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Difficult Patient Encounters: Medical Education and Modern Approaches

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Abstract One might expect the physician–patient encounter to routinely be a rewarding experience. The patient needs help with a medical problem; the physician provides relief for that medical problem. However, conflict within these encounters continues to arise. Though research indicates physicians, medical systems, and patients contribute to potential conflict, medical education and practice provides limited guidance to physicians how to recognize and avoid these exhausting and sometimes confrontational experiences.

Keywords Calmer (catalyst for change alter thoughts, listen and diagnosis, make an agreement, education and follow-up, reach out and discuss feelings) · Rebels (recognize, empathy, boundaries, emphasize, language, and solutions) · Difficult patients · Doctor–patient interaction · Communication · Interactions

Introduction

The language used to describe difficult patient encounters often pins the blame solely on the patient. Terms such as difficult, problem, hateful, and heartsink patient have all been used to describe this archetype [1]. The term heartsink patient seems particularly evocative as it describes physician reaction without reference to cause. It suggests the anticipatory anxiety one feels when certain patient names appear on the schedule and the expectation the encounter will be frustrating and unsatisfying. Physicians report as many as 1 in 6 patient encounters as difficult [2–4]. Patients in turn are not immune to negative feelings about the encounter [5]. As many as a third of patients give their doctors negative ratings and overall consumer satisfaction for hospitals rates lower than that for public utilities (73–78 % over the past 5 years) [6, 7]. Since the physician's role is exclusively in service to the patient, it seems ironic that we sometimes find ourselves frustrated in our attempts to be helpful.

In addition to the emotional frustration experienced by both parties, failure to develop a therapeutic working relationship can cause long-term detriment to patient health and physician well-being. Patients identified as difficult were more likely to be removed from care, either through referral or outright discharge [8, 9]. Physicians treating these patients reported decreased job satisfaction and increased frequency of feeling "burned out" [10–12]. They also described increased instances of delivering suboptimal care and the expectation they will make future errors in their practice [10]. Physicians also behaved differently toward patients labeled as difficult. They experienced more pessimism regarding treatment, failed to provide structure or a goal for treatment, and more frequently referred patients to additional providers [8]. The authors hypothesized these attitudes might actually reinforce troublesome patient behaviors, and certainly contributed to physician/patient dissatisfaction. As with most human interactions, factors contributing to the difficult patient encounter appear to be multi-factorial. System constraints, physician attributes, and patient characteristics can all negatively impact the clinical encounter.

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The Medical Encounter

Despite efforts to improve formal education in patient interviewing and communication skills, medical training most extensively prepares physicians as diagnosticians. Trainees must master data collection, consideration of differential diagnosis, use of appropriate diagnostic tools and treatment options. Since these skills constitute physicians' expertise, it is natural to assume that patients are coming to you for this expertise. Sociological description of the sick role identifies some of the following features of the ideal patient: *the patient has a clearly delineated disease for which they are not responsible, the patient makes an effort to recover and, once treated, is cured and leaves the system* [13–16]. Patients may not be aware of these expectations, however, and present with their own agenda.

In approximately 50 % of encounters, patients offer some clue to the evaluating physician they have emotional or personal concerns, yet these issues are rarely addressed. In one study of videotaped clinical encounters between primary care doctors or surgeons and their patients, primary care doctors only responded to 21 % of patient clues and surgeons responded to 38 % [17]. Other studies using videotaped interviews show doctors actively re-direct patients away from emotional topics and onto medical facts [18, 19]. This behavior can be partially explained by physician fear addressing emotional issues will consume too much time. However, research suggests that patient expression of emotions adds relatively little time to the encounter, responds well to physician redirection and enhances patient satisfaction with the visit [20–23]. Allowing patients to express their full agenda may actually reduce overall clinical time as it can decrease utilization due to repeat visits for the same problem [24].

Failure to elicit patient needs often begins at the initiation of the interview. Anywhere between 25 and 75 % of patients' reasons for physician consultation go unrecognized [25], including those interviews done by primary care physicians with fellowship training in communication skills and family counseling [26]. Doctors typically interrupt patients after expression of one concern, redirecting them as early as 18 seconds into the interview. In one study, only once in 52 visits did the redirected patient return to their original agenda [27]. Yet patients report, on average, three concerns per office visit [28, 29]. Allowing patients to fully articulate their agenda before proceeding with questions only added an average of six additional seconds to the encounter [27]. Patients report concerns about their potential diagnosis, prognosis, their own concept of what is wrong, potential side effects to treatment, desire to refuse a prescription and providing information that relates to social context as their most commonly unvoiced concerns [25, 30]. Of these items, only discussion of potential side effects, and possibly prognosis, fit neatly into the patient encounter model taught in medical training.

