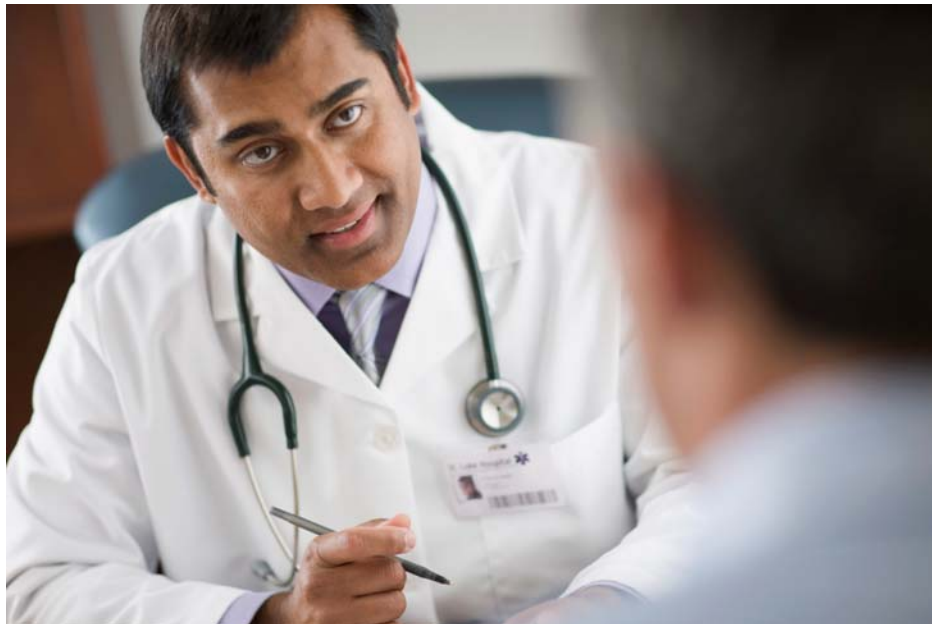


## Annotated Bibliography

# “Difficult” Clinician-Patient Relationships



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Allegritti A, Borkan J, Reis S, Griffiths F (2010). Paired interviews of shared experiences around chronic low back pain: classic mismatch between patients and their doctors . *Family Practice* 27:696-83

**BACKGROUND:** current treatments for chronic low back pain (LBP) appear to be inadequate and there are growing calls for new approaches. This study explores the paired interviews of shared experiences among chronic LBP patients and their physicians with the ultimate goal of improving doctor-patient communication and clinical outcomes.

**METHODS:**

in-depth interviews of a purposeful sample of paired chronic LBP patients and their doctors were conducted, transcribed and analysed using a multistep iterative process. Interview pairs were examined for important themes and major areas of convergence and divergence/mismatch.

**RESULTS:** patients' stories focused on their suffering from severe and disabling LBP while conveying a high level of reliance on their family physicians. Physicians described many challenges in treating this patient population. Patient and doctor stories were convergent regarding the severity/seriousness of illness, the lack of effective treatments and the existence of many barriers to care. Notable areas of mismatch: biomedical/biomechanical versus biopsychosocial (BPS) models of illness, treatment expectations/goals of reducing pain versus improving function and the importance of a definitive diagnosis.

**DISCUSSION:** patient and physician stories revealed shared themes and convergences, as well as significant discordance and mismatch. Family physicians, trained in and adherent to the BPS model, may have great difficulty when matched with biomechanically oriented patients. Re-conceptualizing doctors and LBP patients as a single teachable dyad may be useful. Clinical application of paired interviews of shared experiences may be useful in bridging communication and paradigmatic gaps, reducing mismatch and developing shared treatment plans.

Back AL, Arnold RM, Baile WF, Edwards KA, Tulsy JA (2010). The art of medicine: When praise is worth considering in a difficult conversation. *Lancet*, 376:866-67

Physicians tend to overlook praise as part of the communication repertoire. Although we acknowledge that praise has received little attention empirically, we think praise deserves special mention because we find that, if used judiciously, praise is a powerful tool that can help deepen conversation and enable physicians and patient to move through difficult conversations. Praise can perform an important role in the patient-physician relationship, as a communication tool that explicitly recognises the work that patients and family members do to deal with illness. When we can praise a patient's effort in an authentic way, we can move our own attention (and the patient's) above surface issues that might be vexing, and move the conversation to a more meaningful plane. Although not in any way a substitute for more fundamental communication skills like listening carefully, observing emotional cues, or providing medical expertise, what praise can add is a measure of personal engagement by a physician, and a sense of that physician's generous spirit that may otherwise be absent. It is the kind of gesture that enables a physician to practise medicine that feels less like a checklist and more like a personal handicraft.

Batchelor J, Freeman MS. (2001). Spectrum: the clinician and the "difficult" patient. *S D J Med.*;54(11):453-6.

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 interactional 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.

Bodner S. (2008). Stress management in the difficult patient encounter. *Dental Clinics of North America*;52(3):579-603, ix-x.

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.

Bressmann T, Eriks-Brophy A. (2012). Use of simulated patients for a student learning experience on managing difficult patient behaviour in speech-language pathology contexts. *International Journal of Speech Language Pathology*, 14(2):165-73.

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.

Breuner CC, Moreno MA. (2011). Approaches to the difficult patient/parent encounter. *Pediatrics*, 127(1):163-9.

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.

