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Abstract:
II t has long been recognized that patients bring their own agendas to the medical encounter [1,2], and that conflicting doctor and patient agendas are an impediment to effective care [3–6]. The importance of reconciling conflicting agendas and establishing a common or shared agenda is such that it has become the focus of a variety of educational approaches. Interviewing techniques have been developed to help practitioners identify and elicit the patient's agenda [7,8]. Teaching physicians specific skills related to eliciting patient concerns and clarifying the patient's perspective has been demonstrated to significantly reduce patient emotional distress [9]. Yet a recent study [10] of experienced family physicians found that more than two thirds tended to redirect and focus the interaction before the patient's full agenda was elicited. When patients are considered "difficult" by their physicians, the problem of disparate doctor/patient agendas is further complicated. Patients who are extremely frustrating for physicians to work with [11,12] can engender a range of negative emotions in their doctors, including anxiety, anger, and guilt

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Conflicting Doctor and Patient Agendas: A Case Illustration

Johanna Shapiro, PhD, Roginelli Yu, MD, and Maysel Kemp White, PhD

It has long been recognized that patients bring their own agendas to the medical encounter [1,2], and that conflicting doctor and patient agendas are an impediment to effective care [3–6]. The importance of reconciling conflicting agendas and establishing a common or shared agenda is such that it has become the focus of a variety of educational approaches. Interviewing techniques have been developed to help practitioners identify and elicit the patient's agenda [7,8]. Teaching physicians specific skills related to eliciting patient concerns and clarifying the patient's perspective has been demonstrated to significantly reduce patient emotional distress [9]. Yet a recent study [10] of experienced family physicians found that more than two thirds tended to redirect and focus the interaction before the patient's full agenda was elicited. When patients are considered "difficult" by their physicians, the problem of disparate doctor/patient agendas is further complicated. Patients who are extremely frustrating for physicians to work with [11,12] can engender a range of negative emotions in their doctors, including anxiety, anger, and guilt [13]. Unless these emotions are adequately managed, they may result in persistent difficulties in establishing a physician-patient alliance.

The following case presents transcripted excerpts from a single, audiotaped "difficult" doctor-patient encounter, illustrating how conflicting agendas can occur over the course of a visit and how a failure to reconcile them can impede patient care. At key points in the interview, we provide an analysis of the exchange and suggest alternative approaches the physician might have used to advance a common agenda. A junior faculty member, Dr. B, who had recently completed residency training, conducted the interview.

Interview

Martin W. is a 51-year-old, non-Hispanic white man who was diagnosed with type 2 diabetes 5 years ago. He is presenting to his regular family physician for a follow-up visit secondary to a recent hospitalization for a diabetes-related scrotal abscess. Because of missed appointments, he has seen this physician only twice previously. Martin has received standard diabetes education, but his diabetes remains poorly controlled, a cause of deep concern to Dr. B. His wife and young son are present in the examination room.

It's Very, Very Painful

Dr: (*entering*) How're you doing, Martin?
Pt: (*big sigh*) Better than last week.
Dr: Better than last week? I heard you were in the hospital. *(The physician had been informed by the admitting team of the patient's hospital course and had been in contact with the home health nurse regarding the patient's low pain tolerance during his wound packing.)*
Pt: I was.
Dr: Uh-huh. Is the nurse coming every single day for a dressing change?
Pt: No.
Dr: How often is she coming?
Pt: She only came twice, and she's not coming any more.
Dr: Okay. And did she teach you how to do the dressing change?
Pt: It's very, very painful.
Wife: It's very painful, and I can't do it. The nurse upstair's going to do it for me.
Dr: She ended up doing it?
Wife: No, she's going to do it for me because I can't.
Pt: Cause right now I don't have any packing in there.
Dr: You don't?
Wife: It just fell out.
Pt: No. It just hurt too bad the other day.

In this opening sequence, we see Dr. B quickly introducing her own agenda: Wound Care and Packing. This agenda is one that might realistically be accomplished in a discrete, limited visit and appropriately addresses an acute medical need of Martin's. However, by concentrating on establishing her own agenda so early in the interview, the physician forecloses the possibility of asking for and surveying the patient's agenda. She also misses an opportunity to elicit the story of the patient's hospitalization.