Physicians may feel inadequately trained to respond to issues outside the medical model, or they may experience patients' questions as a challenge to their expertise. Although physicians often ascribe difficult encounters to patient characteristics, physician attributes also significantly contribute [31]. Physicians less comfortable discussing psychosocial problems with patients report more difficult patient encounters than those more comfortable with these issues (23 vs. 8 %, respectively) [4]. Additionally, younger and less experienced physicians tend to report more frustrating patient encounters. Physician depression, anxiety, stress and work hours >55/week also show a positive correlation [32] suggesting physician factors can either contribute to the perception of a difficult encounter or create the conflict itself.

Patients often experience difficult encounters as the fault of the physician. Complaints about health care professional attitudes are four times more common than other complaints about health care delivery [33•]. Patients report health care professionals appear to doubt their symptoms, ignore their requests for pain relief, and prescribe medications not well tolerated in the past. They feel disrespected or minimized by treaters, saying answers to questions were given hurriedly and in language not comprehensible to laypeople, bad news was delivered abruptly or without the presence of adequate support, and lack of continuity between physician and nursing teams caused absent or contradictory communication of information [34, 35]. Patients sometimes stated they were aware the staff viewed them as difficult based on overheard conversations and the sighs and body language of their treaters [35]. Physician training and redefining the approach to the patient interview can facilitate these encounters and make their outcome more agreeable to both patients and their clinicians.

Strategies to Improve Physician Efficacy

The Accreditation Council for Graduate Medical Education now designates communication among its core competencies for medical student education and students must demonstrate proficiency on their medical licensing exams. The benefits to improving communication are evident both in physician satisfaction and patient health measures. Studies have suggested improved communication can be a major factor in mitigating difficult encounters [36, 37]. Patient ratings of provider communication also positively correlate with improved patient compliance, symptom resolution, pain control, and objective measures of health

([24, 38] for reviews). Brief courses using role play or standardized patients offer education in improving physician–patient communication and offer modest, yet significant, positive results [39]. Customer service-based initiatives target improvement in office staff communication with patients. One 1.5 h training program designed to shorten time to return patient calls; improve delivery of test results; and expand discussion of medications, symptom explanation and overall time spent with patients resulted in improvement in patient satisfaction scores, a 40 % decrease in formal complaints and 20 % decrease in patient phone abandonment [40]. Efforts focused on improving patients' ability to communicate with their physicians also show promising results. Patients who completed pre-visit agenda cards experienced a 50 % reduction in unmet visit expectations [41]. A similar strategy using cards with the prompt "tell us what is important for you today" showed improved patient satisfaction with quality of care despite no difference in patient understanding of relayed information [42].

Unfortunately physician–patient interactions can still become challenging and confrontational. Formal strategies such as CALMER and REBELS emphasize concrete approaches to change this interaction. These models advise physicians to provide practical guidance to motivate patients to change their behavior, improve patient education, and provide opportunities for patients to articulate their concerns and participate in their treatment [43•]. When these strategies fail, consultation with a conflict mediator can also help physicians and patients re-establish a therapeutic relationship [44].

Patient Characteristics

Sometimes patients have underlying cognitive or psychiatric conditions that limit their ability to navigate medical encounters effectively. James Groves described 4 patient archetypes: the dependent clinger, the entitled demander, the manipulative help rejecter , and the self-destructive denier, that mimic types of personality pathology and continue to occupy physician descriptions of difficult patients [13, 45, 46]. In psychiatric parlance, these patients may be diagnosed with either a Cluster A (withdrawn or eccentric), Cluster B (demanding, self-absorbed), or Cluster C (anxious, obsessive) disorder [47]. Since patterns of maladaptive behavior and interpersonal difficulties define personality disorders, it should be little surprise patients identified as difficult have a higher prevalence of such diagnoses [2, 3, 48]. Those identified as challenging or referred for psychiatric evaluation most frequently demonstrate evidence of dependent or obsessive traits (26–33 %), while approximately 19 % show Cluster B traits (Narcissistic and Borderline personality disorders) [49, 50]. It might be particularly frustrating for physicians working with patients diagnosed with chronic pain and somatization disorders as personality disorders appear to be over-represented in these populations [49, 51–53]. Management of these disorders relies on trust in the patient's self-report of symptoms and function, yet these patients can be difficult to trust and difficult to like. They can exhibit diminished capacity for managing stress, trouble with trust, and difficulty navigating power in relationships, all of which can cause negative emotional reactions in their treaters [54]. Yet, these patients are also more likely to suffer a variety of co-morbid conditions that make them particularly vulnerable to failed treatment.