Brown JB, Weston WW, Stewart MA (1989). Patient-centred Interviewing Part II: Finding common ground *Canadian Family Physician*, 35:153-57

Effective patient care requires attending as much to patients' personal experiences of illnesses as to their diseases. Diseases are ferreted out by using the conventional medical model, but understanding illnesses requires a different approach. A patient-centred method focuses on four principal dimensions of patients' experiences: their ideas about what is wrong with them; their feelings about their illnesses, especially their fears; the impact of their problems on functioning; and their expectations about what should be done. The key to this approach is attention to patients' cues related to these dimensions; the goal is to follow patients' leads, to understand patients' experiences from their own point of view. This method improves patient satisfaction, compliance and outcome, and is applicable to the everyday work of family physicians with "ordinary" patients.

Browning DM, Meyer EC, Truog RD, Solomon MZ. (2007). Difficult conversations in health care: cultivating relational learning to address the hidden curriculum. *Academic Medicine*; 82(9):905-13.

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.

Brunero S, Lamont S. (2010) The difficult nurse-patient relationship: Development and evaluation of an e-learning package. *Contemporary Nurse* 35(2):136-46

Nurses in most clinical settings experience difficult 'nurse patient relationships' at various times. Attempts to describe and articulate how to manage such difficult relationships can be found, but often lay blame at the patient level and ultimately leave the nurse less confident to improve patient care. This study uses an action research approach in working with nurses in a generalist setting in developing an educational strategy that helped to improve their knowledge, skills and confidence in working within the 'difficult nurse patient relationship' paradigm. Through the experiential style learning methodology of scenario based learning and applying this via e-learning, an effective educational approach has been developed. Using a quasi-experimental design to evaluate the e-learning package, significant increases in knowledge, skill, confidence and reduced nurse stress as measured on the 'difficult patient stress scale' were shown. This approach allows nurses to reflect on their own behaviour and improve their ability to enhance patient care in difficult to manage nursing care situations.

Cannarella Lorenzetti R, Jacques CH, Donovan C, Cottrell S, Buck J (2013). Managing difficult encounters: understanding physician, patient, and situational factors. *American Family Physician*, 87(6):419-25

Family physicians commonly find themselves in difficult clinical encounters. These encounters often leave the physician feeling frustrated. The patient may also be dissatisfied with these encounters because of unmet needs, unfulfilled expectations, and unresolved medical issues. Difficult encounters may be attributable to factors associated with the physician, patient, situation, or a combination. Common physician factors include negative bias toward specific health conditions, poor communication skills, and situational stressors. Patient factors may include personality disorders, multiple and poorly defined symptoms, nonadherence to medical advice, and self-destructive behaviors. Situational factors include time pressures during visits, patient and staff conflicts, or complex social issues. To better manage difficult clinical encounters, the physician needs to identify all contributing factors, starting with his or her personal frame of reference for the situation. During the encounter, the physician should use empathetic listening skills and a nonjudgmental, caring attitude; evaluate the challenging patient for underlying psychological and medical disorders and previous or current physical or mental abuse; set boundaries; and use patient-centered communication to reach a mutually agreed upon plan. The timing and duration of visits, as well as expected conduct, may need to be specifically negotiated. Understanding and managing the factors contributing to a difficult encounter will lead to a more effective and satisfactory experience for the physician and the patient.

Carey TS, Hadler NM. (1986). The role of the primary physician in disability determination for Social Security insurance and Workers' Compensation. *Ann Intern Med*;104:706-710.

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.

Carroll JG, and Goldstein MG (2003 October). Difficult patients or relationships. *AAOS Online Bulletin*. Available at <http://www2.aaos.org/aaos/archives/bulletin/oct03/comm.htm>

These authors from the Institute for Healthcare Communication (IHC) highlight their model for recognizing, repairing and preventing difficulties in the clinician-patient relationship that was developed (White & Keller 1998). The first step is simply to observe and reflect upon the tension level in the relationship. This means noticing one's own level of tension or frustration, observing any frustration on the part of the patient and being curious about the origins or sources of this tension. Part of this process is considering one's own feelings or emotions as data. In other words, take a moment to think about what is going on, why he or she is reacting this way and which sources of difficulty may be at work. The next stage involves the "ADOBE" model, a communication strategy with five components, each of which may be employed either to repair the communication difficulty or to prevent it from taking hold:

- Acknowledge the difficulty that you are experiencing in the working relationship at this moment. Make a simple statement that reflects your point of view. For example, "I am finding it difficult to proceed at this point because I think our individual agendas may be somewhat different today."
- Discover the meaning to the patient of the loss of functional status, for example. The meaning to the patient could be literal, symbolic or very personal. For example, "Can you tell me more about the way this injury is affecting your daily life?" or "How is this affecting your family?"
- Respond to Opportunities for compassion in the form of empathic statements (e.g., "You are clearly very upset about the impact of the injury on your life.") as well as with overt action such as helping a patient to find a more comfortable chair, assisting with their coat or offering a glass of water.
- Set Boundaries or effective ground rules for working together with this patient. For example, what kind of clinical data or diagnostic information would you require in order to consider completing an evaluation for employment disability?
- Extend the system of care to include a colleague, clergy or a social service agency. Sometimes the best way to improve the working relationship might be to refer the patient to another resource for additional help, such as to a chronic pain program or patient support group.

Connell BF, Gunter J, Mayer T, Miller S, Segal J, Smith HW, Tardy E, Waldman SR, Chatham DR. (2008). Roundtable: discussion of "the difficult patient". *Facial Plastic Surgery Clinics of North America*; 16(2):249-58, viii.

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.

Daberkow D (2000). Preventing and managing difficult patient-physician relationships. *J La State Med Soc*,152(7):328-32.

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.

DelBanco TL.(1992). Enriching the doctor-patient relationship by inviting the patients' perspective. *Ann Intern Med*, 116:414-418.

