

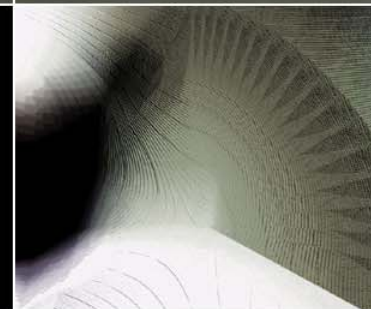
# Turning Lemons to Lemonade

Dealing with the difficult patient encounter

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# Declaration

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# Observation

- Half audience to observe the patient
- Half audience to observe the physician
- Observe
  - What is said
  - What is not said
  - Behaviour

# Setting the scene

- o Patient Mrs Jones is 40 years old and has had low back pain for 18 months. She was seen by a colleague, Dr Hill who suggested surgery was not an option, however Mr Jones was dissatisfied with that and wanted a second opinion.
- o Dr Hill who referred on to Dr Smith is well known by Dr Smith and he trusts his judgement. However, Dr Smith has reluctantly agreed to see Mr Jones to provide a second opinion. Mr Jones has waited seven months to see Dr Smith. Dr Smith has managed to put her in as an extra at the end of a busy clinic.

QuickTime™ and a  
H.264 decompressor  
are needed to see this picture.

# The encounter

- For whom was this difficult?
- Why?
- Was the patient satisfied?
- Was it rewarding for the physician?
- What will the patient do next?

# Why are some encounters difficult ?

- Uncertainty (not being able to give a diagnosis or explanation)
- Fear of loss of control
- Challenging competence
- Some doctors find certain patients difficult
- Some patients find certain doctors difficult!

# Who is the difficult patient?

- “the one who impedes the clinician’s ability to establish a therapeutic relationship” (Simon et al 1999)
- “a person who does not assume the role expected by the professional... Who causes the caregiver to experience doubt” (Macdonald 2003)

# Who is the good patient?

- “the one who presents with objective signs and symptoms of a treatable disease process, makes no emotional demands on the clinician, cooperates in the treatment process (ie obeys orders), and upon getting well, displays gratitude for the help received.” (Ford 1983)

# Differing agendas

- The primary source of tension in the patient encounter comes from differing agendas
- It is natural that we have different goals for the encounter
- Therefore, good communication is the key to resolving this conflict.

# Why bother with better communication ?

- Vital part of good clinical competence
- Enables practitioner to become better clinically
- Improves patient care, adherence, satisfaction & outcome
- Improves practitioner satisfaction, prevents burnout

# The evidence

- Clinician factors associated with perceiving encounters as difficult (Mathers et al 1995):
  - Less experience
  - Higher perceived workload
  - Low job satisfaction
  - *Lack of communication skills training*

# The evidence

- Breakdown in communication is a well-recognized cause of medico-legal problems
- A study of depositions identified the following problems:
  - Deserting the patient
  - Devaluing the patient's views
  - Delivering information poorly
  - Failing to understand patient's perspective

# Quotes from Patients

- “He never looked up once”
- “I don’t think he heard a word I said”
- “I didn’t feel believed”
- “She had already made her mind up before I went in”
- “We’re the professionals, we know better than you”

# And more quotes...

- "What do you want us to do?"
- "Felt being laughed at"
- "You're fine, don't worry"
- "Wearing a white coat"
- "Wearing a stethoscope"

# Some different quotes...

- “She sat and listened”
- “He let me tell *my* story”
- “I felt believed”
- “I felt they respected my view”
- “They looked at me”

# What do the quotes tell us?

- *Evidence that physicians interrupt after average 18 seconds is supported by patient experience*
- *Patients make assumptions about what we are thinking based on body language and subtle language cues*

# Quotes from Clinicians

- “I don’t think he heard a word I said and I have spent ages explaining things to him”
- “Patients don’t understand the limits of medicine”
- Passive unassertive patients
- Asking about non pain related problems
- “My GP asked me to ask you ...”

