Difficult Clinician-Patient Relationships

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Introduction

All clinicians encounter patients whom they regard as difficult [1–17]. Clinicians diverge, however, on who merits this label [8,18]. We have shown videotapes of "difficult" patients to more than 1000 clinicians from a variety of geographic and practice settings. The clinicians are shown five sets of patients with three patients in each set and are asked to name the patient in each set who they would find most challenging. Consistently, each of the 15 patients is judged both "most difficult" and "least difficult" by different clinicians. This consistent variance in labeling patients surprises clinicians. The exercise demonstrates, however, that interpersonal perceptions and relationships are covariates rather than objective attributes of the patient.

Clinicians can often list demographic characteristics or personality traits that they associate with "difficult" patients. A perspective that identifies the locus of dysfunction in the patient, however, oversimplifies the clinician-patient relationship, overlooks the tremendous variety of experiences that occur in the medical care setting, and runs the risk of becoming a self-fulfilling prophecy. We have developed a model that recognizes four sources of difficulty: the patient, the clinician, the illness, and the system.

All of us, clinicians and patients both, find ourselves in situations in which we catch ourselves reacting in ways we would prefer not to act. A statement, a request, or a tone of voice pushes our hot button, triggering an immediate intense reaction. Afterward, we may recognize our automatic responses and wish we had behaved differently. 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 reliable indicator that our hot button was activated. Our hot buttons may lead to difficulties in relationships.

Another source of difficulty may be the illness itself. It may be one that the clinician and patient are unable to clearly communicate about due to anxiety, fear of failure, or even boredom. The health system, too, may be a source of difficulty, such as when an insurance benefit plan does not cover certain tests or treatments. A social system that lacks adequate resources to support healthy lifestyles also may pose difficulties.

Rather than label certain patients "difficult," we believe it is more useful to speak about "difficult relationships" and to focus on ways of interacting in these relationships with the goal of achieving more satisfying outcomes.

Why Difficulties Occur

We have identified three core problems associated with difficult clinician-patient relationships: frustrated success, inflexibility, and misaligned expectations.

Frustrated Success

Clinicians seek success [19], and success most often is defined as effective clinical problem solving or "cure." When success is unlikely or threatened, clinicians may use negative labels to describe patients. For example, a patient whose asthma is difficult to control due to socioeconomic or psychological stressors may frustrate the clinician. Patients also want success. Patients may become depressed, angry, or demanding when treatment does not work or if they perceive that the clinician is blaming them for their illness. At the same time, clinicians may feel that the patient is blaming them for the lack of progress. These clinician and patient frustrations and blaming attitudes can contribute to mutual dissatisfaction.

Inflexibility

Clinicians and patients may have a low tolerance for diversity, such as differences in language, ethnicity, socioeconomic status, values, gender, or health beliefs and practices. For example, in one study, the "least troubling" patients were described by male physicians to be middle-aged, "hard-working" men with illnesses that quickly resolved or with which they came to terms quickly [18]. Allopathic clinicians may be inflexible in their rejection of alternative treatments such as acupuncture or chiropractic care. Patients also may be inflexible. They may have strong preferences to be treated by a male or a female clinician, to see a specialist or generalist, or

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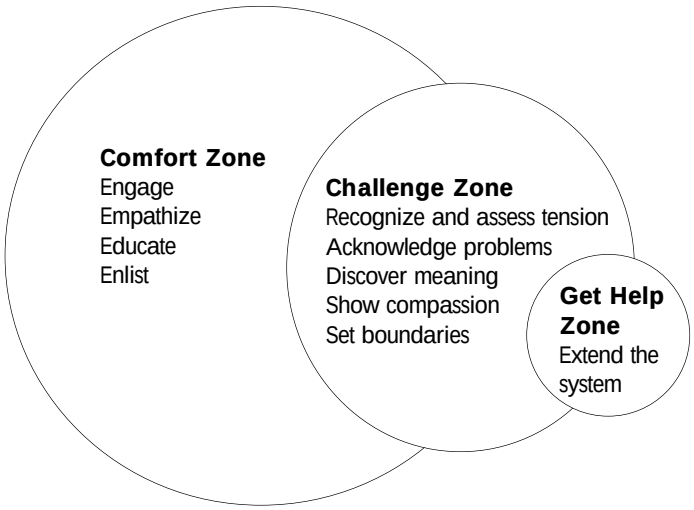

Figure. Most relationships take place in the comfort zone. Different clinical behaviors are needed for more challenging zones of interaction.

to participate little or extensively in health care decisions. When clinicians or patients "dig in their heels" and insist on getting their way, they are likely to be regarded as difficult.