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.

Elder N, Ricer R, Tobias B. (2006). How respected family physicians manage difficult patient encounters. *Journal of American Board of Family Medicine*; 19(6):533-41.

**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.

Epner DE, Ravi D, Baile WF. (2011). When patients and families feel abandoned. *Support Care Cancer* (19);1713-17.

**PURPOSE:** Patients with serious illness derive a sense of security by forming strong, healing relationships with their providers. These bonds are particularly strong in life-threatening illnesses, such as cancer, which carry the stigma of death and suffering. These strong relationships create expectations in patients that are not necessarily shared by their clinicians. Providers often focus on treating disease and emphasize technically excellent, "evidence-based" practice while failing to fully appreciate the power of the patient-provider relationship. In contrast, vulnerable patients expect much more than technical competence, including open and clear communication, security, continuity, and access. Patients are often left feeling abandoned when their providers do not meet their expectations, even when their care is technically sound.

**METHODS/RESULTS:** In this paper, we describe scenarios that can lead to feelings of abandonment and discuss strategies to avoid and respond to them.

**CONCLUSIONS:** These strategies can help us maintain healing relationships with our patients by maintaining their trust, confidence, and satisfaction. Cultivating relational aspects of medical practice requires an interchange and takes time. Experienced doctors know this and continue to do so because being present and staying with the patient during difficult times is a pillar of moral and ethical training and a fundamental attribute of a good physician.

Ferrando SJ, Okoli U. (2009). Personality disorders: understanding and managing the difficult patient in neurology practice. *Semin Neurology*;29(3):266-71.

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.

Fiester A. (2012). The “difficult” patient reconceived: an expanded moral mandate for clinical ethics. *American Journal of Bioethics, Healthcare Management*, 12(5):2-7.

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

Frosch DL, May SG, , Rendle KA, Tietbohl C, Elwyn G (2012). Authoritarian physicians and patients’ fear of being labeled ‘difficult’ among key obstacles to shared decision making. *Health Affairs*, 31(5):1030-38

Relatively little is known about why some patients are reluctant to engage in a collaborative discussion with physicians about their choices in health care. To explore this issue further, we conducted six focus-group sessions with forty-eight people in the San Francisco Bay Area. In the focus groups, we found that participants voiced a strong desire to engage in shared decision making about treatment options with their physicians. However, several obstacles inhibit those discussions. These include the fact that even relatively affluent and well-educated patients feel compelled to conform to socially sanctioned roles and defer to physicians during clinical consultations; that physicians can be authoritarian; and that the fear of being categorized as “difficult” prevents patients from participating more fully in their own health care. We argue that physicians may not be aware of a need to create a safe environment for open communication to facilitate shared decision making. Rigorous measures of patient engagement, and of the degree to which health care decisions truly reflect patient preferences, are needed to advance shared decision making in clinical practice.

Gordon GH, Baker L, Levinson W. (1995). Physician-patient communication in managed care. *West Journal of Medicine*; 163:527-531.

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.

Gourlay DL, Heit HA (2009). Universal precautions revisited: Managing the inherited pain patient. *Pain Medicine* 10:S115-23

“Universal Precautions in Pain Medicine: A Rational Approach to the Treatment of Chronic Pain” was published in 2005. In it, a unified 10-step approach to the assessment and management of patients suffering from chronic pain was proposed. As well, a triage scheme of risk stratification was offered. By placing patients into risk categories of low, medium, or high (Groups I, II, and III), it became possible to recommend to primary care practitioners those patients whom they might



confidently manage on their own, co-manage with specialty support, or refer to specialty clinics with more experience and resources to tackle these often challenging cases. It is important to note that Universal Precautions is not simply about opioid prescribing, although the use of opioids does highlight the value inherent in managing risk in all patients. Moreover, it should serve to remind health care professionals that the presence of significant psychiatric co-morbidities, including substance-use disorders, may represent treatable conditions that must be addressed in order to optimize outcomes. Universal Precautions as a concept should be based upon mutual trust and respect between patient and practitioner, both of whom should be committed to setting and achieving realistic goals in both cancer and non-cancer pain patients. The goal of this article is to explore the application of a Universal Precautions approach to manage the care of patients with chronic pain who no longer have an appropriate source of the medications upon which they have become physically dependent—so-called inherited pain patients.

Grazzi L. (2008). Behavioural approach to the “difficult” patient. *Neurol Science*;29 Suppl 1:S96-8.

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.

Haas LJ, Leiser JP, Magill MK, Sanyer ON. (2005). Management of the difficult patient. *American Family Physician*,15;72(10):2063-8.

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.

Halpern J (2007). Empathy and patient-physician conflicts. *Journal of General Internal Medicine*, 22(5): 696-700.

Physicians associate empathy with benevolent emotions and with developing a shared understanding with patients. While there have been many articles on managing “difficult” patients, little attention has been paid to the challenges physicians face during conflicts with patients, especially when both parties are angry and yet empathy is still needed. This topic is especially important in light of recent studies showing that practicing medicine increasingly requires physicians to manage their own feelings of anger and frustration. This article seeks to describe how physicians can learn to empathize with patients even when they are both subject to emotions that lead to interpersonal distancing. Empathy is defined as engaged curiosity about another’s particular emotional perspective. Five specific ways for physicians to foster empathy during conflict are described: recognizing one’s own emotions, attending to negative emotions over time, attuning to patients’ verbal and nonverbal emotional messages, and becoming receptive to negative feedback. Importantly, physicians who learn to empathize with patients during emotionally charged interactions can reduce anger and frustration and also increase their therapeutic impact.