Patients with personality disorders have a 25–50 % increased risk of clinical depression and a 25–50 % increased likelihood of a substance misuse disorder [55, 56]. Increased clinical depression and anxiety in this population can contribute to poorer outcomes on various health measures separate from their mental health problems [3, 57]. They are also more likely to suffer accidents and physical illness, require Emergency Department treatment and hospital admission [56, 58]. Yet complicating psychosocial needs and co-morbid mental illnesses might limit the supports they would need to manage certain medical conditions. Physicians can easily feel overwhelmed by the emotional and psychosocial needs of these patients. Though psychiatrists receive specialized training in working with patients with personality disorders, most practitioners receive little education how to recognize or manage individuals with personality pathology. Brief education can increase physician confidence, optimism, and positive feelings for these patients [59]. Such supplemental education, multi-disciplinary team management, and psychiatric consultation have all been recommended strategies to improve clinical competence in working with this population.

Maladaptive attachment style is another patient variable that can adversely impact clinical encounters, and is present in as much as 20 % of the adult population [60]. Unlike personality disorder diagnoses, which encompass a wide range of cognitive and behavioral abnormalities, attachment theory specifically describes patterns of behavior in intimate relationships. John Bowlby first articulated a theory of attachment based on observations of children and their primary caregivers, usually their mothers [61]. His model included secure attachment reflective of healthy development and evidenced by a child's willingness to explore and engage with strangers when the primary care giver is close, and maladaptive styles characterized by anxiety ("pre-occupied"), arrogance ("dismissive") or pessimism ("fearful"). Though using different terminologies, these subtypes should be

recognizable in Groves' description of undesirable patient characteristics. The anxious patient who cannot be mollified with reassurance, the challenging, demanding patient and the pessimistic patient who rejects help continue to emerge as characteristics most frustrating to physicians [8, 46]. In one study that examined attachment styles in patients judged difficult by their clinicians, only 1 patient (2 %) with a secure attachment style was described as difficult compared to 39 % of patients with a fearful attachment style. Of the patients deemed difficult, 37 % showed dismissive attachment styles, 33 % exhibited fearful attachment and 26 % had preoccupied attachment [62]. Unfortunately, patients with these problems experience increased difficulty trusting their doctors, and subsequently experience poorer satisfaction with their care and deficits in treatment response, compliance, and participation in medical decisions [63–67, 64, 65, 66, 67•]. In contrast to the psychiatric literature, there is limited research into approaches working with these patients in other medical settings. Physician education around this topic tends to be minimal; however, brief courses can help physicians recognize potential conflicts and offer suggested responses to address patient anxiety or resistance [68].

Malingering and Factitious Disorders

Malingering describes one of the more difficult patient behaviors for certain medical specialties. The current diagnosis of malingering, according to the DSM-V, includes the intentional production of "…false or grossly exaggerated physical or psychological symptoms, motivated by external incentives…" [47]. Conceptually, it is based on Beck and Beck's descriptions of deceptive clinical behavior: presence of an external incentive, absence of a causative factor, patient resistance to receiving treatment, symptom complaints inconsistent with true illness, and course of the disorder inconsistent with true illness [69]. In the most extreme circumstance, malingering describes outright criminal behavior which can understandably frustrate clinicians whose time and trust such patients misuse. Circumstances with potentially high reward seem to be particularly associated with higher rates of malingering or symptom exaggeration. As many as 29 % of individuals seeking personal injury claims, 30 % of those seeking workman's compensation and 19 % of criminal cases showed evidence of malingering [70–72]. Estimates in routine practice, however, appear to be much lower (1–8 %), though some chronic conditions such as pain and head injury carry higher estimates [73–75]. Challenges to identify patients who might be malingering include the time and expertise needed to use screening tools, challenges to the validity of the diagnosis and the complexity of deceitful behavior.

