficult by clinicians.

OBJECTIVES: Explore patient and physician characteristics associated with being considered "difficult" and assess the impact on patient outcomes.

DESIGN: Prospective cohort study.

PARTICIPANTS: Seven hundred fifty adults presenting to a primary care walk-in clinic with a physical symptom.

MAIN MEASURES: Pre-visit surveys assessed symptom characteristics, expectations, functional status (Medical Outcome Study SF-6) and the presence of mental disorders [Primary Care Evaluation of Mental Disorders, (PRIME-MD)]. Post-visit surveys assessed satisfaction (Rand-9), unmet expectations and trust. Two-week assessment included symptom outcome (gone, better, same, worse), functional status and satisfaction. After each visit, clinicians rated encounter difficulty using the Difficult Doctor-Patient Relationship Questionnaire (DDPRQ). Clinicians also completed the Physician's Belief Scale, a measure of psychosocial orientation.

KEY RESULTS: Among the 750 subjects, 133 (17.8%) were perceived as difficult. "Difficult" patients were less likely to fully trust (RR = 0.88, 95% CI: 0.77-0.99) or be fully satisfied (RR = 0.78, 95% CI: 0.62-0.98) with their clinician, and were more likely to have worsening of symptoms at 2 weeks (RR = 0.75, 95% CI: 0.57-0.97). Patients involved in "difficult encounters" had more than five symptoms (RR = 1.8, 95% CI: 1.3-2.3), endorsed recent stress (RR = 1.9, 95% CI: 1.4-3.2) and had a depressive or anxiety disorder (RR = 2.3, 95% CI: 1.3-4.2). Physicians involved in difficult encounters were less experienced (12 years vs. 9 years, p = 0.0002) and had worse psychosocial orientation scores (77 vs. 67, p < 0.005).

CONCLUSION: Both patient and physician characteristics are associated with "difficult" encounters, and patients involved in such encounters have worse short-term outcomes.


Discussion of importance of cross-cultural medicine and cultural/ethnic diversity in communication with patients, and in discovering the meaning of illness. Examples of questions to ask. What do you call your illness? What do you think caused it? How long do you think it will last? Is there anything you (or anyone else) can do about it?

Based on casual conversations among those working in dialysis units, dialysis facility staff often face situations created by difficult or disruptive patients, yet relatively little is known about these situations. A computer interactive session at a national meeting in April 2000 was used to gather information on this topic from 203 persons who worked in dialysis facilities. Most respondents viewed situations with such patients as an increasing problem for the nephrology community. Although 71% of the respondents were frequently involved in the attempted resolution of these situations, only 50% indicated that they were adequately trained to intervene. Approximately 38% of the participants' facilities had discharged a patient because of behavioral difficulties in the preceding year. Many facilities lacked policies that could provide guidance to both staff and patients about their rights and responsibilities, as well as policies that specifically addressed difficult/disruptive patient situations. These results highlight the need for increased training for personnel and the development of policies by dialysis units to address this increasingly common problem.


Disengagement is the main enemy for the consultation-liaison psychiatrist. The goal of the first interview is to transform the unwilling, uncooperative, and often difficult and hostile patient into an engaged interview participant. Otherwise, the interview is an unproductive interrogation and an unpleasant power struggle. Once the difficult patient is engaged, the more typical psychiatric interview can begin. The three interview-engagement tips or techniques described are among the author's favorite ways to overcome the impediments to engagement most often associated with difficult patients.


Twelve mental health clinical nurse specialists (CNSs) working in outpatient mental health settings were interviewed and asked to describe situations where they had experienced difficult client behavior. Study data, analyzed via the grounded theory method, revealed the basic social process of Evolving Meaning. Evolving Meaning signifies change over time, based on both Enhancing Experience and Expanding Understanding. The phases of Personal Meaning, Negotiating Meaning, and Illuminating Meaning were recognized as central to the basic social process of Evolving Meaning. The study findings emphasized the importance of the nurse-client relationship process. Although the CNS participants did describe client behavior that created difficulty for them, the CNS-client relationship was viewed as being interactive and subsequently, difficult behavior was viewed within the context of that relationship. Clinical supervision was recognized as an essential component of outpatient mental health CNS practice, even by the more experienced study participants. In this study, positive components of clinical supervision included validation, insight, and system support. A surprising finding of the
study was the intrusive behavior of clients, including stalking of some CNSs, their family members, or both.


Most common ways for clinicians and patients to disagree is in the nature of the illness and the methods of treatment. Describes practical negotiating techniques including direct education, second opinion, re-define the problem, brainstorm options, provide sample treatment, share some control, make some concessions, empathically confront, and make standards of care clear.


