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POLICY FORUM

Roles of Physicians and Health Care Systems in "Difficult" Clinical Encounters

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Abstract

Physicians are, by definition, contributing partners in "difficult" patient-physician encounters. Although research on relevant physician qualities is limited, common themes mirror the more extensive literature on physician burnout. Focusing on primary care, we discuss physician-level factors in difficult encounters related to psychosocial attitudes and self-awareness, communication skills, and practice environments. Potential approaches to mitigating these factors include changes to medical training, such as structured peer case discussion groups and communication skills development, and changes to workplace environments, such as integrated mental health. Modifying physician-level factors in difficult encounters could ease perceived difficulties and improve outcomes for both physicians and patients.

Introduction

The "difficult patient" is a long-standing focus of medical scholarship and a common topic of discussion among physicians. "Difficult patients" have been defined primarily from the perspective of physicians, with most studies conducted in primary care settings. These studies are fairly consistent in their characterization of "difficult patients" as more likely to have multiple physical symptoms, high health care utilization, or functional impairment related to mental health diagnoses or substance dependence [1-3].

Of course, it takes two to tango, so what about "difficult doctors"? Here, we do not focus on physicians who commit malpractice or patient abuse but on the broad category of physicians most likely to be involved in subjectively difficult physician-patient encounters. We are not aware of studies that have identified such "difficult physicians" from a patient or third-party perspective. Instead, research on the physician side of difficult interactions has focused on physicians who report more "difficult patients" or difficult encounters than their colleagues do [1, 4-13]. Such "difficult doctors" might be more accurately described as physicians with a lower difficulty perception threshold. Regardless of what we call them, physicians who see relatively more encounters as difficult or frustrating have been the focus of a small number of studies from which a preliminary profile has emerged.

Research on the "Difficult Physician"

Physicians who perceive more encounters as difficult report having more negative attitudes about psychosocial aspects of medicine, less experience or training, and more work-related stress or dissatisfaction than their colleagues who report fewer difficult encounters. In the national Physicians Worklife Survey, physicians who considered high proportions of patients "generally frustrating to deal with" were more likely than their less-frustrated colleagues to be under 40 years of age, work more hours, have higher stress, and report caring for more patients with complex psychosocial and substance abuse problems [4]. In the Minimizing Error, Maximizing Outcomes Study, physicians who considered more encounters difficult were younger, more likely to report burnout, and less likely to report high job satisfaction than those who considered fewer encounters difficult [5]. A study of British general practitioners found that those reporting more "heartsink" patients had greater perceived workload, lower job satisfaction, and less training in counseling and communication skills than those reporting fewer heartsink patients [6]. Two studies examining physicians' perceptions of walk-in visits found that physicians who considered more encounters to be difficult were more likely to have negative attitudes about psychosocial aspects of care [1, 7]. Qualitative research also has identified clinician traits that may contribute to clinicians' tendency to perceive more encounters as difficult, many of which mirror the above findings: limited training in psychosocial care, difficulty setting boundaries, poor communication skills, emotional burnout, exhaustion, and perceived time pressure [8-13].

Physician Burnout and Physician-Perceived Difficulty

Findings from literature on physician-related factors in difficult encounters have intriguing parallels with research on physician burnout. Reported job dissatisfaction and burnout are themselves characteristics of physicians who perceive more encounters as difficult [4-6, 8-10, 13], and physician burnout and difficult physician-patient encounters might have similar causes and consequences. Physician burnout is a complex construct that incorporates dimensions of practice environment, social and cultural influences, and personal qualities [14, 15]. Although age, gender, and specialty do not consistently predict burnout [16, 17], limited self-awareness and inability to set professional and personal boundaries do [18]. These self-awareness and boundary challenges are also noted in physicians who perceive more encounters as difficult [8, 10-12]. Similarly, both physicians who report high burnout levels and physicians who report more difficult encounters describe their workplaces as characterized by limited control over scheduling and by high workload and time pressure [4-6, 17-20]. Improvement in factors common to physician burnout and physician-perceived difficult encounters may mitigate both of these pressing problems. In what follows, we focus on three key categories of physician-related qualities—psychosocial attitudes and self-awareness, communication skills, and

practice environments—that contribute to difficult patient-physician encounters and on the teaching of skills that might reduce such encounters.

