Difficult Doctor Patient Encounters

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Difficult patients from a historical perspective

- It started with descriptions of difficult patients (heart-sink patients, etc.)
- It went on with the idea that difficulties in interactions are necessarily a dyadic phenomenon; from difficult patients to difficult encounters
- It ended up with the assumption that finally doctors are responsible for failure or success of an interaction

Kroenke K.; Arch Intern Med 2009

How Often Do the Following Patient Interactions Occur?

- Insist on being prescribed an unnecessary drug
- Show dissatisfaction with your care
- Have expectations for care that are unrealistic
- Visit regularly, but ignore medical advice
- Persistently complain, although you have done everything possible to help
- Insist on an unnecessary test
- Are verbally abusive
- Do not express appropriate respect

Burden of Difficult Encounters in Primary Care: Data From the Minimizing Error, Maximizing Outcomes Study

ARCH INTERN MED/VOL 169; 2009:410-2

Difficulty Cluster, % of Physicians		
High (n=113)	Medium (n=268)	Low (n=41)

Interesting to see that 6 out of 8 characteristics relate to a criterion that was introduced by the doctor

What characterises doctors who more often complain about difficult patients I?

	Percent HI	Percent MED	Percent LO
% Family physicians (vs general internists)	41.6	49.6	58.5
Age, mean (SD), y	40.8 (9.0)	43.3 (9.0)	46.1 (13.4)
Female sex	50.4	44.6	26.8

What characterises doctors who more often complain about difficult patients II?

		OR	P-value
High job satisfaction	High vs low	0.26 (1.64-9.11)	p=0.023
	High vs medium	0.37 (1.82-4.02)	p<0.001
Burned out	High vs low	12.20 (2.70-55.56)	p=0.012
	High vs medium	2.17 (1.32-3.56)	p=0.023

A Cohort Study Assessing Difficult Patient Encounters in a Walk-In Primary Care Clinic, Predictors and Outcomes

Sherri A. Hinchey, MD MPH[1] and Jeffrey L. Jackson, MD MPH[2,3]

- 750 adult patients; pre-visit: PRIME-MD, SF6. post-visit: satisfaction (Rand-9), unmet expectations and trust.
- After each visit, clinicians rated encounter difficulty using the Difficult Doctor-Patient Relationship Questionnaire

Table 4. Independent Predictors of Difficulty

Characteristic	OR (95% CI)
>5 somatic symptoms on presentation	1.8 (1.3–2.3)
Report of increased stress in preceding week	1.9 (1.4–3.2)
Presence of depression or anxiety disorder	2.3 (1.3–4.2)

J Gen Intern Med 2011: 26(6):588–94

BMC Health Services Research

BioMed Central

Research article

Open Access

The difficult doctor? Characteristics of physicians who report frustration with patients: an analysis of survey data

Erin E Krebs*[1,2], Joanne M Garrett[3] and Thomas R Konrad[4]

- The upper quartile of doctors reports about 15 to 100% (!) patients who are ‘frustrating’
- Predictors from the physician’ side
  - Age below 40 years
  - More than 55 hours of work per week
  - A higher proportion of patients with psychosocial problems or substance abuse
  - Higher work-related stress
  - Higher depression- and anxiety scores

BMC Health Services Research 2006, **6**:128 doi:10.1186/1472-6963-6-128

What is the essence of an encounter that both sides perceive as successful?

- Perhaps something like trust?
- What we know from oncology: Doctors do strange things, but patients by and large show a big heart towards their doctors…

Doctors' communication of trust, care, and respect in breast cancer: qualitative study

Emma Burkitt Wright, Christopher Holcombe, Peter Salmon

Breast cancer consultation: what the surgeon did!

Patient	*I can't help worrying how things will go*
Surgeon	*Listen, for all our technology, we don't know everything. Do you believe in God?*
Patient	*Yes*
Surgeon	*Well, leave things in the hand of God.*

Patient interview: how the patient responded

"He was marvellous … so different from the other fellow who'd practically said he was [God]. It was such a relief"

Wright et al.; BMJ 2004 doi:10.1136/bmj.38046.771308.7C

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Social Science & Medicine 63 (2006) 552–562

SOCIAL SCIENCE & MEDICINE

www.elsevier.com/locate/socscimed

Physicians' difficulty with emergency department patients is related to patients' attachment style

