



IHC Patient-Centered Communication Series:

“Difficult” Clinician-Patient Relationships (DCPR) Faculty Course (Train-the-Trainer)

Overview

In the provision of healthcare services, many factors come into play in the strength and character of the provider-patient relationship. Clinician factors may include workload, communication skills, experience, familiarity with the patient and level of comfort with uncertainty (Haas 2005). What one clinician finds difficult, a colleague may find easy, and vice versa. Clinicians’ expertise can influence their perceptions of patients, and their personalities, emotional responses and expectations can also play a role. Patients’ medical conditions, appearance, demeanor, personalities, complaints and behaviors can be key factors, and patients bring their own feelings, expectations and unspoken assumptions to the medical encounter. Even experienced clinicians with awareness of and expertise in core communication skills (engage, empathize, educate, enlist) experience some patient interactions as difficult.

Some believe that there is an objective reality called “difficult patients.” Historically, the professional literature supported this belief, and many articles describe and discuss the “difficult patient.” One study estimated that more than 17 percent of patients in a primary care practice were perceived by clinicians as “difficult” (Hinchey 2011). An examination of the impact of “difficult patient encounters” in primary care on the quality of care did not find degradation of the quality of care, but did find higher rates of provider dissatisfaction and burnout (An 2013).

Researchers and educators have come to regard the idea of objectively “difficult patients” as a misperception. They are coming to realize that it is the relationship or the interaction that contributes to the difficulty. When difficult interactions persist, clinicians and patients both feel frustrated and victimized.

Organizations are increasingly aware of the importance of helping clinicians avoid burnout. A 2012 national study found elevated rates of burnout among physicians compared with US workers generally, with nearly half of physicians reporting one or more symptoms of burnout. (Shanafelt 2012) IHC’s **“Difficult” Clinician-Patient Relationships (DCPR) workshops** give clinicians enhanced communication skills to get difficult interactions back on track and to return interactions to a more productive mode. The workshop challenges clinicians to examine the patterns of interactions with patients that cause them the greatest difficulty and to move away from the construct that there is an objective “difficult patient.” Through increased self-awareness and evidence-based skill practice during the workshop, clinicians are more likely to act effectively, leading to reduced frustration and increased satisfaction for themselves and their patients. IHC’s **DCPR** faculty course provides organizations with an effective and cost-effective way to enhance their

professional development capacity and bring evidence-based training to large numbers of clinicians. This intensive 2.5-day course is designed for individuals who will teach **DCPR** workshops.

Audience

The ***“Difficult” Clinician-Patient Relationships (DCPR)*** workshop is targeted toward clinicians in all specialties and at all stages of their careers. The **DCPR** faculty course is for clinician leaders and educators involved in professional development who will teach the **DCPR** workshop.

DCPR faculty courses can accommodate 6-30 participants to ensure effective experiential learning in small and large groups.

Content

The ***“Difficult” Clinician-Patient Relationships (DCPR)*** faculty course provides foundational training for learners returning to their institution to teach IHC’s **DCPR** workshop to colleagues and staff. Course content is focused on learning specific workshop content, adult learning theory, facilitation techniques and coaching and feedback skills for small learning group settings (1:5 IHC trainer/learner ratio). Learners practice presenting portions of the **DCPR** workshop for their peers, with peer and expert faculty feedback. In addition, learners practice communication skills in contextually relevant patient simulations in small group settings.

Two conceptual models are introduced in the ***“Difficult” Clinician-Patient Relationships (DCPR)*** workshop to frame the problems of difficult relationships and the possibilities for repair. The first examines some of the factors that lead clinicians to apply the label “difficult” to a situation. The **DCPR** workshop is predicated on the understanding that “difficulty” arises from the interaction and is not an inherent property of an individual. The conceptual model recognizes that clinical relationships occur in the context of the patient, clinician, and illness, embedded in the larger family and healthcare system setting. Difficult interactions may arise when treatment is unsuccessful, patients’ and clinicians’ expectations are misaligned, or there is insufficient flexibility on the part of providers, families or the healthcare system.

The second model outlines communication strategies that clinicians can use to respond to situations they experience as difficult or challenging and is embodied in the **“ADOBE”** acronym, below. Clinicians can experience fewer “difficult” relationships using the following skills:

A: Be Aware and Acknowledge your own thoughts or feelings that generate impulses to behave in a certain way. For example, if feeling challenged by a patient, you may find yourself impulsively responding in a defensive tone. Being aware of internal messages that indicate “something is wrong” and acknowledging the difficulty within the relationship can keep a challenging interaction from escalating. An example of an acknowledging response is, *“Mr. Smith, I can see you’re angry and I really would like to work this through with you.”*

D: Discover meaning. When an interaction seems to be heading towards shaky ground, in addition to your own self-awareness, find out what the patient is experiencing. This means discovering the meaning for the patient. He may be experiencing something very different than you and only through asking will you find out. *“We both want your diabetes to improve and for you to feel better AND we may have different ideas about how to make that happen. I want to work with you to find a plan where we can consider both...”*