Illness makes patients vulnerable to shame and humiliation which can be precipitated by their having to find their way through the maze of medical care. Clinicians can also be shamed by not knowing, causing pain, not being able to help, etc. Feelings of shame, and experiences of being humiliated by others, can lead to anger, nonadherence, withdrawal, and other relationship difficulties. Awareness and acknowledgment of shame or humiliation helps the relationship.


Specific patient and physician characteristics may contribute to a perception that a particular headache patient is "difficult." Headache patients with psychiatric pathology, multiple unexplained symptoms, substance abuse problems, or refractory headaches are commonly perceived as challenging to manage. Physicians who are younger, under more stress, and who do not use collaborative treatment models are more likely to find patients difficult. General principles that may be helpful in coping with headache patients perceived as difficult include: (1) evaluation for possible psychiatric or substance abuse problems with institution of specific treatment if found; (2) a shift in treatment philosophy away from a goal of cure toward a goal of management; (3) the use of written agreements that outline conditions of treatment, including medication amounts; and (4) an integrated, multimodality treatment approach including behavioral and non-pharmacological treatment.


Anger is a "syndrome" of thoughts, feelings and physiologic reactions. Behavioral responses to anger are influenced by multiple contextual factors. Patients and family members may express anger in response to their own experiences of illness, the healthcare system, or the physician-patient/family relationship. Anger may evoke a
variety of clinician responses that while understandable, inadvertently escalate patient and family anger. Clinicians who cultivate personal awareness, practice mindful self-monitoring during their interactions, explore the differential diagnosis of anger, demonstrate specific communication skills, set clear boundaries and seek personal support can overcome the challenges of these difficult conversations, and begin to restore trust in the physician-patient/family relationship.


BACKGROUND: Communication skills and relational abilities are essential core competencies that are associated with improved health outcomes, better patient adherence, fewer malpractice claims, and enhanced satisfaction with care. Yet, corresponding educational opportunities are sorely underrepresented and undervalued.
OBJECTIVE: To evaluate the impact of an interdisciplinary experiential learning paradigm to improve communication skills and relational abilities of pediatric critical care practitioners.

DESIGN: Prepost design, including baseline, immediate follow-up, and 5-month self-report questionnaires.

SETTING: Tertiary care pediatric hospital, Children's Hospital Boston.

PARTICIPANTS: One hundred six interdisciplinary clinicians with a range of experience levels and clinical specialties.

MEASUREMENTS: Participants rated their sense of preparation, communication and relational skills, confidence, and anxiety. Open-ended questions asked participants about lessons learned, aspects of the training they found most helpful, and suggestions to improve the training.

MAIN RESULTS: When questions were posed in a yes/no format, participants were nearly unanimous (93% to 98%) that the training had improved their sense of preparation, communication skills, and confidence immediately after and 5 months posttraining. Ninety percent of participants reported improvements in establishing relationships immediately after the training and 84% reported improvements 5 months posttraining. Eighty-two percent reported reduced anxiety immediately after training and 74% experienced reduced anxiety 5 months posttraining. On Likert items, 70% estimated their preparation had improved; 40% to 70% reported improvements in communication skills, confidence and anxiety, and 15% in relationship skills. Four qualitative themes emerged: identifying one's existing competence; integrating new communication skills and relational abilities; appreciating interdisciplinary collaboration; and valuing the learning itself.

CONCLUSIONS: A 1-day experiential learning paradigm focused on communication skills and relational abilities was highly valued, clinically useful, and logistically feasible. Participants reported better preparation, improved communication and relational skills, greater confidence, and reduced anxiety. Participants deepened their understanding of family perspectives, recognized valuable existing competencies, and strengthened their commitment to interdisciplinary teamwork.


Described anger as a normal and powerful reaction for patients and family members facing medical problems. Anger was viewed as a response to provocation or as a threat to equilibrium. When anger is inappropriate, it is almost always a manifestation of fear and hidden insecurity. A table of do's and don'ts for handling the angry patient was provided. In addition, there were examples of what to say to angry patients.


Comprehensive review of the role of physician self-awareness in patient care. This is an expansion of a four-part core curriculum in psychosocial medicine for primary care physicians that was published in the Feb. 1984 Ann Intern Med. Items in the curriculum
include: physician beliefs and attitudes (personal philosophy, family of origin issues, gender and sociocultural influences); physician emotional responses (conflict and anger, caring and attraction); “difficult” relationships including caring for dying patients and acknowledging mistakes; and physician self-care (balancing personal and professional life, prevention of burnout).


