Current Emergency and Hospital Medicine Reports (2018) 6:1–7
https://doi.org/10.1007/s40138-018-0152-y

Difficult Relationships: Patients, Providers, and Systems

John S. Rozel [1]

Published online: 5 February 2018
© Springer Science+Business Media, LLC, part of Springer Nature 2018

Abstract

Purpose of Review Perspectives on difficult patients have evolved substantially over the years; this paper exams some of the recent developments and trends in literature on this topic.

Recent Findings Conflict between providers and their patients was once seen as the fault of the patient; more recently, models have evolved to look at how provider behavior and attitudes as well as systems of care can play a significant role in creating—and, hopefully—defusing such conflict. Conflicts may be informal or escalate to formal complaints; monitoring and remediating both can play a significant role in mitigating exposure to malpractice litigation. Conflicts, complaints, and litigation can have significant impact on clinical operations and teams.

Summary Conflicts between providers and patients are now recognized as a dynamic and interpersonal process rather than the fault of the patient. Verbal de-escalation, or variations thereof, is seen more and more as a "best practice" approach to managing conflict and complaints in healthcare and other settings.

Keywords Disruptive patients · De-escalation · Patient complaints · Risk management · Difficult patients · Behavioral health

Introduction and the History of "Difficult Patients"

What makes a patient difficult? Any number of explanations may suffice: challenging diagnoses, complex and imperfect treatments, or vexing system issues converging in a single case. Most challenging perhaps are the difficulties which arise not through the technical challenges of biology or operational obstacles of modern healthcare, but from the difficulties which arise between two people: the provider and the patient. This paper will summarize recent developments in managing the latter issue which—as the evidence will suggest—is more about the relationship than about the patient.

Illness, pain, anxiety, and uncertainty do little to soothe one's temperament. These states are common, expected, and even requisite in the experience of many patients. These states can also contribute significantly to irritability and frustration. It is little wonder, then, that some patients may be seen by their providers as difficult. A bit more wondrous, perhaps, is the time it has taken for perceptions of difficult patients to evolve since early concepts of "hateful patients" in need of restraint and medication [1, 2].

Much of early literature on difficult patients categorized problems in terms of patient behaviors such as care avoidance, ambivalence, and demandingness [3]. After a generation, medicine is beginning to look past blaming patients for difficult relationships. Recognizing and responding to the role of physicians and other providers in perpetuating disruptive relationships—and their critical role correcting these issues—has become the central theme as well as a regulatory priority in modern medicine [4]. This should not be taken to justify or excuse intentionally disruptive behavior by patients or family members; this is a significant issue, with as many as 80% of practices dismissing disruptive patients in a 2-year time frame [5]. Rather, it is intended to stress that the patients do not bear responsibility alone for problems in the relationship between themselves and their providers and the providers—as professionals—may have a special duty to correct these conflicts.

Earlier approaches to difficult patients amounted to defusing the provider's hostility and countertransference while creating protective shells around the provider and patient alike. More progressive approaches suggest that while

This article is part of the Topical Collection on *Behavioral Health*

✉ John S. Rozel
rozeljs@upmc.edu

[1] Western Psychiatric Institute and Clinic, UPMC, 333 North Braddock Ave., Pittsburgh, PA 15208, USA

such countertransference can be extremely disruptive to the doctor-patient relationship, it is best used as a telltale. When a clinician notices such strong feelings, it should be a signal to step back and reflect on what is not working in the relationship and how they, as a provider and a professional, can act to improve the relationship [6••].

Further, it has been compellingly argued that physicians have an ethical duty to rebuild and correct such pathological relationships when feasible and to consider a positive relationship as central to the purpose of healthcare [7]. A broader, integrated perspective on the centrality of the relationship to the mission of healthcare emphasizes that there are mutual and reciprocal responsibilities between the patient and provider [8]. Patient complaints may be rightly seen as the leading indicator of problematic relationships and processes making their recognition and management of the utmost importance [9, 10].