Psychosocial Attitudes and Self-Awareness

Negative attitudes toward psychosocial care, a common theme in existing research on difficult physicians, develop under mixed influences of medical training and individual physicians' personal backgrounds [21, 22]. Medical training's focus on pathophysiology has important implications for our approach to biopsychosocial problems: disproportionate attention to the biological aspects of these problems implies psychosocial aspects are secondary or separate—beyond our scope of practice [23]. Physicians' own psychosocial attributes and self-awareness also matter for patient care [21, 22]. Some physicians are well aware of the cultural influences of race, ethnicity, gender, or sexual orientation on their own identities and might easily recognize tensions related to such influences within medical encounters [24]. Other physicians may have a hard time seeing their personal background as culturally relevant and recognizing how their backgrounds can influence patient interactions. In addition, some attributes of physicians who perceive more encounters as difficult, such as discomfort with uncertainty and inability to set boundaries [8, 10], are personal qualities that people can have difficulty identifying and modifying in themselves [22]—and that can worsen physician burnout if unaddressed [18]. Mentored development of self-awareness skills might help to reduce both physician burnout and perceived difficulty of encounters.

Several approaches have been developed to support clinicians in psychosocial insight and self-reflection in both educational and practice settings, including structured peer-case discussions such as modified Balint groups and Schwartz Rounds™. Introduced by Michael and Enid Balint in the 1950s and grounded in psychoanalysis, Balint groups are small clinician groups that meet regularly to discuss patient interactions that participants have found difficult [25, 26]. Such groups aim to help physicians gain perspective on the role their own traits, attitudes, and behaviors play in difficult encounters and develop skills they can apply in future practice [25, 26]. Schwartz Rounds build similar principles into interactive case discussions in the larger, familiar grand rounds format, again focused on improving psychosocial and personal awareness for the sake of improved patient communication and care as well as physician support [27]. Interestingly, this emphasis on physician self-awareness and on completing the "emotional work" of difficult patient interactions [28] was fundamental to the concept of patient-centered care as described by Balint in 1969 [25]. Although evidence suggests structured group discussions may help build practical self-reflection habits into medical training and can ultimately improve job satisfaction [13, 27], approaches to improving physician self-awareness have remained on the margins of undergraduate and postgraduate medical training [29]. Further research is needed to determine whether their broad implementation could lead to substantial improvements in patient care and physician well-being [26]. More educational grounding in the biopsychosocial model of health, with

structured training in self-awareness and communication skills, could produce physicians who find—and make—care less "difficult" for all involved.

Communication Skills

Success in a healing role—an important source of personal meaning and professional satisfaction for many doctors [8, 10, 18]—requires high-level communication skills. Physicians must convey nonjudgmental interest, empathy, and respect to build the therapeutic alliance while efficiently accomplishing clinical tasks [8, 10, 30, 31]. Insufficient communication and patient management skills can impede clinical care, compound physicians' emotional work, and predispose physicians to burnout [11, 13, 14, 30].

Patient-centered communication and shared decision-making involve skills that have become increasingly well-defined through research [32, 33]. In many common symptomatic conditions, physician communication is the core intervention. For example, acute back pain guidelines recommend self-care advice and education but no diagnostic tests or specific treatments for most patients [34]. Training primary care physicians to effectively communicate this advice improves patient distress and reduces additional care seeking [35]. In many chronic conditions, such as diabetes and longitudinal HIV care, effective communication and perceived patient-centered care can promote adherence to prescribed treatments and behavior change recommendations [30, 36-41]. Furthermore, physicians who use communication skills effectively report more positive experiences of patient care, particularly with psychosocially challenging diagnoses [42, 43].