Screening for malingering uses tests of effort and response bias [76]; however, these tests can miss deception, even when performed on healthy test subjects instructed to feign their symptoms [77, 78]. Since the tests are performed by neuropsychologists, patients typically need referral for testing which occurs separate from their medical encounter. This separation limits routine testing in offices or emergency rooms, and is often reserved only for patients seeking legal or monetary compensation. Evidence for clinical suspicion of malingering has typically included symptom complaints that fail to correlate with known physiology; however, patient access to the internet may limit the utility of this criteria [79]. Challenges to the validity of this diagnoses, along with that of factitious disorder, have arisen, in part, due to inconsistencies in their identification and the potential artificial separation of primary and secondary gain as diagnostic criteria [80, 81].

According to the DSM-V, psychological needs constitute primary gain, whereas secondary gain reflects a reward outside of this internal motivation, e.g., avoiding work, receiving disability. Unfortunately, human behavior is not quite so simple and discussion of deceit involves theory of mind, intent, subconscious thought and various other philosophical concepts. Quite simply, seemingly deceitful behaviors can represent a range of intentions [82]. A certain amount of deception is even assumed to be inherent in social interactions, and within the medical profession [83, 84]. Doctors admit they would lie in order to benefit their patients [85, 86]; the justification being the health care system places constraints on their ability to deliver optimal care. One could argue the patient who appears to exaggerate their symptoms is also trying to optimize their care as they may also experience legitimate insurance constraints or mistrust in the medical system. For example, a patient with an unpredictable or episodic disease course may feign symptoms during periods of remission to prevent loss of financial support or insurance should their disease worsen. Deception could also reflect ingrained, maladaptive attempts to manage legitimate concerns. Patients with personality pathology may not be maliciously attempting to manipulate the physician, but are instead using whatever meager resources they have to do what has worked for them in the past.

Interventions in cases of suspected malingering can have a range of efficacy depending on the ability of the physician and patient to ally their needs. Direct confrontation may not cause patients to admit their deceit and can disrupt attempts to rebuild a therapeutic alliance. However, nonjudgmental inquiry into existing stressors may uncover underlying issues [87]. Sometimes, clinical staff can help with the underlying problem, but even in situations beyond their expertise, showing empathy toward patient needs can still feel more rewarding. One strategy using the acronym

ABCs outlines a general approach to the patient with suspected deceitful behavior: (A) avoid the accusation of lying, (B) beware of countertransference, (C) seek clarification rather than confrontation, (s) have adequate security nearby, should the situation escalate [88]. Meeting these patients' needs may be outside the typical medical encounter, but can be personally rewarding once the physician and patient are no longer in conflict with each other.

Conclusion

The expectation doctors and patients will form an alliance allowing patients to play an active role in their treatment constitutes a relatively modern treatment paradigm. The American Medical Association's code of ethics reflects this change which has moved from a paternalistic model to the current dictum the patient has the right to make decisions regarding health care that is recommended by his or her physician [89]. Although clinical encounters have likely always included patients with emotional needs and physician attempts to reduce patient anxiety, this expectation is now codified in the assumption the physician must first conquer these obstacles so the patient can become an educated consumer. Unfortunately, system constraints have worked against achieving this goal. Residence mobility, changing insurance and increased presence of medical subspecialists limit the number of patients receiving treatment by their life-long physician. Yet, despite this increased need for physicians to quickly establish therapeutic relationships, medical education and practice demands mastery of an expanding list of diagnostic tools and treatments. Patients and physicians occupy two diverging models of medicine. Patients continue to expect physicians to address their emotional concerns, a difficult task to perform while facing a computer screen checking boxes in electronic medical records, ensuring accurate ICD coding and figuring out which computer your prescription printed to, assuming you did not accidentally send it to the wrong pharmacy electronically. For those who entered the medical field exclusively because of their love of science or procedure, difficult patient encounters may continue to be a source of stress. However for those who genuinely enjoy forming relationships with their patients, listening to a story about their lives outside of their illness or providing empathy can dramatically benefit both physician and patient satisfaction.

Compliance with Ethics Guidelines

Conflict of Interest Dr. Chepenik has nothing to disclose.

Human and Animal Rights and Informed Consent This article does not contain any studies with human or animal subjects performed by any of the authors.

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