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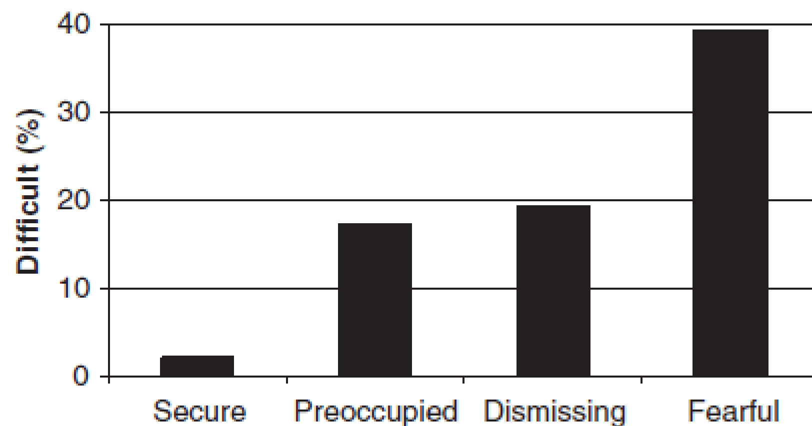

Fig. 1. Prevalence of patient difficulty by attachment categories in 165 emergency department patients.

Secure binding: trust in others, realistic expectations from the other

Preoccupied: unable to distance one self from negative experiences

Dismissing: The lonely hero

Fearful: Negative experience with others, pessimistic, low self-esteem

What is interesting in the idea of attachment behaviour?

- According to their pre-existing experience, patients seek another person, who can counter-balance their deficits or another person that respects their (alleged) independence
- According to their pre-existing experience in life doctors are more or less prepared to respond to these relational needs or to reject them (preferably) in a friendly manner if they come to realise that patients’ needs go beyond their capacity

As we won’t be able to perform an attachment interview with each patient and as it is unlikely that we all will undergo psychotherapy, we do not know in the beginning how best to meet a patient and how to realise what specifically this patient will induce in ourselves

Therefore, If we realise things are getting difficult or uncomfortable, or if we anticipate a difficult patient: Go Slow!

If I am the poor guy who is blessed with difficult patients, why not try to learn something about oneself as a doctor?

E.g. in Balint groups, intervision groups, or in supervision

An anatomy of conflicts in primary care encounters: a multi-method study

Michael A Weingarten[a,b,c,*], Nurit Guttman[d], Henry Abramovitch[b], Ruth Stashevsky Margalit[e], Debra Roter[f], Amitai Ziv[g], John Yaphe[a,c] and Jeffrey M Borkan[b]

- 291 videotaped routine encounters

TABLE 1 *Typology of conflict issues between doctors and patients*

Conflict issues (N = 113 encounters)	Percentage
Medical management of the presenting problem: medications, lab tests, imaging, specific diets, psychologist, second opinion, double-checking results and 'wait and see' approach	52.3
Management of background health issues: different diagnoses, test results and lifestyle	19.4
Bureaucratic: authorisations and certificates	27.5

An anatomy of conflicts in primary care encounters: a multi-method study

TABLE 2 *Distribution of talk during doctor–patient encounters (as percentage of total utterances) in conflictual and non-conflictual encounters*

	Opening	History	Exam	Counselling	Closure
Non-conflictual encounters	10.5*	38.7	9.0	35.4	6.4**
Conflictual encounters	5.3*	39.3	10.2	41.9	3.2**

$*P \leqslant 0.05$, $**P \leqslant 0.05$.

A more careful opening session…

- Prepares doctor and patient for the structure and the content of the encounter
  - Time frame
  - Items on the agenda
- Early identification of conflictual material
- Reduced risk of disappointment later in the interaction. Both sides know from the beginning that certain elements will be difficult to pursue

Some patients with psychiatric problems are

MISSION IMPOSSIBLE

BECAUSE

Problems with the regulation of closeness and distance characterise psychiatric disorders

- Severely depressive people, people with relationship problems (narcissist personality or borderline personality, etc.) and psychotic patients perceive the world in a very specific and hard to understand manner
- →They may be difficult to reach, correspondence with helpful others might become impossible

Problems in the regulation of proximity and distance go two ways

- Too little distance
  - Inappropriate behaviour, addressing a stranger too soon as a buddy (premature ‘Du’ in German), high intensity touch, inappropriate wording, etc.
- Too much distance
  - Sympathy is rejected as an action of transgression
  - An offer to respond on an emotional level is responded to on a factual basis

Wladimir Iljitsch Lenin: What is to be done?
Burning questions of our movement, 1902

Take Home Message 2013/2014/2015/2016/ 2017/2018

- The difficult patient is quite common
- The difficult doctor is quite common
- If these people meet, interactions and relationship get difficult!