As perspectives on the nature of difficult relationships have evolved, new models and interventions have been developed. The medical field has developed better approaches to understanding complaints, the link between disruptive and difficult relationships and adverse outcomes, and the use of de-escalation and mediation to mitigate adverse outcomes. Verbal de-escalation, an intervention rooted in emergency psychiatry, has been embraced not just across medicine but has begun to penetrate other fields as well. This paper will summarize relevant and recent developments in the field of difficult clinical relationships.

Disruptive Relationships Impact Team Performance

Numerous factors can contribute to anger or hostility from patients. Some of these factors may be intrinsic to the patient or family member, some to the environment, some to the provider. Such emotional displays can be unsettling to providers and impair optimal decision-making. The role of emotion and stress in disrupting complex decisions related to future outcomes, risk, and complex tasks has been well studied for generations and are well recognized as factors in clinical scenarios as well [11•, 12, 13]. It is little surprise then to note that the rudeness or hostility of patients or their family members can significantly decrease the quality of medical decision-making by their providers as has been shown in at least two recent empirical studies [14, 15•]. Many clinicians can relate to the experience of feeling unsettled or distracted when an initial approach to a patient or family member is interrupted with unexpected, and hostile.

Reassuringly, one of these same studies also identified interventions that can be taught to providers to mitigate the impact of such behavior [14]. Inviting structured feedback early from parents of children with complex care needs can be helpful in improving outcomes and decreasing complaints [16]. By proactively identifying patient and family needs and preferences in cases anticipated to be highly complex or particularly conflictual, it is possible to avoid unneeded misunderstandings, assumptions, or conflicts later on. This approach seems similar to the use of recovery plans and advance directives which have been beneficial in mental health and medical settings alike.

Complaints Matter

Complaints can be a leading indicator of concerning provider behavior and systems issues and warrant careful monitoring and thoughtful response [9, 10]. Capturing complaints can be challenging; complaints may be handled at multiple levels or locations within an organization with varying degrees of capture of cases or specific information. When enough data is collected, identified trends and patterns can suggest problematic processes and behavior patterns which can be corrected. When there is inadequate information in the complaint feedback process, it is intrinsically difficult to identify appropriate targets for performance improvement. Critical steps include centralized reporting, simplified complaint reporting processes, and improved cultural engagement with the intention of improving response times and satisfactory resolutions [17].

Assuring that specific feedback is delivered to appropriate providers is a recurring theme and may provide an early opportunity to correct behaviors leading to increased risk of malpractice litigation [18]. In addition to the specific feedback, deliberate and structured interventions to improve provider performance are critical. Patient complaints may not be evenly distributed: most providers will incur some complaints but the high-complaint outliers can be a high yield target for supportive intervention [19]. Comparative data between providers can help identify high-risk outlier providers and serve as a useful metric for individual providers reflecting on their performance compared to their peers. Few physicians—or other providers for that matter—like to think of themselves as in the lagging quintile.

Similarly, using consistent approaches to responding complaints and delivering bad news may be helpful. One simple model for responding to complaints uses the mnemonic BLAST: Believe, Listen, Apologize, Satisfy, Thank [20]. These elements are not necessarily unique to the domain of medical apologies but the mnemonic may be a useful tool for providers.

Adverse events and complaints both can have a significant deleterious effect on providers. The emotional impact can be staggering ranging from changes in clinical practice patterns, increased self-doubt, worry and anxiety, and even an increased risk of suicidal thoughts [21•, 22•].

Informed Consent as a Tool to Improve Engagement and Alignment

A simple—even fundamental—intervention to decrease complaints and conflicts can be improvements in the informed consent process. Often informed consent is seen as a cognitive exercise to explain and assess a patient's preference between two interventions with an emphasis on the technical and quantitative aspects of the procedure and the outcomes. Done properly, however, informed consent can also be a powerful tool for exploring patient and family expectations, beliefs, feelings, and fears. In most settings, the technical aspects of obtaining informed consent are more than adequately met however the opportunity to explore the more affective elements of the process may be missed.