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What might have been an alternative approach? Dr. B's opening is engaging: she greets the patient by name and expresses interest in his well-being. The query about the hospital stay is an open-ended statement. Instead of switching immediately to the agenda of Wound Care, the physician might have used another open-ended prompt (eg, "Tell me what happened to you") as a means to learning the patient's perspective on this critical event. The patient's agenda might have been elicited by asking, "What are you concerned about today? What would you like me to take care of?" The issues Martin identified might then have been prioritized, with the patient's participation. Instead, the patient himself spontaneously introduces his primary agenda—Pain—as a response to the physician's agenda. In his mind, they are clearly related, as packing the wound may cause pain. Yet Dr. B does not respond to Martin's agenda of pain. The physician had already concluded that he had "low pain tolerance" and complained a great deal without much justification.

The jockeying of physician and patient agendas continues. After the patient reveals he no longer has any packing in the wound because "it just hurt too bad" to replace (an elaboration on his agenda of Pain), he introduces his second agenda, Blurry Eyes.

Pt: I got my new glasses . . . But my eyes are still real blurry. The test results . . . they told me I don't have any glaucoma.

The patient offers test results to corroborate the importance of his second agenda, but after a lengthy search the physician finds that the papers discuss a 2-year-old colonoscopy for hemorrhoids. The physician then attempts to switch the agenda back to Wound Care. The patient, however, is tenacious, returning to his second agenda of Blurry Eyes, and introducing a third agenda, Dizziness.

I Get Real Dizzy

Dr: Okay, Martin, so are you having any fevers at all?
Pt: No, but right now my eyes are real blurry. It's harder and harder for me to see without glasses . . .
Dr: Okay, okay.
Pt: . . . and a lot of . . . I lay down and get real dizzy. I don't know what that's caused by . . .
Dr: Uh-huh, I think it's just . . . Are you drinking fluids?
Pt: Not as much as I'm supposed to.
Dr: Yeah. I think what's going on is the fact that you've been through a lot. You're just out of the hospital. You'll still feel a little weak even just because you were just lying in the hospital bed, not doing anything. So after lying in bed . . .
Pt: (*partially repudiating the doctor's explanation*) But this was before, too.

How could this somewhat disorganized progression of the interview have been averted? At this point, the patient is offering random symptoms that distract Dr. B into following whatever path he suggests. Yet because the physician has not really accepted these agendas, she does not treat them seriously or work them up carefully. Rather, she attempts to dismiss them by providing quick-fix explanations so that she can return to her own agenda.

In the following exchange, Dr. B uses Martin's dissatisfaction with her innocuous explanation for his dizziness (lying in bed and not drinking enough) to introduce a new agenda, the patient's Poorly Controlled Diabetes. The physician thinks she sees a way of linking several of Martin's complaints back to his underlying disease, with the hope of addressing the problem of his uncontrolled diabetes in a more satisfactory way. Unfortunately, like most of the verbal shifts in this interaction, it is made unilaterally, and the patient's lack of consent to this agenda presents insuperable problems. Further, because of her covert frustration with this patient, the physician adopts a mildly hectoring tone, as if scolding a disobedient child, as she introduces this agenda, thus guaranteeing a negative response on the part of the patient.

Your Diabetes Is Poorly Controlled

Dr: Your diabetes is poorly controlled, Martin. I've been wanting to get you back into this clinic for quite some time. You've missed a few appointments. The next thing I'd heard about you is the fact that you're in the hospital.
Pt: In the hospital.
Dr: So I mean it's understandable why you're feeling all these things. It's because of the diabetes and we really need to take care of that.
Pt: The last 3 months the doctor did some kind of test and said, "I can tell you haven't been staying on your [diet] . . ." It's been a roller coaster the last 3 months. It's been out of control. Half the problem was . . . I don't know, I just . . . I care about myself, but I forget to do this, I forget to do that . . . my eating habits . . . Now I really cut down, I'm not eating. . . . I just lost weight, down to 216, and I think I was 235 the last time I was here.
Dr: You were 218 the last time you were here.
Pt: 218?
Dr: Uh-huh.
Pt: I'm surprised.