Misaligned Expectations

Clinicians and patients frequently differ on the role expectations they hold for one another [15,20,21]. Patients may enter treatment with a specific expectation, such as obtaining a prescription for a narcotic or getting an MRI for a headache. Physicians may have a different expectation, such as expecting the patient to learn to live with the chronic pain or to attend physical therapy and follow an exercise regimen. When expectations for treatment or the roles that each will take differ, either party may label the other as "difficult."

All three core relationship problems are illustrated in the following monologue. The patient is a 27-year-old highway construction worker presenting to his primary care physician stooped over with his hand on his lower back:

Patient: *Don't mind me with these positions. It's my back. It's like before. I will be talking and then all of a sudden I'll move and it will just lock up on me. It's like someone is twisting a knife in my back. I know it's the disk. I don't want to see a surgeon and I don't want to have any type of extensive work done on it. At work they're making noises about me and about this particular injury, so I think it's time that we claim this as a disability. I brought these papers for you to sign.*

In this scenario, success is likely to be frustrated for the clinician because the patient has diagnosed his own problem and prescribed his own treatment plan, which is no treatment. For the patient, success may be frustrated if his goal is to obtain signed disability papers. This also is an example of expectations being misaligned. The clinician may have the expectation that the patient will seek information, participate in a discussion of the available treatment options, and follow through with the appropriate medical treatment. At the same time, the patient may have the expectation that nothing will help him medically and he is entitled to go on disability, especially in light of his chronic pain. Finally, flexibility may be insufficient. The clinician may not feel comfortable signing disability papers when it is clear to him or her that there are other more appropriate options. The patient also appears to be inflexible in his willingness to explore other options. If these differences are not handled appropriately, it is likely that both parties will leave the encounter feeling angry or dissatisfied.

A Three-Zone Model

Most clinician-patient interactions are satisfying for both the clinician and the patient. Although some stress is normally associated with the medical setting, interpersonal stress usually is minimal and the relationship between clinician and patient is not in jeopardy. Such interactions take place in what we call the "comfort zone." In the comfort zone, conventional interviewing techniques, such as Cohen-Cole's three-function approach (gathering information, building a relationship, and motivating adherence) [13] and the Bayer Institute's 4-E approach (engage, empathize, educate, enlist) [22–25], are useful for obtaining information and furthering the relationship. However, when a core relationship problem exists, interactions move out of the comfort zone into more challenging zones of interaction (**Figure**). The boundaries of these zones are idiosyncratic to the clinician and the nature of the practice.

Sometimes the clinician-patient dyad does not have the resources to accomplish the medical or relationship tasks at hand, and the relationship moves into the "get help" zone. For example, with a diabetic patient who needs to make lifestyle

Table. Clinical Approach to the Difficult Relationship

Perform an internal cognitive and affective review
Recognize tensions
Don't just do something; stand there
Assess the source of difficulty
The clinician
The patient
The illness
The system
Identify core relationship problems
Expectations are misaligned
Success is frustrated
Flexibility is insufficient
Commit to working on the relationship in addition to addressing the medical problem
Acknowledge the difficulty and offer a problem-solving approach
Discover the meaning of the illness for the patient
Show compassion
Set boundaries
Extend the system

changes, the clinician might extend the system to include a dietitian, behavioral therapists, and other family members.

Recognizing the Challenge Zone

When a person is in the challenge zone, the person may note a global sense of distress accompanied by an interior monologue such as, "I wish I were somewhere else." But recognizing that a relationship is in trouble is not always easy. Feelings of distress may not be clear at the outset. Fortunately, there are three other clues that signal a difficult relationship. We refer to these clues as the *IRS*: Either the patient or the doctor frequently *I*nterrupts the other, frequently *R*epeats their statements (getting louder with each repetition), or uses *S*tereotypical responses that promote disengagement (responses that are too pat or general to be meaningful). These clues indicate that the relationship needs attention.

Although there is a large body of literature describing difficult clinician-patient interactions, empirical studies of techniques for dealing with these relationships are limited [26]. We do know, however, that the problems of difficult relationships do not respond to conventional interviewing techniques and are not likely to disappear.

Clinical Approaches for Difficult Relationships

In the following scenario, a 28-year-old woman has had ovarian hemorrhage and intractable uterine bleeding leading to unexpected oophorectomy. Although this rare complication of fertility medication was discussed and documented during informed consent, the patient decided to accept the risk in hopes of having a child. Neither party expected this outcome.