Complaints about the informed consent process can consume significant organizational resources in proportion to other types of complaints [23]. This would suggest that effort spent optimizing informed consent at the beginning of a sequence may be rewarded with savings in time spent fielding and managing complaints downstream.

A critical element of informed consent is assuring the patient or decision maker appreciates the nature of the decision at hand. While the concept of "appreciation" is often seen as a process dependent on the patient's understanding, in many ways, it also directly reflects the efficacy of the process by which the clinical situation and options are explained to them by the provider. Some scholars have suggested that there is significant operational room and ethical need to improve the informing stage of informed consent to assure better understanding by the patient [24]. Significant recent research looking at improving the consistency of information provided and using multimedia tools, including prerecorded materials, can significant improve the quality of the informed consent process [25–27]. Prerecorded and printed materials can also assure that a uniform minimal standard of information is provided to all patients seeking similar treatment at a facility. In the context of medical ethics, this approach deftly supports both autonomy and justice.

Malpractice Risk and Complaints

A bad relationship between a provider and a patient as may be evidenced by negative affect or overt complaint may be a significant—and potentially correctable—risk factor for malpractice suits [28]. The correlation between hostility towards a provider and perceived hostility from a provider have long been recognized as risk factors for medical malpractice litigation [29•, 30•]. To wit: patients do not sue merely because of bad outcomes, but also—and significantly—because of bad feelings.

While providers may excel at discussing technical aspects of their care, communication with a patient about their emotions relating to high-risk procedures can be lagging [31]. A perception of a lack of empathy from the physician may drive malpractice litigation risk. Difficulty in communicating complex alternatives between different treatments can drive frustration [32]. Improving these "soft skills" may prove a useful strategy to improve the quality of care and decrease litigation risks. Interestingly, some of these same communications problems—especially processes which drive provider shame or anxiety after adverse events—can occur at a systems level. When such systems issues occur, malpractice risk may increase as incidents go unreported [33]. Open, supportive communication by doctors to patients and by hospitals to doctors can make a significant impact in decreasing adverse outcomes: further empirical evidence of the value of a just culture model of promoting safety [34].

There continues to be evidence that some providers fuel animosity of patients towards other providers through negative, critical, and undermining comments [35]. Put colloquially: we tend to throw each other under the bus. This finding is particularly alarming when one recalls past research where derogation by another provider can be a trigger for a patient to pursue a malpractice complain [29]. Any number of factors can contribute to this dynamic but hindsight bias—the cognitive error of judging a process by the outcome—is often a factor [36••]. A more psychodynamic interpretation would be the aphorism from work with patients with borderline personality that the patients do not split the providers but the providers allow themselves to be split.

Malpractice attorneys look at a number of factors beyond the purely academic criteria of negligence in choosing to pursue a case. Factors such as the relative likability of a provider versus a patient—the optics, if you will—can play a significant role in how attorneys respond to potential cases. So too can the perceived payout for a settlement or plaintiff verdict [37, 38]. A physician who is seen as cold and uncaring or unlikable, no matter how technically proficient, can become a more appealing target for litigation because attorneys are very aware of how jurors perceive and sympathize with different parties in a malpractice case.

Frequent complaints and low satisfaction scores about specific providers may be a useful predictor of future malpractice risk [39]. With the increasing prevalence of patient satisfactions surveys, this data can prove to be a useful tool in supervising front line providers about effective patient communication—and, perhaps, the opportunity to decrease the risk of litigation may prove a useful motivator for the supervisees. Patient feedback scores in isolation and without structured feedback and improvement plans may be of limited value [40]. Peer counseling amongst professionals may be one effective way to provide performance improvement coaching for providers with interpersonal issues leading to complaints and low patient ratings [41].

The Medical Apology

The connection between well-delivered apologies and decreased risk for litigation has long been examined with new and more sophisticated research supporting this position [42•, 43•]. Apologies are not a panacea but can serve to defuse common sentiments in litigants including feeling unheard, excluded, or disrespected by the clinical team. Critical elements of effective apologies have been identified, including empathy, disclosure, and possibly early offers in the context of bona fide error that appear to be essential to providing effective apologies [44, 45].