The patient responds to the physician's agenda but does so in a defensive manner. He does, however, acknowledge that his diabetes is out of control, offering Dr. B the chance to establish common ground (eg, "You're right, Martin. We both

agree that things are still out of control.") Instead, she chooses to challenge his optimistic claims of dietary progress by presenting data indicating that his weight loss has been minimal, thus creating greater distance between her and her patient. A more successful approach might have been to reject focusing on the details of Martin's weight loss and to instead reinforce Martin's previous efforts, no matter how ineffectual, as a prelude to talking about increased commitment to behavioral change. Instead, after this exchange, Dr. B elaborates on her second agenda of Poorly Controlled Diabetes by introducing a corollary, Lack of Patient Commitment.

I Can't Be at Your House 24 Hours a Day

Dr: So what do you want to do here, Martin? I just really need to see a little more commitment on your part, in trying to help yourself control the diabetes better. I can't be at your house 24 hours a day . . .

Pt: No, that's true.

Dr: . . . to make sure you are taking your medicine or to make sure you are going to your appointments. I just want to make sure we don't run into these problems again because this infection will take a while to resolve because of your diabetes . . . Okay, and so we need to make sure that not only do you heal well, but also that we control your diabetes well, by taking your medicines, by eating the proper diet.

In this statement, the physician makes a plea for the patient's cooperation and commitment. Unfortunately, her helplessness and frustration with Martin are evident in her language and tone of voice. Phrases such as "So what do you want to do?" and "I can't be at your house 24 hours a day" use a confrontational, sarcastic style that shuts down, rather than opens up, dialogue. The doctor might have done better to express her feelings directly, for example, "Martin, I have to admit I'm frustrated by our inability to get your diabetes under control. Let's talk about how we can change our approach to help you have more success." This acknowledgment of physician frustration, combined with the language of therapeutic alliance (ie, the repeated use of "we," suggesting patient and doctor are on the same team) might have put Martin sufficiently at ease to accept discussion of this important agenda. Because Dr. B introduces this corollary agenda more as emotional catharsis than as a topic for serious discussion with her patient, she makes no real effort to get Martin to respond. Thus he is able to ignore this agenda and simply say nothing.

It's Very, Very Painful (Redux)

Dr: Now I'm not sure how well this is going to do. I usually recommend premedicating yourself with the pain medicines before the packing occurs. I'm not sure how the Xylocaine jelly will help with the pain of packing.

Pt: It's very, very painful, I've never had so much pain in my life. (*The patient attempts to tell the story of his hospitalization but is ignored by the physician.*) To tell you the truth when I went to the emergency room last Sunday, I never really thought they would admit me. See right now you look fuzzy . . . I just took my glasses off. I don't know if it's diabetes that makes you look fuzzy.

Wife: Should he be driving with fuzzy eyes?

Dr: (*shortly*) No, I wouldn't.

The issue of patient commitment disappears without resolution. Apparently by mutual consent, the physician reverts to her first agenda, Wound Care and Packing. The patient reverts to his agendas of Pain and Blurry Eyes. Although the physician does indirectly allude to the Pain agenda, she does so in a negative and blaming way. Dr. B suggests the wound packing is going to be painful, and intimates that this result, precisely what the patient fears most, is his own fault for not having taken the pain medication as prescribed. In an alternative approach, the physician might have considered addressing this agenda proactively and positively, nonjudgmentally identifying the patient's fear and suggesting specific steps that could be taken at present to reduce the pain of the procedure.

Dr. B is detoured into a lengthy discussion of Martin's "fuzzy eyes" (not excerpted). Toward the end of the discussion, Martin again reverts to a discussion of his hospitalization experience, a trauma he very much wants his physician to understand and sympathize with. The patient introduces this topic in a dramatic way, apparently hoping to get Dr. B's attention.

So Obviously You Don't Have Gangrene

Pt: The doctor was worried about gangrene, that's why he told me he admitted me.

Dr: So obviously you don't have gangrene . . .

Pt: No.

Dr: So that's good.

Pt: But he says I'm lucky I got there in time.

The physician does not appear very interested in this story, and indeed seems to mock the patient's opening salvo. Rather than listen to the hospitalization story, she continues to prepare the patient for the packing, thus pursuing the one agenda over which she has some control. In her single-minded focus, Dr. B also ignores the fact that the patient's family is still in the room, although given the nature and location of the abscess privacy issues may be of concern to the patient and family members.

Do You Want Us To Leave?