What might help: Explicit structure

- As shown above, it seems that investing in the opening phase of an encounter is worth the time and effort
- In the beginning
  - Doctor and patient must accept the time frame
  - Doctor and patient must agree on the points on the agenda
- This helps to prevent uncomfortable surprises in the end («Oh, by the way doctor…»; «And you must stop…») and disappointment from both sides

What might help: working on myself as a doctor

- In the majority of papers it was the doctor's disappointment with his own standards that were not met that lead to the label 'difficult patient'
- Therefore, one would recommend taking a critical stance towards one's expectations towards patients and towards oneself
- This includes the questions: what is the mate-rial on which such a reflection takes place?

Searching for the material…

- We examine reports from medical students on their way to becoming a doctor
  - We hope that they did not yet develop techniques to deal with difficult patients
  - If not, we might get a glimpse upon the difficult interaction in its pure form
- We analyse student reports responding to the question: «What made this interaction difficult?»

History:

A patient had revealed that in the morning she had sensed increasingly intense pain in the right lower quadrant. In the end, it turned out that she had suffered a complication after an hysterectomy that was not performed well.

Impression:

According to the student, the patient seemed disoriented, whe wrote: «While I was talking with the patient, she was more an more unable to speak. Very soon it was evident that the whole history of the hysterectomy posed not only a medical problem but also psychological problems. I liked her, she was a very kind person.“

The student commented

To me talking with Mrs B was special because I felt very naiv, clueless how I should behave in such a situation. It was the first time I ewas in contact with a patient who apparently felt very ill. I felt insecure and did not know how to be helpful. I was afraid I might say something inappropriate.

Had it been a friend or someone from my family, I had known what to do. But how should I console a stranger?

- Another student relates to an interaction with an even younger patient who seemed embarrassed right from the beginning. Apparently he tried to solve the situation by acting cool: „You know there's a knot in my ass!"

- While the GP takes the history, the student realises: «I couldn't listen. I was focussed on regaining my professional stance!"

- In the midst of these thought she is 'hit' by the request from the GP: «So, then you do the examination, while I write down the history."

The student commented

“Even though an anal thrombosis is not necessarily embarrassing, I felt deeply embarrassed, when I realised how embarrassed he was. After all, he had about my age. Outside the practice I would be so much different, more friendly and open.“

Commonalities

- Students report on the difference between interactions in private and professional interactions assuming the identity of a doctor
- The latter are difficult because what we normally do in private does not necessarily work as a doctor
  - I would know how to console a friend
  - Normally I would not address such a problem (an anal knot)
  - Because 'my role' is unclear to me and to the patient

Difficult interactions are…

- Interactions in which students are unsure, which professional stance they should take
- What is missing is a professional identity that differs from the private identity
- New Phenomenology offers the term **Fassung** to describe the characteristics of a professional stance
- In English ‘Fassung’ is difficult to translate; what do we loose when we losse our ‘temper’ or composure or whits?

More on ‘Fassung’:

- An individual has more than one ‘composure’
- Which is easy to understand because it takes different actions by a patient, a grandson, a wife, etc. to make me loose my temper.
- What students try to develop is a ‘composure as doctor’ which is necessarily different from the familiar ‘composure as young man/woman’
- Part of the hidden curriculum and probably an ongoing task for senior doctors is the development or refinement of one’s composure

And how does this relate to the topic: The difficult patient?

- Difficult patients put to the test whether my ‘composure as doctor’ is flexible enough to deal with unexpected aggression, exaggerated needs, inappropriate behaviour, etc.
- At the same time the idea of a ‘professional composure’ elucidates the relevance of my very personal expectations: How should the idea patient behave? What is inappropriate behaviour?

Summary

- Someone who never experiences that s/he is about to loose control, is 'solid as a rock', but unlikely to be emotionally affected by another person's suffering
- Is this how we understand ourselves as doctors?
- A person's composure/temper/control needs fine-tuning to avoid too much flexibility (the menace of doctor burnout) and too much rigidity (the menace of cold-blooded negligence)

Working on one's professional composure = Balint Groups?

08.-14.9.2019, www.sils-balintwoche.ch