Formal organizational processes and explicit culture supporting disclosure of errors can help counterbalance physician reticence to disclose errors [33, 46]. Preference for alternative dispute resolution pathways including apologies, mediation, and early offers seems to be ethically, legally, and even financially preferable for the organization [47, 48]. Practical manuals built on providing excellent customer care up front and appropriate service recovery through structured apologies after adverse events remain widely accepted and easily followed guidance [49, 50]. There is some continued debate as to whether state apology laws alone have any impact on malpractice risk, suggesting that it may require more than mere apology alone to mitigate malpractice risk after adverse events [51].

Providers Are Impacted by Adverse Events

The psychological impact of adverse outcomes on treatment providers can be significant, leading to the idea of "second victims" [22•]. The impact ranges from primary psychological distress (including suicidal thoughts), anxiety, stress, decreased work performance, and discord in social and romantic relationships. Failure of timely feedback or organizational support for second victims can prolong or worsen the impact [52••]. Knowing that disruptive and difficult patients can lead to increased medical errors, one can easily imagine a frequent sequence of initially difficult interactions, which in turn increase the likelihood of errors and enough hostility to pursue litigation, and the subsequent psychological impact on providers [14, 15•]. It is bad enough to face a lawsuit for a bad outcome; for a provider to be left wondering if initial shifts in treatment due to early patient complaints or resistance contributed to such an outcome is especially vexing.

Mental Health Consultation Can Help with the Management of Difficult Patients

Psychiatric consultation in the general medical setting has historically been a dual role: manage the psychiatric and behavioral health of the medical and surgical patients (consultation) and provide coaching and guidance in navigating difficult interpersonal relationships between patients and providers (liaison). The role of consult liaison psychiatry has taken a more central role in medical settings with the advancement of integrated medicine models in inpatient and outpatient settings [53, 54]. Optimally, integrated care models will allow improved coordination and collaboration between mental health and physical health providers in many settings. One of many potential benefits of integrated care is improved ability to quickly manage angry and difficult patients. Multiple studies continue to show that psychiatric or psychological consultation continues to be significantly helpful for medical teams dealing with difficult relationships with a patient [55, 56].

Training Can Improve Provider Readiness to Handle Conflict

Improving communication and empathy in providers is seen as a critical avenue to preventing and managing difficult interactions [57, 58]. Research has identified several factors in supporting staff responding to behavioral emergencies: negotiation skills and improved self-awareness play a prominent role [59]. Empathy and emphasizing treating people with dignity and respect are also identified in playing a key role in supporting family members and waiting patients [60]. Simulation training can be extremely helpful in helping professionals improve their communication skills for more challenging interactions [61]. One innovative program exposes professional students to customer service through mentored work as a reception desk to improve interpersonal and problem solving skills [62].

De-escalation: One Tool That Can Help in Many Situations

De-escalation is a systematic approach to defusing anger and agitation through verbal engagement, development or restoration of a collaborative relationship, and helping the person manage their own emotions through verbal techniques. This model has become a gold standard of first-line intervention for behavioral emergencies in psychiatric and emergency settings [63••]. The process and elements of verbal de-escalation used in managing behavioral emergencies overlap substantially with critical elements of apologies after adverse events and service recovery after complaints as outlined above. The elements are also similar to mediation and problem focused negotiation [64, 65]. The tools all address safe and effective approaches to correcting conflict while defusing intense emotion and play a critical role in many clinical settings [66]. While frontline practitioners can be taught

effective techniques, improved and quantifiable approaches to measuring and modelling de-escalation will help develop this model further [67]. Recent national controversies about the use of force by law enforcement have become commonplace. In response, numerous law enforcement groups have endorsed a unified policy on the use of force which emphasized the role of de-escalation as a preferred intervention before any physical intervention when possible [68].