Hinchev SA, Jackson JL (2011). A cohort study assessing difficult patient encounters in a walk-in primary care clinic, predictors and outcomes. *Journal of General Internal Medicine*, 26(6):588-94.

**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.

Hsu I, Saha S, Korthius PT, Sharp V, Cohn J, Moore RD, Beach MC (2012). Providing support to patients in emotional encounters: A new perspective on missed empathic opportunities. *Patient Education and Counseling*, 8:436-46.

**OBJECTIVE:** Studies have repeatedly found that providers miss 70-90% of opportunities to express empathy. Our study sought to characterize provider responses to patients’ emotions, with the overall goal of better understanding reasons for lack of empathic response.

**METHODS:** We analyzed 47 visits between patients and their providers. We defined empathic opportunities as instances where patients expressed a strong negative emotion. We then developed thematic categories to describe provider response.

**RESULTS:** We found a total of 29 empathic opportunities within 21 visits. Provider responses were categorized as ignore, dismiss, elicit information, problem-solve, or empathize. An empathic statement occurred at some point in the response sequence in 13/29 opportunities (45%). When problem-solving was the initial response, empathic statements rarely occurred in subsequent dialogue. Among the 16 instances with no empathic statements, providers engaged in problem-solving in 8 (50%).

**CONCLUSION:** Similar to other studies, we found providers missed most opportunities to respond empathically to patient emotion. Yet contrary to common understanding, providers often addressed the problem underlying the emotion, especially when the problem involved logistical or biomedical issues, as opposed to grief.

**PRACTICE IMPLICATIONS:** With enhanced awareness, providers may better recognize situations where they can offer empathy in addition to problem-solving.

Jackson JL, Kay C. (2013). Heartsink hotel, or “Oh no, look who’s on my schedule this afternoon!” *Journal of General Internal Medicine*, 28(11):1385-86.

In this editorial, the authors discuss “difficult” in the context of “difficult patient” as a label that has been applied to describe a particular, and deeply personal, emotional experience. Viewed through this lens, it’s odd that it’s taken so long to recognize that it might not just be the patient’s problem. Less

experienced clinicians and those reporting greater workload and less communication training report having more “difficult” patients. Both parties to these “difficult” encounters are troubled. Both patients and providers emerge from these encounters with lower rates of satisfaction. Patients have less trust, more unmet expectations and are less likely to experience symptom improvement. Much of the work in this area has focused on a single patient and a single provider. Patient care is evolving rapidly. This could provide new opportunities for improving the care of “difficult” patients. A team approach is likely to be helpful and the patient-centered medical home might provide a method of sharing care that could improve both how providers feel about these patients and improve outcomes. Though it is also possible that less continuity, more handoffs could provide more opportunities for such patients to doctor shop and fall through cracks.

Johnson TM, Hardt EJ, Kleinman (1995). A. Cultural factors in the medical interview. In: Lipkin M, Putnam SM, Lazare A (eds): *The Medical Interview: Clinical Care, Education, and Research*, New York, Springer-Verlag, 153-162.

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?

Kahn MW. (2009). What would Osler do? Learning from “difficult” patients. *New England Journal of Medicine*, 361(5):442-43.

The author offers his perspective and experiences leading a “difficult patient rounds” with interns and residents. Based on Oslo’s famous quote “It is much more important to know what sort of a patient has a disease than what sort of a disease a patient has”, the author encouraged his trainees to invite patients deemed “difficult” to share their stories and to ask questions that invite an understanding of their perspective. This paradigm shift of applying the “knowing the patient” philosophy proved to be useful for the trainees who reported three benefits: 1) provided opportunity to practice advance interviewing skills at bedside 2) demystified common psychiatric concepts and 3) provided a more strategic perspective on engaging and better understanding a wide range of patients.

Keller VF, Goldstein MG, Runkle C (2002). Strangers in crisis: communication skills for the emergency department clinician and hospitalist. *Journal of Clinical Outcomes Management*, 9(8):439-444.

Physicians treating patients in the hospital face a unique set of communication challenges. This article from the Institute for Healthcare Communication (formerly the Bayer Institute) offers strategies for communicating with patients, their families, and other clinicians in the emergency department and inpatient settings.

King K, Moss AH (2004). The frequency and significance of the “difficult” patient: The nephrology community’s perceptions. *Adv Chronic Kidney Dis.*;11(2):234-9.

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.

Knesper DJ. (2007). My favorite tips for engaging the difficult patient on consultation-liaison psychiatry services. *Psychiatric Clinics of North America*;30(2):245-52.

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.

Kockkoki B, van Meijh B, van Ommen J, Pennings R, Kaasenbrood A, Hutschemackers G, Schene A (2010). Ambivalent connections: a qualitative study of the care experiences of non-psychotic chronic patients who are perceived as 'difficult' by professionals. *BMC Psychiatry*, 10:96;1-11

**BACKGROUND:** Little is known about the perspectives of psychiatric patients who are perceived as 'difficult' by clinicians. The aim of this paper is to improve understanding of the connections between patients and professionals from patients' point of view.

**METHODS:** A Grounded Theory study using interviews with 21 patients from 12 outpatient departments of three mental health care facilities.

**RESULTS:** Patients reported on their own difficult behaviours and their difficulties with clinicians and services. Explanations varied but could be summarized as a perceived lack of recognition. Recognition referred to being seen as a patient and a person - not just as completely 'ill' or as completely 'healthy'. Also, we found that patients and professionals have very different expectations of one another, which may culminate in a difficult or ambivalent connection. In order to explicate patient's expectations, the patient-clinician contact was described by a stage model that differentiates between three stages of contact development, and three stages of substantial treatment. According to patients, in each stage there is a therapeutic window of optimal clinician behaviour and two wider spaces below and above that may be qualified as 'toxic' behaviour. Possible changes in clinicians' responses to 'difficult' patients were described using this model.