Patient: *(Agitated and angry) I can't believe this is happening. This replacement therapy is driving me crazy. I've tried very hard to go along with you. I never thought that this could happen. Three months ago I was thinking I would have a child! You told me you didn't think you'd have to take my ovaries. You quoted me statistics. You said you were sure I'd be fine. Now I'll never have a child. I'm a wreck. It's impossible to have sex. You act as though you could care less that you've left me totally worthless without anything to live for. You have ruined my life and you promised me that I would be fine. I can't believe the way you are acting! You just don't care!*

Some techniques for facilitating this relationship are outlined below and in the **Table**.

Recognize and Assess the Source and Nature of the Tension

The first step in resolving a difficult situation is an internal cognitive and affective review in which the clinician recognizes the tension, controls his or her own affective response, assesses the source and nature of the difficulty, and commits to working on the relationship.

- Recognize tensions. (*Oh no, am I in for it here! I'm feeling defensive and afraid this woman is going to sue me. I want to pull out the chart and show her what we went over before.)*

- Don't just do something; stand there [10]. (*I need a second to think. What if I just acknowledge that she is upset and let her vent a while and pull my thoughts together.)*

- Assess the source and nature of the difficulty. (*I think several things are going on here. This patient had an expectation that the surgery would go fine and she would have at least one healthy ovary. My expectation was that while I also hoped for that outcome, I did what was necessary to save her life. This woman also is frustrated because she has defined success as being able to get pregnant and have a family of her own. My guess also is that this woman needs to grieve the terrible losses she feels. Also, the medication may be playing a role in the degree of her agitation.)*

- Make a decision to work on the relationship in addition to addressing the medical problem. (*I need to empathize with her and find out what this outcome and loss mean for her. OK, I'm ready to go.)*

Acknowledge the Difficulty and Offer a Problem-Solving Approach

Doctor: *Mrs. Jones, I hear that you are very troubled by this outcome and I see that you have suffered a terrible loss. I'd like to find out more about what this means to you and to find a way to deal with this together if you are willing to talk to me about it.*
Patient: *What do you mean?*

Discover the Meaning of the Illness

Doctor: *Well, you said you feel totally worthless and have nothing to live for. That sounds awful.*
Patient: *Yes, well, it is. I have always dreamed of having children of my own. We put it off for a while so that we could establish ourselves and be able to provide the kind of life we wanted for our children. My husband is very upset and doesn't understand how this has happened to him. He wants a child very badly and now I can't give him that. I'm afraid he may leave me.*
Doctor: *That sounds like a tragedy for both of you.*
Patient: *Yeah . . . (weeps). I just feel so angry.*
Doctor: *Yes, and it's totally natural given what you've just been through. It's going to take some time for you to absorb all that's happened. I can imagine that you also can't see any solutions at this point.*
Patient: *No, I just feel so terrible and frightened and alone.*

Show Compassion

Doctor: *Mrs. Jones, is there anything I could do for you at this point, anything you need from me?*
Patient: *No. I want to be angry at you, but I know you didn't really have a choice.*

Set Boundaries

Doctor: *Yes, well I imagine you have many questions about what happened and why. I'll be glad to cover those when you feel up to it. We also may need to adjust your replacement therapy . . .*
Patient: *Thanks, but you're right. I couldn't concentrate just now. I think I just need to be sad.*
Doctor: *(Touches patient on the elbow)*
Patient: *(Cries)*
Doctor: *I don't want to rush you at all. I know this is a difficult time and you need to grieve. Would it be OK if I step out and attend to other patients? You can stay here as long as you need and I'll check back in a few minutes.*
Patient: *No, that's OK. I think I'll wash my face and go home.*
Doctor: *Will you be OK to drive yourself or can I call someone?*
Patient: *No, really, I'll be fine.*

Extend the System

Doctor: *OK, just one other thing. Would it be helpful if I or both of us talked with your husband? Or is there anyone else who can be a support for you?*
Patient: *That may be helpful down the road, but he's pretty angry at you also.*
Doctor: *Well, I'm available to talk to him anytime it would be helpful to you.*
Patient: *Thanks. So, I'll be back in 2 weeks.*
Doctor: *Yes, please call me if anything changes or if you have any problems or questions.*

Conclusion

Because the state of the art of dealing with difficult interpersonal relationships is still quite primitive, these suggestions for working with difficult clinician-patient relationships must remain far from definitive. Although drawn from research findings in several disciplines, there is a great deal we do not know. Thus, we must approach the use of these techniques from the perspective of the clinical trial, or what Donald Schon calls "reflective practice" [27]. Reflective practice calls upon the clinician to consider how effective a particular action was in achieving the goal that prompted the action: "I said X to him because I thought he would respond Y. Did he? If he didn't, what else could I have said?"

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