Conclusion

The last 5 years has seen continued movement from the concept of difficult patients to the recognition of difficult relationships where systems and provider factors can also play a significant role in creating and maintaining conflict. Simultaneously, methodologies for managing conflict have converged from across several service areas, most relevantly, in responding to complaints, apologizing for errors, and de-escalating agitation. Organizations may benefit from using conflict and complaint management models which not only meet the minimum regulatory requirements but which proactively explore, engage, and manage potential system and employee issues to decrease future risks.

As a parting consideration, note the following poem [see Box 1 below] that the author first saw in 2010. The original source remains unknown. It does an exceptional job of articulating the experience—and nidus of distress—for so many patients in modern healthcare facilities. The content is noteworthy, but so too is the context: it was found in a staff lounge at a general hospital's security department. It was there, framed, as a reminder to the team to remember every day the experience of the people they care for.

Box 1 An anonymous poem expressing patient experience

Poem, anonymous

This may be a normal day at work for you, but it's a big day in my life.
The look on your face and the tone of your voice can change my entire view of the world.
Remember, I'm not usually this needy or scared.
I am here because I trust you; help me stay confident.
I may look like I'm out of it, but I can hear your conversations.
I'm not used to being naked around strangers. Keep that in mind.
I'm impatient because I want to get the heck out of here. Nothing personal.
I don't speak your language well. You're going to do what to my what?
I may only be here for four days, but I'll remember you the rest of my life.
Your patients need your patience.

Compliance with Ethical Standards

Conflict of Interest The author declares that he has no conflict of interest.

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

References

Papers of particular interest, published recently, have been highlighted as:
• Of importance
•• Of major importance

1. Groves JE. Taking care of the hateful patient. N Engl J Med. 1978;298:883–7.
2. Perry SW, Gilmore MM. The disruptive patient or visitor. JAMA. 1981;245:755–7.
3. Koekkoek B, van Meijel B, Hutschemaekers G. "Difficult patients" in mental health care: a review. Psychiatr Serv. 2006;57:795–802.
4. Rosenstein AH, O'Daniel M. A survey of the impact of disruptive behaviors and communication defects on patient safety. Jt Comm J Qual Patient Saf. 2008;34:464–71.
5. O'Malley AS, Swankoski K, Peikes D, Crosson J, Duda N, Day T, et al. Patient dismissal by primary care practices. JAMA Intern Med. 2017;177:1048–50.
6.•• Gunderman RB, Gunderman PR. Forty years since "Taking Care of the Hateful Patient". AMA J Ethics. 2017;19:369. **A modern reexamination of a classic article on countertransference**
7. Johnson M. Do physicians have an ethical duty to repair relationships with so-called "difficult" patients? AMA J Ethics. 2017;19:323.
8. Shepherd LL, Mohrmann M. Welcome, healing, and ethics. Wake For Law Rev. 2015;50:259–86.
9. Reader TW, Gillespie A, Roberts J. Patient complaints in healthcare systems: a systematic review and coding taxonomy. BMJ Qual Saf. 2014;23:678–89.
10. Gallagher TH, Mazor KM. Taking complaints seriously: using the patient safety lens. BMJ Qual Saf. 2015;24:352–5.
11.• Kahneman D. Thinking, fast and slow. 1st pbk. ed. New York: Farrar, Straus and Giroux; 2013. **A lengthy but comprehensive exploration into the science of cognitive bias**
12. Scarry E. Thinking in an emergency. 1st ed. New York: W.W. Norton & Co; 2011.
13. Kleespies PM. Decision making in behavioral emergencies: acquiring skill in evaluating and managing high-risk patients. 1st ed. Washington, D.C: American Psychological Association; 2014.
14. Riskin A, Erez A, Foulk TA, Riskin-Geuz KS, Ziv A, Sela R, et al. Rudeness and medical team performance. Pediatrics. 2017;139:e20162305.
15.• Schmidt HG, van Gog T, Schuit SC, den Berge KV, Daele PLV, Bueving H, et al. Do patients' disruptive behaviours influence the accuracy of a doctor's diagnosis? A randomised experiment. BMJ Qual Saf. 2017;26:19–23. **Thought-provoking study likely to evoke a feeling of familiarity amongst many clinicians**
16. Steinmiller EA, Ely E. Patient, family, and provider complex care situations in pediatric acute medical care: creation of the Red Flags Situation Assessment Tool. J Spec Pediatr Nurs. 2015;20:290–7.
17. Levin CM, Hopkins J. Creating a patient complaint capture and resolution process to incorporate best practices for patient-centered representation. Jt Comm J Qual Patient Saf. 2014;40:484–AP12.
18. Hultman CS, Gwyther R, Saou MA, Pichert JW, Catron TF, Cooper WO, et al. Stuck in a moment: an ex ante analysis of patient complaints in plastic surgery, used to predict malpractice risk profiles,