**CONCLUSIONS:** The incongruence of patients' and professionals' expectations may result in power struggles that may make professionals perceive patients as 'difficult'. Explication of mutual expectations may be useful in such cases. The presented model gives some directions to clinicians how to do this.

Korsch BM (1989). Current issues in communication research. *Health Communication*. 1(1):5-9.

In the last 10 to 15 years, there has been no aspect of the communication process that has not received serious attention: verbal and nonverbal communication, voice tones, the filtering out of words, openings, endings, samples of various points in the encounter, questions posed by the provider, questions posed by the patient, relative amounts of activity by each participant, sequences, content, affect, subtle ethnolinguistic components, points at which participants change the subject, interruptions, fear-arousing communications and threats, supporting and reinforcing communication, social distance, authority, paternalism versus partnership building in the therapeutic alliance, information sharing and withholding, psychosocial (personalized) approaches versus task-oriented communication, and so forth.

Korsch BM, Gozzi EK, Francis V. (1968). Gaps in doctor-patient communication. 1. Doctor-patient interaction and patient satisfaction. *Pediatrics*. 42(5):855-71.

The "art of medicine" has been the topic of much discussion but has never been subjected to scientific scrutiny. Whereas other aspects of medical practice are included in the physician's training, the approach to the patient is expected to be on the basis of intuition, and it is traditionally learned only by percept and experience.

Korsch BM, Negrete VF. (1972). Doctor-patient communication. *Scientific American*. 227(2):66-74.

Observations in the pediatric clinic of a large hospital indicate that the physician often talks jargon or seems not to fully heed the patient's concerns. Mutual dissatisfaction is a frequent result.

Lamiani G, Meyer EC, Browning DM, Brodsky D, Todres ID (2009). Analysis of enacted difficult conversations in neonatal intensive care. *Journal of Perinatology*, 29:310-16

**OBJECTIVE:** To analyze the communicative contributions of interdisciplinary professionals and family members in enacted difficult conversations in neonatal intensive care.

**STUDY DESIGN:** Physicians, nurses, social workers, and chaplains (n=50) who attended the

Program to Enhance Relational and Communication Skills, participated in a scenario of a preterm infant with severe complications enacted by actors portraying family members. Twenty-four family meetings were videotaped and analyzed with the Roter Interaction Analysis System (RIAS). RESULT: Practitioners talked more than actor-family members (70 vs 30%). Physicians provided more biomedical information than psychosocial professionals ( $P<0.001$ ), and less psychosocial information than nurses, and social workers and chaplains ( $P<0.05$ ;  $P<0.001$ ). Social workers and chaplains asked more psychosocial questions than physicians and nurses ( $MD=P<0.005$ ;  $RN=P<0.05$ ), focused more on family's opinion and understanding ( $MD=P<0.01$ ;  $RN=P<0.001$ ), and more frequently expressed agreement and approval than physicians ( $P<0.05$ ). No differences were found across disciplines in providing emotional support. CONCLUSION: Findings suggest the importance of an interdisciplinary approach and highlight areas for improvement such as using silence, asking psychosocial questions and eliciting family perspectives that are associated with family satisfaction.

Laskowski C. (2001). The mental health clinical nurse specialist and the "difficult" patient: evolving meaning. *Issues Mental Health Nursing*; 22(1):5-22.

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.

Lazare A. (1995). The Interview as a clinical negotiation. In: Lipkin M, Putnam SM, Lazare A (eds): *The Medical Interview: Clinical Care, Education, and Research*, New York, Springer-Verlag, 50-64.

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.

Lazare A. (1987). Shame and humiliation in the medical encounter. *Arch Intern Med*, 147:1653-1658.

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, non-adherence, withdrawal, and other relationship difficulties. Awareness and acknowledgment of shame or humiliation helps the relationship.

Levinson W, Gorawara-Bhat R, Dueck R, Egener B, Kao A, Kerr C, Lo B, Perry D, Politz K, Reifsteck S, Stein T, Santa J, Kemp-White M (1999) Resolving disagreements in the patient-physician relationship: tools for improving communication in managed care. *Journal of American Medical Association*, 282(15):1477-83.

Managed care uses financial incentives and restrictions on tests and procedures to attempt to influence physician decision making and limit costs. Increasingly, the public is questioning whether physicians are truly making decisions based on the patient's best interest or are unduly influenced by economic incentives. These circumstances lead to the potential for disagreements and conflict in the patient-physician relationship. We convened a group of individuals in October 1998, including patient representatives, leaders from health care organizations, practicing physicians, communication experts,

and medical ethicists, to articulate the types of disagreements emerging in the patient-physician relationship as a result of managed care. We addressed 3 specific scenarios physicians may encounter, including allocation, illustrated by a patient who is referred to a different ophthalmologist based on a new arrangement in the physician's group; access, illustrated by a patient who wishes to see his own physician for a same-day visit rather than a nurse specialist; and financial incentives, illustrated by a patient who expects to have a test performed and a physician who does not believe the test is necessary but is afraid the patient will think the physician is not ordering the test because of financial incentives. Using these scenarios, we suggest communication strategies that physicians can use to decrease the potential for disagreements. In addition, we propose strategies that health plans or physician groups can use to alleviate or resolve these disagreements.

Levinson W, Kao A, Kuby AM, Thisted RA (2005). The effect of physician disclosure of financial incentives on trust. *Archives of Internal Medicine*, 165:625-30.