Communication skills can be taught effectively in medical training environments, both to medical trainees and to their teachers [33, 44]. Nevertheless, most medical schools and residency training programs do not have structured or specific approaches to improving communication skills or ensuring communication competency [32, 33]. More widespread training in techniques such as motivational interviewing, an interactive approach that elicits and engages patients' intrinsic motivation to make personal changes, could improve physicians' effectiveness in the management of a wide range of complex conditions requiring behavior change [45]. Outlining specific communication skills and tactics in policy documents, such as the residency program requirements issued by the Accreditation Council for Graduate Medical Education (ACGME), and building specific communication skills assessments into testing environments such as the objective structured clinical examination (OSCE), could motivate medical schools and residency programs to build up such training. Medical education developers seeking guidance can look to the training programs of our colleagues in clinical psychology and other mental health professions, which have prioritized communication skills development for some time.

Finally, it is a long-standing reality that medical training often occurs in low-resource environments—problematic for patients for many reasons and also for trainees and early-career physicians who might feel least equipped to handle complexities of care. The challenges of care in low-resource settings make it all the more important for training environments to impart communication and personal awareness skills that can have short- and long-term benefits to both physicians and patients [33].

Practice Environments

We must acknowledge the role of practice structure and resource limitations in generating both difficult encounters and physician burnout in primary care settings. Organizational interventions addressing workplace factors might be an effective means of reducing both physician burnout and difficult encounters, although research to date comprises a limited number of studies and a wide variety of approaches, ranging from simple scheduling changes to intensive multifaceted interventions [46].

Perceived time pressure is a common problem cited by both physicians who perceive more encounters as difficult and physicians with high burnout levels [6, 8, 10, 16, 17]. Assessment and management of complex biopsychosocial problems requires time that physicians often don't have or cannot be paid for and can require skills beyond even optimally trained physicians' scope. Even sophisticated interventions targeting psychosocial care are more likely to fail when time, reimbursement, and resources are lacking. For example, a recent trial of a structured behavioral/mental health risk assessment intervention in primary care clinics was successful in its goals of identifying many clinically relevant problems and triaging care but was ultimately found to be too time-consuming to be sustainable in real-world practice [47, 48].

Team-based approaches have the potential to achieve what individual physicians cannot. For example, integration of mental health professionals into primary care settings improves both quality of medical care and patient outcomes [49]. Although this might be a particularly promising approach to addressing psychosocial challenges in primary care, effects on physician outcomes such as burnout are in need of research. A more transformational approach to primary care, the patient-centered medical home model, is a complex organizational intervention intended to make care more team-based, coordinated, and accessible. The patient-centered medical home approach has demonstrated ability to improve patient experiences and delivery of preventive care services [50], but evidence on physician outcomes is somewhat conflicting. A 2013 systematic review found low-strength evidence of beneficial effects on primary care staff satisfaction [50]. More recently, however, one study found that the Veterans Health Administration's patient-centered medical home transformation was associated with a modest increase in primary care physician turnover [51], and another study found no relationship between the level of medical home implementation and burnout prevalence among primary care employees [52]. More research is needed on physician

outcomes of such organizational interventions and on the mechanisms by which these outcomes are achieved.

Conclusion

"Difficult doctors"—or, more accurately, physicians who often report frustration or difficulty with patient encounters—might have more negative attitudes about psychosocial aspects of medicine, less experience or training in relevant skills, and more work-related stress or dissatisfaction. These qualities mirror those found among physicians experiencing burnout and suggest opportunities for improvement in both training and practice organization. Graduate and postgraduate medical education present particularly important opportunities—too often missed—to ensure competency in self-reflection and critical communication skills; it is time to leverage training to teach these skills more pragmatically and effectively. Primary care practice changes, such as integrated mental health, the patient-centered medical home, and other organizational approaches might deliver better patient care and have the potential to improve physician well-being; more research is needed to determine when, where, and how such organizational changes can live up to this potential. Such training and practice changes merit further investigation to determine whether and how they might ease perceived difficulties for both physicians and patients, in line with the fundamental principles of patient-centered care.

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