from a large cohort of physicians in the patient advocacy reporting system. Ann Plast Surg. 2015;74:S241–6.

19. Bismark MM, Spittal MJ, Gurrin LC, Ward M, Studdert DM. Identification of doctors at risk of recurrent complaints: a national study of healthcare complaints in Australia. Qual Saf Health Care. 2013;22:532–40.
20. Steinman HK. A method for working with displeased patients—BLAST. J Clin Aesthetic Dermatol. 2013;6:25.
21.• Bourne T, Wynants L, Peters M, Audenhove CV, Timmerman D, Calster BV, et al. The impact of complaints procedures on the welfare, health and clinical practise of 7926 doctors in the UK: a cross-sectional survey. BMJ Open. 2015;5:e006687. **An important study exploring the frequency of complaints and the subjective impact of such complaints on the clinicians**
22.• Seys D, Wu AW, Gerven EV, Vleugels A, Euwema M, Panella M, et al. Health care professionals as second victims after adverse events a systematic review. Eval Health Prof. 2013;36:135–62. **A comprehensive review of the literature on the impact of adverse clinical events on health care professionals**
23. Posner KL, Severson J, Domino KB. The role of informed consent in patient complaints: reducing hidden health system costs and improving patient engagement through shared decision making. J Healthc Risk Manag. 2015;35:38–45.
24. Saks E. The consent dilemma [Internet]. Polit. Agenda. 2017 [cited 2017 Sep 10]. Available from: http://politi.co/2vMrqB4
25. Heerman WJ, White RO, Hotop A, Omlung K, Armstrong S, Mathieu I, et al. A tool kit to enhance the informed consent process for community-engaged pediatric research. IRB Ethics Hum Res. 2016;38:8–14.
26. Palmer BW, Harmell AL, Dunn LB, Kim SY, Pinto LL, Golshan S, et al. Multimedia aided consent for Alzheimer's disease research. Clin Gerontol. 2017;0:null.
27. Koonrungsesomboon N, Traivaree C, Chamnanvanakij S, Rungtragoolchai P, Thanapat Y, Karbwang J. Improved pregnant women's understanding of research information by an enhanced informed consent form: a randomised controlled study nested in neonatal research. Arch Dis Child - Fetal Neonatal Ed. 2017;fetalneonatal-2017-312615.
28. Schleiter KE. Difficult patient-physician relationships and the risk of medical malpractice litigation. Virtual Mentor VM. 2009;11:242–6.
29.• Beckman HB, Markakis KM, Suchman AL, Frankel RM. The doctor-patient relationship and malpractice. Lessons from plaintiff depositions. Arch Intern Med. 1994;154:1365–70. **A classic study identifying critical themes driving medical malpractice litigation. One of the sources of the proverbial adage of bad feelings are as important to understanding malpractice as bad outcomes**
30.• Levinson W, Roter DL, Mullooly JP, Dull VT, Frankel RM. Physician-patient communication. The relationship with malpractice claims among primary care physicians and surgeons. JAMA. 1997;277:553–9. **An elegant study highlighting the role of interpersonal style of physicians as a risk protective factor for malpractice complaints**
31. Levinson W, Hudak P, Tricco AC. A systematic review of surgeon-patient communication: strengths and opportunities for improvement. Patient Educ Couns. 2013;93:3–17.
32. Sonnenberg A. Ignorance isn't bliss: why patients become angry. Eur J Gastroenterol Hepatol. 2015;27:619–22.
33. Renkema E, Broekhuis M, Ahaus K. Conditions that influence the impact of malpractice litigation risk on physicians' behavior regarding patient safety. BMC Health Serv Res. 2014;14:38.
34. Dekker S. Just culture: balancing safety and accountability. 2nd ed. Farnham, Surrey, England; Burlington: Ashgate; 2012.