As opposed to a casual discussion, crucial conversations happen between two or more people when opinions vary, stakes are high, and emotions run strong. Whether you are approaching a boss who is breaking his or her own policies, critiquing a colleague's work, or talking to a team member who isn't keeping commitments, keeping the conversation productive can be very difficult. Following the first edition of *Crucial Conversations* which revolutionized the way millions of people communicate when stakes are high, the second edition provide tools to: Prepare for high-stakes situations; Transform anger and hurt feelings into powerful dialogue; Make it safe to talk about almost anything; Be persuasive, not abrasive. The authors draw our attention to those defining moments that literally shape our lives, our relationships, and our world.


The authors of *Crucial Conversations* present how to achieve personal, team, and organizational success by healing broken promises, resolving violated expectations, and influencing good behavior. Discover skills to resolve touchy, controversial, and complex issues at work and at home. Behind the problems that routinely plague organizations and families, you'll find individuals who are either unwilling or unable to deal with failed promises. Others have broken rules, missed deadlines, failed to live up to commitments, or just plain behaved badly--and nobody steps up to the issue. Or they do, but do a lousy job and create a whole new set of problems. Accountability suffers and new problems spring up. New research demonstrates that these disappointments aren't just irritating, they're costly--sapping organizational performance by twenty to fifty percent and accounting for up to ninety percent of divorces.


Provided several case studies of “difficult” patients. Recommended a mutual participation approach.

This article describes a middle ground between the clinician as general (Do as I say) and private (I’ll do what you want). Patients are entitled not only to facts and information, but also to your experience and expertise. Make clear to the patient which are which. Also recall that patient requests for information does not necessarily mean a desire to participate in decision-making.


Doctors “train for certainty” and there is always a right or best answer. Doctors and patients both expect that the doctor will know everything. Traditionally, uncertainty is taboo to discuss with patients. However, we see a lot of patients for whom we are uncertain as to the cause of their symptoms or the best treatment. This article suggests using the relationship to identify hopes and opportunities when the diagnosis or treatment is uncertain, and to partner with the patient in identifying and working toward goals other than “find it and fix it” when that approach hasn’t worked.


When difficult relationships occur it often helps to make roles and boundaries explicit so they can be discussed. Examples include antibiotics for a cold, narcotics for chronic pain, refusal to acknowledge psychosocial aspects of illness. Both parties need to gain something from the relationship. Neither clinician nor patient should go beyond what he/she thinks are in the patient’s best interests. Sometimes an agreement cannot be reached and it becomes clear that you and a patient are unable to work together. These concepts help dispel the notion that great communication skills can make any relationship more successful.


The term difficult patient refers to a group of patients with whom a physician may have trouble forming a normal therapeutic relationship. The care of these patients can present many ethical dilemmas, ranging from issues of patient autonomy to questions of appropriate use of resources, which the emergency physician must be prepared to handle. Encounters with these patients also challenge physicians to explore and cultivate many of the character traits and virtues necessary to being a humane, caring, and ethical practitioner.


Presented ideas on “reasons” for failed relationships between clinicians and patients. Four reasons why relationships fail: 1) breakdown in communication, i.e., patient does not understand; 2) clinician fails to gauge correctly patients needs, wants, expectations;
3) clinician fails to recognize the meaning of the illness for the patient; and 4) clinician is frustrated, overwhelmed, drained, powerless. Four suggestions for management of the “difficult” relationship were: 1) acknowledge own feelings; 2) write I=FACH (I feel impotent because I am frustrated, angry, confused, hostile) on these patients’ charts and avoid making value judgments; 3) pay attention to communication- verbal and nonverbal; and 4) accept the patient’s view and symptoms.


We attempt or avoid difficult conversations every day-whether dealing with an underperforming employee, disagreeing with a spouse, or negotiating with a client. From the Harvard Negotiation Project, the authors provide a step-by-step approach to having those tough conversations with less stress and more success. The approach includes strategies to decipher the underlying structure of every difficult conversation; start a conversation without defensiveness; listening for the meaning of what is not said; staying balanced in the face of attacks and accusations; and moving from emotion to productive problem solving.


The basic skills are: recognizing when emotions are present but not directly expressed; inviting exploration of unexpressed feelings; and effectively acknowledging the feelings so that the patient feels understood. Physicians are empathic but rarely express it overtly. This is probably the least utilized of the communication skills but one that is most closely associated with patient satisfaction and other outcomes.


Managing the "difficult" patient is a challenge all dentists face. This paper describes a psychodynamic model that pictures the dentist-patient relationship as a two-way interaction that involves unconscious processes. The model uses the three ego states: the parent, the adult, and the child, to understand problematic encounters and how to manage them. Using this model has the potential to enhance the therapeutic alliance, decrease malpractice claims, and lessen anxiety for the patient and the dentist.