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Repairing "Difficult" Patient-Clinician Relationships

Denise M. Dudzinski, PhD, MTS, and Carrol Alvarez, MS, RN

Abstract

Using a case example, we offer guidance for improving "difficult" clinician-patient relationships. These relationships may be repaired by acknowledging a clinician's part in conflict, empathizing with patients, identifying a patient's skill deficits, and employing communication and engagement techniques used by mental health professionals. Clinicians will inevitably take on more of the work of repairing damaged relationships, but doing so improves the odds of these patients receiving the help they need.

Introduction

Jane, a patient with hypertension, diabetes, and chronic back pain, calls your internal medicine clinic asking to see you urgently. She has missed every scheduled appointment in the past two months but calls the office several times a week requesting narcotics prescriptions or same-day appointments. You have been treating her for a year, and she rarely follows your treatment regimen. When you see her the next day, she again requests a prescription for narcotics for her back pain. As always, you suggest other remedies including exercise, nonsteroidal anti-inflammatory drugs (NSAIDs), and relaxation techniques. Jane becomes angry, confrontational, and tearful. She yells, "Why don't you believe me? You don't feel what I feel! I'm telling you what I need. I know what works and I'm in pain—lots of pain! I've tried all those routines before and they're worthless. Do you care about me at all?" Dr. Balewa tries to keep calm, but his anger escalates with hers. He tells her if she misses another appointment, he will have to stop seeing her. She storms off but calls the next day for an appointment, telling the receptionist what a great doctor he is. He is exhausted from yesterday's appointment, dreads seeing her again, and feels guilty that he can't seem to help her and probably made things worse. He feels like a failure.

Many physicians find themselves in Dr. Balewa's place. Jane regularly and urgently requests help managing her chronic medical conditions then ignores or rejects most of the care offered. She requests medications not indicated, then becomes agitated and disruptive when a prescription is not forthcoming. "Difficult" patients commonly struggle with chronic, incurable, or elusive illnesses [1, 2], which may be borne of tragedy, loneliness, poverty, or other psychosocial factors. Communication is frustrating for both

patient and physician. Despite his efforts to maintain professional equanimity, Dr. Balewa became angry and responded with an ultimatum. Both physician and patient seemed to expect failure from themselves and each other, and their expectations were met. What can Dr. Balewa do to repair this relationship?

Clinicians will inevitably encounter patients with whom they share strained and complicated relationships. Initially it might seem that the problem is due to the patient's noncompliance, substance abuse, mental illness, or demanding or disruptive behavior. In contrast, bioethicist Autumn Fiester describes the "difficult" patient as "someone who perceives himself as wronged in the medical encounter—perceives being treated unfairly, disrespectfully, dismissively, condescendingly, or offensively" [3]. By acknowledging that the difficulty resides in the *relationship*, not the patient, clinicians honor their fiduciary responsibility to take the lead in ameliorating conflict. We argue that when a clinician brings hope, encouragement, and optimism to an encounter, he sets himself and the patient up for success. In this article, we discuss communication and interpersonal strategies designed to repair difficult patient-clinician relationships.

Take Stock

After exiting the exam room, it is tempting to leave the unpleasant experience behind, but reflecting on the encounter is more productive. Ask yourself what went wrong. Ascertain how you have participated in the malignant relationship by identifying your "triggers" [4]. Do other patients, friends, or family members prompt similar reactions in you? What responses *to you* do these friends and the patients have in common? Try to identify patterns. Do you tend to feel exasperated with patients who need your help with nonmedical issues or who demand treatments you deem inappropriate?

Set Tone and Expectations

Jane's emotions got the better of her, prompting Dr. Balewa's *in*validation of her internal experiences when what she, and others like her, seeks is validation [5]. Dr. Balewa could help by lowering his voice, being still and calm in the midst of Jane's anger, and by setting concrete expectations and boundaries early in the appointment. With preparation and practice, he can de-escalate emotional intensity by creating a more collaborative atmosphere. For example, he could begin by saying, "I would like us to find a plan that we both believe will work for you, one that is within standards of good clinical care. We might have to start with small steps. In order to accomplish our goal, we will have to be respectful of each other. If one of us becomes too frustrated to continue, we may have to stop at that point and pick up again at our next visit." This approach improves collaboration and emphasizes mutual respect and responsibility, because the plan applies to both patient and physician. It also avoids the abrupt imposition of an ultimatum borne of the physician's frustration. This strategy is useful in that it allows a time-out period for the patient, and perhaps the physician, early rather than late in the escalation process. Patients with emotional dysregulation may have difficulty regaining

control once escalation has begun, and providing a structured way to interrupt the process is beneficial.