35. McDaniel SH, Morse DS, Reis S, Edwardsen EA, Gurnsey MG, Taupin A, et al. Physicians criticizing physicians to patients. J Gen Intern Med. 2013;28:1405–9.
36.•• Saposnik G, Redelmeier D, Ruff CC, Tobler PN. Cognitive biases associated with medical decisions: a systematic review. BMC Med Inform Decis Mak. 2016;16:138. **An important article looking at an understudied and under-discussed topic in clinical decision-making**
37. Trautner MN. Tort reform and access to justice: how legal environments shape lawyers' case selection. Qual Sociol. 2011;34:523–38.
38. Shepherd J. Uncovering the silent victims of the American medical liability system. Vanderbilt Law Rev. 2013;67:151.
39. Fullam F, Garman AN, Johnson TT, Hedberg EC. The use of patient satisfaction surveys and alternative coding procedures to predict malpractice risk. Med Care. 2009;47:553–9.
40. Boiko O, Campbell JL, Elmore N, Davey AF, Roland M, Burt J. The role of patient experience surveys in quality assurance and improvement: a focus group study in English general practice. Health Expect. 2015;18:1982–94.
41. Shapiro J, Whittemore A, Tsen LC. Instituting a culture of professionalism: the establishment of a center for professionalism and peer support. Jt Comm J Qual Patient Saf. 2014;40:168–AP1.
42.• Robbennolt JK. Apologies and legal settlement: an empirical examination. Mich Law Rev. 2003;102:460. **A classic study highlighting the potential positive benefits of apology after adverse events**
43.• Dahan S, Ducard D, Caeymaex L. Apology in cases of medical error disclosure: thoughts based on a preliminary study. PLoS One. 2017;12:e0181854. **A more recent—and well designed—study looking at apologies after adverse events.**
44. Prothero MM, Morse JM. Eliciting the functional processes of apologizing for errors in health care: developing an explanatory model of apology. Glob Qual Nurs Res. 2017;4:2333393617696686.
45. Nazione S, Pace K. An experimental study of medical error explanations: do apology, empathy, corrective action, and compensation alter intentions and attitudes? J Health Commun. 2015;20:1422–32.
46. Renkema E, Broekhuis MH, Ahaus K. Explaining the unexplainable—The impact of physicians' attitude towards litigation on their incident disclosure behaviour. J Eval Clin Pract. 2014;20:649–56.
47. Soffer JI. Apoligize first; mediate second; Litigate Never. Rev Litig. 2015;34:493.
48. Evans LS. Enterprise dispute resolution: full disclosure and early offer policies in the event of an indisputable medical error. J Health Care Finance. 2016 [cited 2017 Sep 4];42. Available from: http://healthfinancejournal.com/index.php/johcf/article/view/61
49. Saxton JW. The satisfied patient: a guide to preventing malpractice claims by providing excellent customer service. 2nd ed. HCPro: Marblehead; 2007.
50. Wojcieszak D, Saxton JW, Finkelstein MM. Sorry works! Disclosure, apology and relationships prevent medical malpractice claims. 2nd ed. Authorhouse: Bloomington; 2010.
51. McMichael BJ, Horn V, Lawrence R, Viscusi WK. Sorry is never enough: the effect of state apology laws on medical malpractice liability risk [Internet]. Rochester, NY: Social Science Research Network; 2016 Dec. Report No.: ID 2883693. Available from: https://papers.ssrn.com/abstract=2883693
52.•• Ullström S, Andreen Sachs M, Hansson J, Øvretveit J, Brommels M. Suffering in silence: a qualitative study of second victims of adverse events. BMJ Qual Saf. 2014;23:325–31. **An important study looking at the impact of adverse events on clinicians**
53. Lücke C, Gschossmann JM, Schmidt A, Gschossmann J, Lam AP, Schneider CE, et al. A comparison of two psychiatric service approaches: findings from the Consultation vs Liaison Psychiatry-Study. BMC Psychiatry. 2017;17:8.