Wife: Do you want us to go out?
Dr: If you feel uncomfortable, you can leave.
Wife: The little boy, he doesn't want him to see . . .
Dr: That's fine. *(wife and son leave)*

Martin's wife is compelled to raise the question of their leaving, to which the physician responds rather unempathically. This might have been a good opportunity for the physician to show concern for patient and family by initiating the suggestion that wife and child might be more comfortable in the waiting room.

The battle of the agendas continues. The physician now concentrates exclusively on her initial agenda of Wound Packing, while the patient returns to his earlier agenda of Dizziness. As in other exchanges, the patient successfully evades the physician's agenda, while the physician is diverted into the patient's agenda, albeit in a somewhat exasperated manner.

I Don't Want To Go Upstairs Yet

Dr: Just have you unbutton your . . . here. Now I know that packings do fall out and everything but you really need to work on keeping that packing in, Martin, because the thing is if you leave it the chance of pus and fluid reaccumulating in that space will be high. Okay?
Pt: Ooh, just got so dizzy. Yeah, I feel dizzy right now. What could cause that?
Dr: You have a lot of things that could be causing your dizziness, Martin. Out-of-control diabetes, your lack of fluid intake, and the pain that you're experiencing.
Pt: So they all . . .
Dr: Uh-huh.
Pt: When I'm standing up I'm fine.
Dr: Positional changes will cause you to feel dizzy. You need to drink lots of fluids when you have an infection. I can't recommend that any much more than I'm telling you right now. You need to drink lots and lots of fluids.
Pt: Water, like 8 glasses of water?
Dr: More than 8 glasses of water. I want you drinking at least 2 liters a day.
Pt: 2 liters. I want to be around. I don't want to go upstairs yet.

In a startling and unanticipated development, the patient introduces a critically important agenda, the underlying issue that has been lurking behind the pain, blurriness, dizziness, and scariness of the hospitalization. This agenda is Fear of Dying. Almost in spite of himself, the patient offers the physician a remarkable opening to talk about the meaning of the illness for this patient. However, Dr. B's frustration with Martin initially makes her respond with a slightly sarcastic edge. She then attempts to link this patient agenda to her own agenda of Lack of Commitment.

Dr: Well, Martin, you're really doing a great job on working yourself up there, okay? We really need you to stay here and work with us. You got it? Okay. Let's take a look at this [wound].

In her effort to make this connection, however, she omits explicit acknowledgment of the patient's fear, which perhaps contributes to his nonresponsiveness. As an alternative, the physician might have acknowledged that she heard the patient's statement about fear of death: "You're worried you might not be around as long as you'd like because of this diabetes. That must be a pretty scary thought." Once the patient felt understood, the doctor could then pair with him: "You know, Martin, that's what I'm worried about too. That's why I keep coming back to the issue of control. We both want the same thing—for you to be around long enough to see that cute little son of yours grow up. Can we talk about this?" But none of this happens. Instead, the doctor returns to the agenda of Packing, and the patient returns to the agenda of Pain. No mutually agreed upon agenda has been established, and the opportunity to simultaneously cut through the patient's defensiveness and the physician's frustration is lost.

The physician attempts to pack the wound but the patient's whimpers and moans force her to abandon the procedure. She asks him about the medication he is taking for pain. The patient uses the question as an opportunity to tell the story of his hospital stay, an elaboration of his Pain agenda.

Doesn't Seem Like It's Working

Pt: Doesn't seem like it's working. It just doesn't seem like it's working and stuff. The pain medicine they gave me in the hospital didn't seem like it was working. It's just so tender. The doctors came in and they were trying to put a needle in my sac down there and then they said oh it's an easy procedure. And then they . . . it just hurt so much. And then they said, well, this isn't gonna work, just gonna have to put me through surgery. And they put me to sleep, and I had to sign a paper. It said 1% chance of death. I said I couldn't take the pain. I said just go ahead put me to sleep.
Dr: Well, Martin, let me tell you this. I don't know . . . It's very difficult on a person like you. Because you apparently have a very low pain tolerance. Okay? The medicines they gave you in the hospital were pretty strong medicines, and that's basically all I can give you here. I could give you a shot of pain medicine right now so

I can pack it. But I don't know how well that's going to affect you now at this point with the way that you're describing your pain.

Pt: It's real tender. I don't know if it's red, I imagine it is.

Dr: No, it actually looks pretty good.

Pt: Then why is it so painful?