O: Opportunity for compassion. A common practice in patient interactions is focusing only on the stated positions or surface statements of the patient. Clients manifest their positions and ideas in many ways and often exhibit feelings along the way. This is apparent through tone of voice rising on the part of a patient who states *“I feel like when I tell you I’m smoking, I feel guilty.”* Commonly, clinicians may assume that a response such as *“I don’t want you to feel guilty”* or explaining to the patient (perhaps repeatedly) the health risks of smoking, will be successful. Rather, consider a compassionate statement that conveys empathy and understanding such as: *“It’s clear that you’re having some difficulty with the plan to stop smoking and I’m glad you feel comfortable enough with me to tell me the truth.”*

B: Boundaries. The boundaries you set, verbally and nonverbally, implicitly and explicitly, tell your patients what you consider to be acceptable and unacceptable. This typically covers four areas: 1) time (yours and theirs), 2) content of the visit (what can reasonably be expected), 3) rights and responsibilities of all parties involved, and 4) space and distance (physical boundaries). *“Mr. Smith, it’s hard for me to help you when you raise your voice and use profanity. I’m going to step out for a moment. When I come back, if it happens again I will need to ask you to leave.”*

E: Extend the system. Sometimes we need to reach outside the boundaries of our practice to heal a patient relationship. There are three questions to consider before reaching outside of the relationship for help: 1) What help is needed? (e.g., financial advice, social services, mental health services); 2) Who can help? (e.g., community resources with contact information); and 3) How will the client be involved in decisions to get help? (e.g., clear action steps).

The optional expanded full-day workshop includes more in-depth subject matter content and additional practice opportunities via small group exercises using video cases.

Expectations

Learners in the **“Difficult” Clinician-Patient Relationships (DCPR)** faculty course are expected to participate in all activities in the 2.5-day workshop. To minimize distraction, IHC recommends that learners be freed from additional work-related responsibilities for the duration of the faculty course.

Upon successful completion of the **DCPR** faculty course, we expect learners to commit to teach the **DCPR** workshop, and we expect sponsoring organizations to support learners’ participation in the faculty course and subsequent teaching activities.

Throughout the **DCPR** faculty course, IHC Senior Trainers and small group facilitators provide feedback to learners and assess their readiness to conduct **DCPR** workshops. In the event that additional support and

coaching is needed prior to teaching the **DCPR** workshop, IHC Senior Trainers are available to provide such personalized support and guidance. Individualized support is scheduled separately and subject to additional fees.

All IHC faculty must use the most up-to-date version of IHC's copyrighted curricular materials for the course(s) they are trained to lead.

Learning Objectives

By the end of the ***“Difficult” Clinician-Patient Relationships (DCPR)*** faculty course, learners will:

1. Gain background knowledge and facilitation skills required to conduct the ***“Difficult” Clinician-Patient Relationships (DCPR)*** workshop at their institution;
2. Develop improved clinical communication skills and the ability to role model those skills through simulated patient sessions;
3. Identify and practice a coaching and feedback model for use with learners and colleagues; and
4. Develop a plan for integrating IHC workshop materials and training to meet the professional development and CE needs at their institution.

Methodology

The ***“Difficult” Clinician-Patient Relationships*** faculty course is fast-paced and interactive. It is conducted over three consecutive days at a host organization, with 6 to 30 learners. All IHC courses are predicated on best practices in clinician-patient communication and are designed to provide learners with opportunities to practice skills and techniques. The format for the session combines brief presentations, videotaped case studies with interactive exercises, active learning techniques and discussions. Learners are encouraged to develop and practice communication strategies with expert and peer feedback. Exercises are graduated and structured to ensure a safe and supportive learning environment.

The materials for the workshop include a faculty manual with slide scripts, facilitation guides, teaching strategies and tools; the workshop workbook with the text of the slides and exercises; training video vignettes; an annotated [bibliography](#) and a carrying case.

Faculty

IHC Senior Trainers who teach IHC's ***“Difficult” Clinician-Patient Relationships*** faculty course bring extensive clinical and educational experience, including teaching a diverse selection of IHC's skill-based workshops and training programs.

CME

The Institute for Healthcare Communication (IHC) takes responsibility for the content, quality, and scientific integrity of this CME /CE activity. IHC is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians. The Institute for Healthcare Communication designates the 3.5-day ***“Difficult” Clinician-Patient Relationships (DCPR) train-the-trainer faculty course*** for a maximum of 19.5 AMA PRA Category 1 Credits™.

IHC is accredited by the American Academy of Family Physicians (AAFP) to provide prescribed credit for continuing medical education programs. This activity has been reviewed and is acceptable for up to 19.5 prescribed credit hours by the American Academy of Family Physicians.

IHC also maintains a co-provider relationship with the University of Pittsburgh, School of Nursing, accredited by the American Nurses Credentialing Center (ANCC) to provide continuing nursing education (CNE).

Continuing education (CE) credit may be available to non-physician participants. IHC will provide a certificate of completion, which can be submitted to learners' respective accrediting organizations. IHC is pleased to provide any necessary documentation to help learners gain CE credits for completion of this activity.

For further information, please contact:

Institute for Healthcare Communication
171 Orange Street, 2R
New Haven, CT 06510-3111
(800) 800-5907
info@healthcarecomm.org
website: www.healthcarecomm.org

Notes

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