54. Desan PH, Lee HB, Zimbrean P, Sledge W. New models of psychiatric consultation in the general medical hospital: liaison psychiatry is back. Psychiatr Ann. 2017;47:355–61.
55. Chipidza F, Wallwork RS, Adams TN, Stern TA. Evaluation and treatment of the angry patient. Prim Care Companion CNS Disord. 2016;18
56. Robiner WN, Petrik ML. Managing difficult patients: roles of psychologists in the age of interdisciplinary care. J Clin Psychol Med Settings. 2017;24:27–36.
57. Leonard P. Exploring ways to manage healthcare professional—patient communication issues. Support Care Cancer. 2017;25:7–9.
58. Anderson PF, Wescom E, Carlos RC. Difficult doctors, difficult patients: building empathy. J Am Coll Radiol. 2016;13:1590–8.
59. Poremski D, Lim XY, Kunjithapatham G, Koh D, Alexander M, Cheng L. Which skills boost service provider confidence when managing people presenting with psychiatric emergencies? Int J Ment Health Nurs. 2016;25:566–73.
60. Cohen EL, Wilkin HA, Tannebaum M, Plew MS, Jr LLH. When patients are impatient: the communication strategies utilized by emergency department employees to manage patients frustrated by wait times. Health Commun. 2013;28:275–85.
61. Kowalski C, Sathanandan S. The use of simulation to develop advanced communication skills relevant to psychiatry. BMJ Simul Technol Enhanc Learn. 2015;1:29–32.
62. Lichtenstein N, Ensmann I, Haak R, Hallal H, Kupke J, Matthes J, et al. “May I help you?”—evaluation of the new student service at the reception desk during the clinical courses at the Department of Operative Dentistry and Periodontology as a part of a longitudinal curriculum of social and communicative competences for dental students. GMS Z Für Med Ausbild. 2015 [cited 2017 May 27];32. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4580440/
63.•• Richmond JS, Berlin JS, Fishkind AB, Holloman GH, Zeller SL, Wilson MP, et al. Verbal de-escalation of the agitated patient: consensus statement of the American Association for Emergency Psychiatry Project BETA De-escalation Workgroup. West J Emerg Med. 2012;13:17–25. **As part of the AAEP Project BETA (Best Practices for the Evaluation and Treatment of Agitation), this article has become a cornerstone of the recent canon on verbal de-escalation**
64. Fisher R, Ury W, Patton B. Getting to yes: negotiating agreement without giving in. 3rd ed. New York: Penguin; 2011.
65. Fiester AM. What mediators can teach physicians about managing ‘difficult’ patients. Am J Med. 2015;128:215–6.
66. Fiester A. De-escalating conflict: mediation and the “difficult” patient. Am J Bioeth. 2013;13:11–2.
67. Mavandadi V, Bieling PJ, Madsen V. Effective ingredients of verbal de-escalation: validating an English modified version of the ‘De-Escalating Aggressive Behaviour Scale’. J Psychiatr Ment Health Nurs. 2016;23:357–68.
68. National Consensus Policy on Use of Force [Internet]. 2017 Jan. Available from: http://www.theiacp.org/Portals/0/documents/pdfs/National_Consensus_Policy_On_Use_Of_Force.pdf