The doctor, defeated, is exasperated and even unsympathetic. Once again she does not respond to the patient's story about his hospital stay, and thus misses a chance to express empathy for his difficult experience [14]. Rather, she chooses the tactic of minimizing his problems as due to "low pain tolerance," with its intimations of patient blame. She might have tried working with the patient's fear of additional suffering by acknowledging its validity (no matter how subjective) and considering implementing additional pain management strategies. In this exchange, Martin, for the first time, expresses an interest in his wound, asking Dr. B for information. When she responds by minimizing his concerns, he quickly reverts to his Pain agenda, but with a question that suggests potential receptivity to a collaborative approach [15]. Dr. B's exasperation and exhaustion with this patient prevent her from exploring this softening on Martin's part. She persistently focuses on completion of the Packing agenda. The patient, however, continues to tentatively reach out to his doctor, and finally (implicitly) acknowledges her corollary agenda of his Lack of Commitment.

I Just Want You To Do It

Dr: You know, I really don't know. Usually after this collection of pus is drained out the pain is relieved . . . I think you're just a very sensitive person. We really need to find some way to get you as comfortable as possible so we can pack this as well as we can. Okay, so what I can do is give you a shot right now and see if that helps with your pain and then we can pack it, okay?

Pt: Okay. You've been on my side for a long time.

Dr: Yeah, I'm trying to be on your side right now, Martin.

Pt: I know. I'm so sorry.

Dr: You really need to help me.

Pt: I'm so sorry I've been screwing up.

Dr: You don't have to apologize to me. I just want you to do it.

Pt: Okay.

At several points during this exchange, even at this late phase of the interview, the physician might have connected with her patient and established a therapeutic alliance on which to build a consensual approach to care. For example, she could have asked Martin what he is feeling sorry about. His response might well have made Dr. B's tacit perception of Martin as a "difficult" patient overt, and therefore discussable and solvable. Instead, the physician remains focused on completion of the packing.

It is unclear what Dr. B is requesting in her last statement. She is certainly asking that Martin cooperate with the packing. However, she may also be indirectly alluding to her earlier agenda of Lack of Commitment, asking her patient once again to enter into a therapeutic alliance with her. But, perhaps because the statement arises from frustration more than genuine compassion, the patient responds only with a cowed, "Okay." For the remainder of the interview, both physician and patient seem subdued, perhaps exhausted by their struggle. The wound is packed and Martin receives a referral for diabetic nutritional counseling, but there appears little chance that either the patient's fear of death, or the physician's need to have him play a more committed role in his health care, will be addressed.

Discussion

Much can be learned from the missteps and wrong turns of this encounter. The physician, although relatively inexperienced and overworked, was not a callous, uncaring individual but rather someone who struggled with and agonized over the frustrations presented by this patient. The patient, although at times irresponsible and meandering, was not "impossible" so much as fearful and overwhelmed by his disease. These two individuals struggled, in this case largely unsuccessfully, to find common ground that would allow both of them a measure of success in the management of a difficult, chronic illness. Lessons for clinicians seeking to increase concordance in the doctor-patient relationship might include the following:

- Allow the patient to tell his or her story, even if you think you already know it. It will help you understand the patient's perspective and make it easier to empathize with his or her predicament.
- Elicit the patient's agenda(s) early in the interview and be prepared to negotiate a common, shared agenda. Never assume that an agreed-upon agenda (such as wound packing) implicitly exists simply because of the nature of the presenting problem.
- If a patient agenda (such as pain) is insistently and repetitively inserted in the discussion, deal with it directly and sympathetically, even if you do not feel it is particularly important.
- When you are about to see a patient you have found to be "difficult" in the past, decide in advance what you want to accomplish and then make every effort to incorporate these goals into a mutually agreed-upon agenda.

- Make a special effort to express concern and show compassion for patients that you find irritating. Even these patients offer many opportunities during a typical encounter to empathize with their fears and suffering.

These and similar efforts, had they been employed in the case described, might have produced a mutually acceptable agenda that would have reduced physician frustrations and patient fears while promoting a more satisfying, authentic exchange.

Dr. B has since left the university-based clinic practice where this encounter took place and joined a local group practice. Efforts to contact Martin to elicit his interpretation of the encounter were unsuccessful, and he did not seek further health care at the clinic. Author commentary is based on a detailed analysis of the full transcript (available on request from Dr. Shapiro) as well as background on previous interactions and patient history provided by the treating physician.

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