# How do clinicians cope?

- Avoidance
- Aggression
- Blocking behaviours

# Blocking behaviours

- Offering advice & reassurance before the main problems have been identified
- Explaining away distress as normal
- Attending to physical aspects only
- Switching topic
- Jollyng the patient along

# Alternative strategies

- Setting the agenda together
- Allowing patient to express their anger in a safe way
- Admitting when no clear answers are possible

# The evidence

- In general, patients say they want their doctors to provide more information than they do
- Patients place the highest value on information on prognosis, diagnosis and causation; physicians tend to assume patients focus on treatment

# The evidence

- Physicians overestimate the amount of time they spend in explanation and planning by up to 900%
- Picking up and responding to patient cues shortens rather than prolongs the encounter

# The evidence

- Chronic headache study: resolution of symptoms correlated more closely with “feeling that they were able to discuss their headache problems fully at the initial visit” than with diagnosis, investigation, prescription, or referral

# Setting the agenda together

- *“Which one shall we tackle/focus on first?”*
- *“What’s the one most troubling you...?”*
- *“How shall we take this forward?”*

# Elicit their experience

- *“You told me that your back was giving you a lot of problems; I was wondering how that was affecting you...”*
- *“I remember that you told me you look after your two young grandchildren – tell me how you are coping...”*

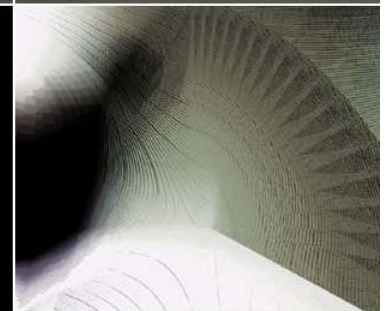
# Elicit their *expectations*

- *“I’m interested in your thoughts about what might be helpful before I make any suggestions...”*
- *“You’ve obviously given this some thought; tell me what you were expecting...”*

# Elicit *ideas and concerns*

- Put yourself in the patient's shoes
- How might they be feeling.... What might the difficulties be for them?
- *"Tell me what you are concerned about at the moment"*
- *"What were your feelings about this?"*
- *"I'm interested in your ideas about your pain. I'd like to hear about them because I think they will help us both understand the problem better..."*

# The Angry Patient



# Anger

- Clinicians often find emotional expression by patients disturbing
- Health care providers are often not taught how to deal with overt expressions of emotion (Smith RC et al 1999)

# Dealing with Anger

- Self
- Situation
- Patient

# Self

- Training (or lack thereof)
- Unrecognized negative responses
  - biases
  - previous experience
  - insecurities

# Self

- Ongoing education
- Seek assistance and support
- Time for reflection

# Situation

- Space
- Time
- Resources

# Situation

- Alternative funding strategies
  - book longer assessment times
  - use multidisciplinary teams
  - Access tertiary care resources when appropriate