**BACKGROUND:** Many physicians receive financial incentives to limit their ordering of expensive tests and procedures. While Medicare mandates disclosure of incentives, it is not clear how to inform patients without undermining trust.

**METHODS:** Our objective was to determine public opinion about physician disclosure of financial incentives and how this might be best communicated to patients. The 2002 General Social Survey included 2765 interviews from a probability sample of English-speaking US households. The interview included questions about financial incentives and an audiotaped scenario of a physician discussing the impact of financial incentives on ordering a magnetic resonance image. Respondents heard 1 of 6 randomly selected disclosure strategies. The measurements included ratings of trust, satisfaction, agreement with the physician's decision, and likelihood of remaining with the physician/health plan or seeking a second opinion.

**RESULTS:** Nearly half (48.8%) of respondents had previously heard of financial incentives to limit test ordering. Of the respondents, 94.8% wanted to be told about incentives, at the time of enrollment in a health plan (80.5%), by a health plan representative (44.8%), their physician (17.1%), or both (38.1%). Of the 6 different disclosure strategies, "addressing emotions" and "negotiation" were associated with the best outcomes, while "common enemy" and "denying influences" were most negatively perceived. Black and Hispanic subjects were less likely to express satisfaction or trust and more likely to disenroll or seek a second opinion.

**CONCLUSIONS:** The public wants information about physician financial incentives. Specific communication styles enhance how this information is conveyed to patients, increasing trust and supporting the physician-patient relationship.

Loder E (2010). The approach to the difficult patient. *Handbook of Clinical Neurology*, 97:233-8.

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.

Lown BA (2007). Difficult Conversations: Anger in the Clinician-Patient/Family Relationship. *Southern Medicine Journal*; 100(1):33-9; quiz 40-2, 62.

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.

Marken PA, Zimmerman C, Kennedy C, Schremmer R, Smith KV (2010). Human simulators and standardized patients to teach difficult conversations to inter-professional health care teams. *American Journal of Pharmaceutical Education*, 74(7)1-8.

**OBJECTIVE:** To design and implement a demonstration project to teach inter-professional teams how to recognize and engage in difficult conversations with patients.

**DESIGN:** Interdisciplinary teams consisting of pharmacy students and residents, student nurses, and medical residents responded to preliminary questions regarding difficult conversations, listened to a brief discussion on difficult conversations; formed ad hoc teams and interacted with a standardized patient (mother) and a human simulator (child), discussing the infant's health issues, intimate partner violence, and suicidal thinking; and underwent debriefing.

**ASSESSMENT:** Participants evaluated the learning methods positively and a majority demonstrated knowledge gains. The project team also learned lessons that will help better design future programs, including an emphasis on simulations over lecture and the importance of debriefing on student learning. Drawbacks included the major time commitment for design and implementation, sustainability, and the lack of resources to replicate the program for all students.

**CONCLUSION:** Simulation is an effective technique to teach inter-professional teams how to engage in difficult conversations with patients.

Matthys J, Elwyn G, Van Nuland M, Van Maele G, De Sutter A, De Meyere M, Deveugele M. (2009). Patients' ideas, concerns, and expectations (ICE) in general practice: impact on prescribing. *Br J Gen Pract.* 59(558):29-36.

**BACKGROUND:** Although studies are available on patients' ideas, concerns, and expectations in primary care, there is a scarcity of studies that explore the triad of ideas, concerns, and expectations (ICE) in general practice consultations and the impact on medication prescribing.

**AIM:** To evaluate the presence of ICE and its relation to medication prescription.

**DESIGN OF STUDY:** Cross-sectional study.

**SETTING:** Thirty-six GP teaching practices affiliated with the University of Ghent, in Flanders, Belgium.

**METHOD:** Participants were all patients consulting on 30 May 2005, and their doctors. Reasons for an encounter (consultation or home visit) with new and follow-up contacts, the identification of ICE, and the prescription of medication were recorded by 36 trainee GPs undergoing observational training. The study included 613 consultations.

**RESULTS:** One, two, or three of the ICE components were expressed in 38.5%, 24.4%, and 20.1% (n = 236, 150, 123) of contacts respectively. On the other hand, in 17.0% (104/613) of all contacts, and in 22% (77/350) of the new contact reasons, no ICE was voiced, and the GPs operated without knowing this information about the patients. Mean number of ICE components per doctor and per contact was 1.54 (standard deviation = 0.54). A logistic regression analysis of the 350 new contacts showed that the presence of concerns (P = 0.037, odds ratio [OR] 1.73, 95% confidence interval [CI] = 1.03 to 2.9), and expectations (P = 0.009, OR = 2.0, 95% CI = 1.2 to 3.4) was associated with not prescribing new medication (dichotomised into the categories present/absent); however, other patient, doctor, and student variables were not significantly associated with medication prescription.

**CONCLUSION:** An association was found between the presence of concerns and/or expectations, and less medication prescribing. The data suggest that exploring ICE components may lead to fewer new medication prescriptions.

Maunder RG, Panzer A, Viljoen M, Owen J, Human S, Hunter JJ (2006). Physicians' difficulty with emergency department patients is related to patients' attachment style. *Social Science Medicine*, 63(2):552-62.