Empathize with Patients in Their Attempts to Solve Problems

It's helpful to recognize that the patients' behaviors are attempts to problem-solve. For example, Jane might believe the physician does not appreciate the intensity of her pain and distress. She believes shouting will call attention to her needs, and she is right. Often patients seek human interaction and empathy from caregivers. Jodi Halpern describes empathy as including "not only spontaneous emotional attunement . . . but also a conscious process of cultivating curiosity about another's distinct perspective" [6]. Sympathy, on the other hand, is "resonating emotionally with the patient" [6]. When the patient is angry, empathy de-escalates conflict and sympathy escalates it. After listening with interest and curiosity to Jane's angry accusations, Dr. Balewa could have said, "I know you've been frustrated and felt unheard. I'm not intending to be disrespectful of your experience. I have guidelines I must follow, but perhaps we can begin with a specific goal and try different approaches." This approach validates the patient's distress and promises a commitment to creatively resolve *the patient's* perception of the problem.

Assess Patient's Skill Deficits

Behaviors that provoke emotional reaction in others may represent skill deficits in the patient. The skills Jane lacks include the ability to effectively regulate intense negative emotions and to communicate effectively in the midst of conflict. Jane might not be able to self-soothe, expecting relief to come from external sources such as the physician or narcotics. Finally, she likely has limited experience of self-efficacy, which plays out in her inability to effectively make and keep medical appointments. If Dr. Balewa sees Jane's behaviors as coping strategies rather than noncompliance, his empathy may increase and he may be better able to help her.

Strategically Manage This and Future Appointments

Dr. Balewa suspects that Jane's diabetes and hypertension are poorly controlled due to a sedentary lifestyle and medication nonadherence. He could begin the next appointment by inquiring about one or two things that have gone well since her last appointment. This strategy would begin the session with an opportunity to reinforce (even limited) successes and could help physicians calibrate how ambitious their next steps should be. In this way, Dr. Balewa would decrease his risk of getting caught up in Jane's emotional intensity. Instead, he could: (1) help Jane maintain her composure with a matter-of-fact manner of interacting; (2) validate her reaction as understandable within her unique experience and context, rather than invalidate it within his own; and (3) refocus on tasks and strategies that are most useful to her.

Setting clear limits provides structure [7] that will help Jane over time. For example, Dr. Balewa can talk with Jane about ways to improve her ability to keep her appointments,

while also developing strategies for missed appointments and requests for next-day appointments. Dr. Balewa can invite Jane to determine whether shorter appointments at shorter intervals would work better, noting that the appointment may end early if an emotional stalemate occurs, with unfinished business deferred to a later appointment.

Once these basic and immediate structures have been established, the physician could invite Jane to set goals by asking what she would like to accomplish for herself in the appointment and in the next few months. He could ask if she would be willing to take small steps toward at least one of those goals and report back about what does and does not work. Modest recommendations generated together allow additional successes for Jane to build upon. In the face of Jane's health problems these small steps might seem inadequate to the physician, but they may allow for better health outcomes in the long run.

Finally, the recommendation that doctors spend more time listening and interrupt less is especially important in difficult encounters [8]. Physicians are inclined to interrupt the patient about 18 seconds after greeting him or her. However, it only takes about 2.5 minutes for patients to tell their stories uninterrupted, which makes patients feel heard, provides rich history relevant to the rest of the visit, and likely saves time overall [9].

Conclusion

Clinicians readily accommodate patients' physical disabilities, but they might neglect to take into account patients' deficits in social and life skills or thorny personal styles. The latter signal the need for different kinds of accommodations. Patients' personal histories may influence their expression of distress, communicated in ways that complicate their ability to receive necessary care. When a clinician encounters a patient whose behaviors are disruptive and distressing, a step back for reflection can provide a shift in perspective.

The basis of trust in the patient-clinician relationship is a fiduciary obligation to protect, respect, and heal vulnerable patients. The patient-clinician relationship is inherently unequal, and the physician marshals her knowledge and power solely to aid the patient. Consequently, clinicians always have more responsibility to repair and rebuild the relationship than patients. The strategies discussed here can help clinicians do just that.

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Denise M. Dudzinski, PhD, MTS, is a professor and the chair of the Department of Bioethics & Humanities at University of Washington (UW) School of Medicine, where she is also chief of the UW Medicine Ethics Consultation Service. She is co-editor, with Paul J. Ford, of *Complex Ethics Consultations: Cases that Haunt Us* (Cambridge University Press, 2010). Her areas of scholarly interest include clinical ethics, organizational ethics, ethical issues in end-of-life care, and ethical issues in mechanical circulatory support.

Carrol Alvarez, MS, RN, is a clinical nurse specialist for psychiatry at Harborview Medical Center in Seattle, where she is also an ethics consultant. Her areas of interest include treatment of people with personality and affective disorders and ethical issues that arise for people with psychiatric illnesses or addictions when they are in health care settings.

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