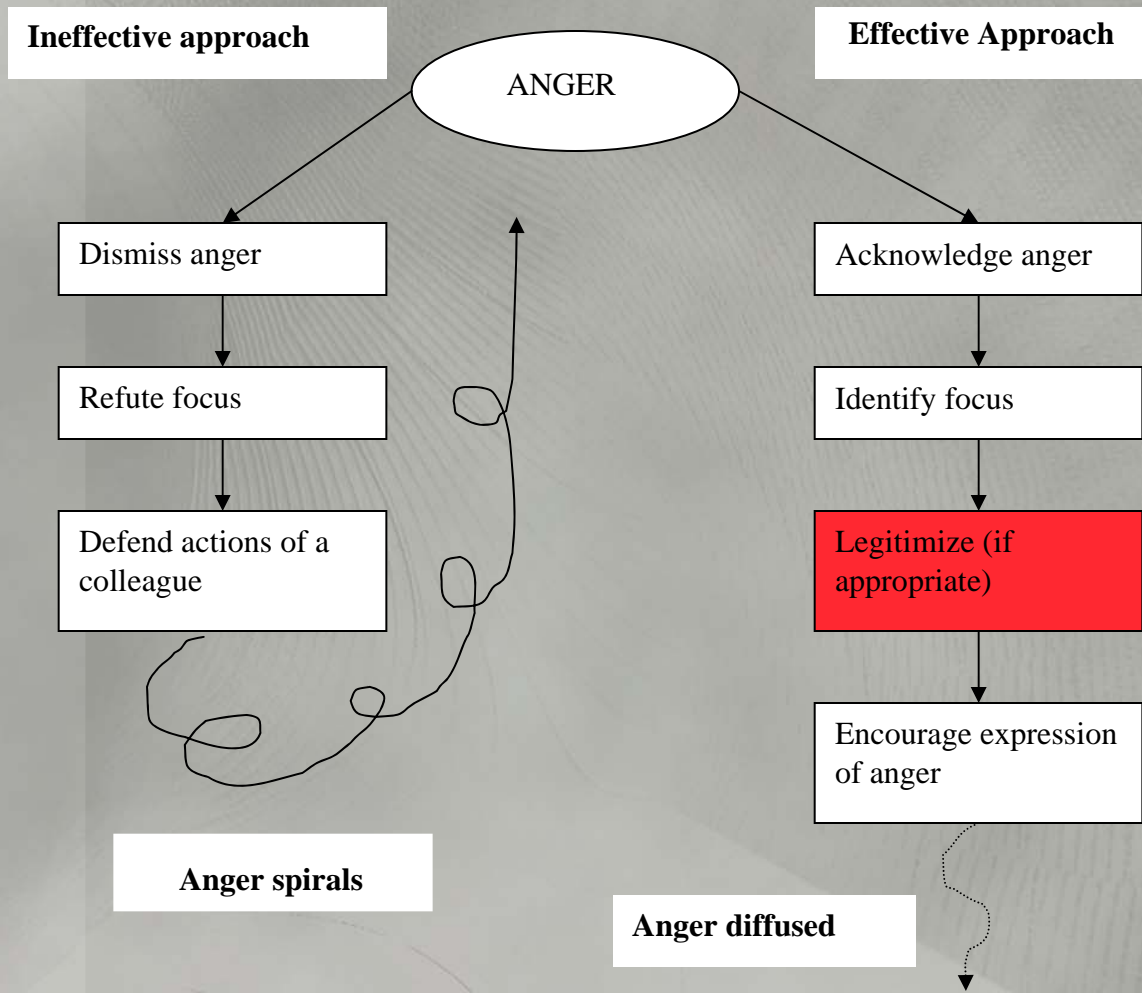
# The patient

- Nature of presenting complaint
- Length of time waiting for consultation
- Lack of readily available and credible information
- Previous bad experiences
- Psychosocial factors
- Occupational/disability/3<sup>rd</sup> party factors

# Anger

- NURS emotions
  - Name
  - Understand
  - Respect
  - Support

# Dealing with anger



# Bottom line

- Any patient encounter can be a difficult one, given the “right” circumstances
- Many difficult encounters stem from differing agendas
- Both parties make assumptions that lead to confusion, resentment, and anger
- Communicating clearly in a safe way can diffuse anger on both sides

# Getting it right

- Rerun the interview
- The audience advise how to do it!
- What are the main issues?
- What are the obstacles?
- What is the patient's agenda?
- What is the doctor's agenda?

# References

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o The following slides are the comments made by the audience during the work shop and are included as a reminded to those who attended.

## Comments from the audience 1

- Don't try to do everything at once
- Active listening
- Elicit expectations (check at the end)
- Be clear about what you can provide
- Joint team assessment
- Stop + attend

## Comments from the audience

- Acknowledge distress
- Use note taking to build rapport and prioritize.
- Reflect on your own assumptions - be prepared to compromise.
- Review notes and link this session to past visits.

# Anger

- STOP + depersonalize
- Acknowledge
- Self-monitoring
- Allow patient to vent in a safe environment
- Find areas of commonality
- Validate emotion