Doctors experience 10-20 percent of patient interactions as being personally difficult, but the sources of difficulty are incompletely understood. In particular, physician-perceived difficulty has not been studied from the perspective of an established model of interpersonal relationships. Our objective was

to determine whether a relationship exists between patients' attachment style and the degree of difficulty experienced by their attending physician in an Emergency Department in Pretoria, South Africa. Patients of an Emergency Department (n = 165) completed the Experiences in Close Relationships-Revised Questionnaire to measure attachment anxiety and attachment avoidance. Their physicians (n = 26), blind to the attachment measure, rated perceived difficulty using the Difficult Doctor-Patient Relationship Questionnaire. Four categories of attachment style were identified by cluster analysis of attachment scores. Patients were divided into difficult and non-difficult groups using a cut-off score. Two percent of patients with a secure attachment style were experienced as difficult, whereas the prevalence of difficulty in the insecure styles was 'preoccupied' 17 percent, 'dismissing' 19 percent and 'fearful' 39 percent ( $\chi^2(2) = 16.383$ ,  $df = 3$ ,  $p = 0.0009$ ), supporting the hypothesis that the physician's perception of patient difficulty is related to the patient's attachment style. The degree to which physicians serve attachment functions for patients in crisis merits further investigation.

Meyer EC, Sellers DE, Browning DM, McGuffie K, Solomon MZ, Truog RD (2009). Difficult conversations: improving communication skills and relational abilities in health care. *Pediatric Critical Care Medicine*;10(3):352-9.

**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:** Pre-post 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 post-training. Ninety percent of participants reported improvements in establishing relationships immediately after the training and 84% reported improvements 5 months post-training. Eighty-two percent reported reduced anxiety immediately after training and 74% experienced reduced anxiety 5 months post-training. 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.

Murtagh J. (1991). The angry patient. *Aust Fam Physician*. 20(4):388-389.

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.



Nicolaidis C (2011). Police officer, deal-maker, or health care provider? Moving to a patient-centered framework for chronic opioid management. *Pain Medicine* 12(6):890-97.

How we frame our thoughts about chronic opioid therapy greatly influences our ability to practice patient-centered care. Even providers who strive to be nonjudgmental may approach clinical decision-making about opioids by considering if the pain is real or they can trust the patient. Not only does this framework potentially lead to poor or unshared decision-making, it likely adds to provider and patient discomfort by placing the provider in the position of a police officer or a judge. Similarly, providers often find themselves making deals with patients using a positional bargaining approach. Even if a compromise is reached, this framework can potentially inadvertently weaken the therapeutic relationship by encouraging the idea that the patient and provider have opposing goals. Reframing the issue can allow the provider to be in a more therapeutic role. As recommended in the American Pain Society/American Academy of Pain Medicine guidelines, providers should decide whether the benefits of opioid therapy are likely to outweigh the harms for a specific patient (or sometimes, for society) at a specific time. This article discusses how providers can use a benefit-to-harm framework to make and communicate decisions about the initiation, continuation, and discontinuation of opioids for managing chronic nonmalignant pain. Such an approach focuses decisions and discussions on judging the treatment, not the patient. It allows the provider and the patient to ally together and make shared decisions regarding a common goal. Moving to a risk-benefit framework may allow providers to provide more patient-centered care, while also increasing provider and patient comfort with adequately monitoring for harm.

Novack DH, Suchman AL, Clark W et al. (1997). Calibrating the physician: Personal awareness and effective patient care. *JAMA*;278:502-509.

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).

Patterson K, Grenny J, McMillan R, & Switzler A. (2012). *Crucial Conversations Tools for Talking When Stakes Are High*, Second Edition. The McGraw Hill Company, New York, New York.

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.

Patterson K, Grenny J, McMillan R, & Switzler A. (2004). *Crucial Confrontations: Tools for Resolving Broken Promises, Violated Expectations, and Bad Behavior*, The McGraw Hill Company, New York, New York.

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.

Powers JS. (1985). Patient-Physician communication and interaction: A unifying approach to the difficult patient. *S Med J.*, 78(4):445-447.

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

Quill TE, Brody H. (1996). Physician recommendations and patient autonomy: Finding a balance between physician power and patient choice. *Ann Intern Med*;125:763-769.

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.

Quill TE, Suchman AL. (1993). Uncertainty and control: Learning to live with medicine’s limitations. *Humane Medicine*;9:109120.

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.

Quill TE. (1983). Partnerships in patient care: A contractual approach. *Ann Intern Med*;98:228- 234.

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.

Simon JR, Dwyer J, Goldfrank LR. (1999). The difficult patient. *Emerg Med Clin North Am.*;17(2):353-70, x.

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.

Slatore CG, Hansen L, Ganzini L, Press N, Osborne ML, Chesnutt MS, Mularski RA. (2012). Communication by Nurses in the Intensive Care Unit: Qualitative Analysis of Domains of Patient-Centered Care. *Am J Crit Care*; 21(6): 410-418.

**BACKGROUND:** High quality communication is a key determinant and facilitator of patient-centered care. Nurses engage in the vast majority of communication with patients and families in the intensive care unit (ICU).

**OBJECTIVE:** To perform a qualitative analysis of nurses' communication.

**METHODS**” The study was conducted in a 26-bed cardiac/medical ICU in an academic hospital and a 26-bed general ICU in a Veterans Affairs hospital in Portland, OR. We reviewed 315 hours of ICU interactions and 53 interviews with 33 nurses to categorize communication interactions into five patient-centered care domains. Interviews were analyzed to identify major themes regarding nurses’ roles and preferences for communicating with patients and families within the domains.

**RESULTS:** Most nursing communication occurred in the biopsychosocial information exchange, “patient-as-person”, and “clinician-as-person” domains. Nurses endorsed the importance of the shared

power and responsibility and therapeutic alliance domains but had relatively few communication interactions in these areas. Communication behaviors were strongly influenced by the nurses' roles as translators of information between physicians with patients and families and what they were and were not willing to communicate to patients and families.

**CONCLUSIONS:** Critical care, including communication, is a collaborative effort. Understanding how nurses engage in patient-centered communication in the ICU can guide future interventions to improve patient-centered care.

Smith AK, White DB, Arnold RM (2013). Uncertainty – The other side of prognosis. *New England Journal of Medicine*, 368:26; 2448-49.

Prognosis, and prognostic uncertainty, has a profound influence on physicians, as well as patients and families. Physician's generally optimistic bias is well-documented. In one study physicians overestimated survival of terminally ill patients by a factor of five, and longer the longer the duration of the patient-physician relationship, the more optimistic the estimate. Clinicians also may have trouble with prognostic uncertainty. Some react by not being willing to talk to the patient about the future at all (commonly expressed as "we have to wait and see" or "no one can tell"). Others, ignoring the uncertainty built into prognostication, do more and more tests in a futile hope of being able to better predict the future. Physicians need to recognize their reaction to uncertainty and how these reactions may influence their conversations with patients. In many respects, the primary communication task of clinicians is the management of uncertainty, and perhaps in no realm is this clearer than in communication about prognosis. By normalizing uncertainty and attending to the affective response to living in the face of an uncertain future, we may help our patients and their families enjoy the time they have now.

Stanley JC. (1991). Physicians and the difficult patient. *Social Work*. ;36:71-79.

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.

Stewart M, Brown JB, Weston W, McWhinney I, McWilliam C & Freeman T. (2013). *Patient-Centered Medicine*, 3rd edition, Radcliffe Health.

This long awaited 3rd edition fully illuminates the patient-centered model of medicine, continuing to provide the foundation for the *Patient-Centered Care series*. It redefines the principles underpinning the patient-centered method using four major components – clarifying its evolution and consequent development – to bring the reader fully up-to-date. By examining and evaluating both qualitative and quantitative research, including reviews and recent studies, the book offers an invaluable compendium of relevant education literature and methods.

Illustrating patient-centered concepts through case studies, *Patient-Centered Medicine* provides clear, inspirational messages about the instrumental role of patient-centered clinical care for both students and clinicians in all healthcare environments

Stone D, Patton B, Heen S. (2010). *Difficult Conversations: How to discuss what matters most*. New York: Penguin Books.

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.

Suchman AL, Markakis K, Beckman HB, Frankel R. (1997). A model of empathic communication in the medical interview. *JAMA*; 277:678-682.

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.

Weingarten MA, Guttman N, Abramovitch H, Margalit RS, Roter D, Ziiv A, Yape J, Borkan J (2010). An anatomy of conflicts in primary care encounters: a multi-method study. *Family Practice*, 27L:93-100

**BACKGROUND:** Medical consultations are replete with conflicts, particularly in the current era of explicit and implicit rationing practices in health care organizations. Although such conflicts may challenge the doctor-patient relationship, little is known about them or their consequences.

**AIMS:** To systematically describe the nature of doctor-patient conflicts in medical encounters and the strategies physicians use when faced with conflicts.

**METHODS:** Analysis of 291 videotaped routine encounters with 28 general practitioners, using a novel adaptation of the Roter interaction analysis system software, provided quantitative empirical data on the conflicts and on the communication process. Seven focus groups (56 GPs) provided qualitative insights and guided the analysis.

**RESULTS:** Conflicts were identified in 40% of consultations; 21% of these were related to the rationing of health care resources. In conflictual encounters, both the opening and closing phases of the encounter were shorter than in non-conflictual encounters. In coping with resource rationing, the commonest strategy was to accept the dictates of the system without telling the patients about other options. When conflict of this type occurred, doctors showed more opposition to the patients rather than empathy.

**CONCLUSIONS:** Doctors often face conflicts in their routine work, but resource-related conflicts are especially difficult and expose the dual loyalties of the doctor to the patient and to the system.

Insights derived from this research can be used to design training interventions that improve doctors' efficacy in coping with conflicts and ultimately allow them to provide better patient care.

White MK, and Keller VF (1998). Difficult clinician-patient relationships. *Journal of Clinical Outcomes Management*, 21-25.

All clinicians encounter patients whom they regard as difficult. All of us at some time or another, find ourselves reacting in ways we would prefer not to act. Later, we often think of better responses. Although we may try to justify our behavior, a nagging feeling of regret about how we responded is a likely indicator that our hot button was activated. Our hot buttons may lead to difficulties in relationships with patients. Managing these relationships is a challenge that begins by considering what the course of difficult is for us in the particular circumstance. This article provides a diagnostic model for assessing the possible source(s) and contributor of difficulty that we all face in practice, e.g., a particular patient, the illness, our practice environments, etc. Second, the article identifies three core problems associated with difficult-clinician patient relationships. Finally, the authors from the Institute for Healthcare Communication provide a communication model using the mnemonic ADOBE that utilizes techniques and tools to address the difficulty more productively.

Woods CD. (2007). The difficult patient: a psychodynamic perspective. *Journal of the California Dental Association*.35(3):186-91.

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.

Yasgur BS (2012 Sept 20). Treating the “Patient from Hell”. *Medscape Business of Medicine*, Available at [www.medscape](http://www.medscape).

While some patients warm your heart, other patient make you wish you had become anything but a physician. In every setting in life, we all get along better with some people than others, and medicine is no exception. When dealing with difficult patients, bear in mind that in the profession of medicine, we tend to see people at their worst, not their best according to one of the contributing authors, August Fortin. We need to build skills that will help treat even what appears to be the most difficult person. This article provides an overview of some skills and techniques for addressing difficulty that manifests in many forms.