Poem

DIFFICULT CLINICIAN-PATIENT RELATIONSHIPS

~~Think about difficult pt.~~

I. THREE PREMISES (Overhead)
   A, Label "difficult" is subjective - clinicians differ in their use of the label
   B. Paradigm shift from "difficult patient" to "difficult" as a function of the relationship between two people, and their interactions
   C. Change is possible in these difficult relationships

II. A THEORETICAL MODEL OF THE DIFFICULT DOCTOR-PATIENT RELATIONSHIP (OVERHEAD) -Think of a difficult pt.
   A. Difficulties may be a function of
      1. The patient
      2. The disease
      3. The clinician
      4. The system
      5. All four

   Difficulties develop when:
   B. Success is frustrated –
      1. Can't make progress with the problem OR can't lower blood sugars / can't get them to lose weight
      2. Success is defined differently by dr and pt pt - pain free; dr. - pt. returns to work increases daily functi—
   C. Expectations of physician and patient are misaligned
      1. Pt wants narcotics, dr wants to recommend pain clinic
      2. Pt wants someone to listen to their story, dr wants to find and fix
   D. There is insufficient flexibility on part of physician and patient
      1. Physician can't adapt strategies to accommodate needs of patient and ~~vice~~ versa pt. can't accept some of constraints, rules of the physician
      2. Physician and patient engage in repetitive, unproductive patterns
         diabetic pt. who won't follow diet, keep track of sugars; dr. who scolds, chastises

III. A MODEL FOR CLINICAN BEHAVIORS IN THE DIFFICULT DOCTOR-PATIENT RELATIONSHIP (OVERHEAD)

   Different situations call for different responses:
   A. Comfort zone (basic doctor-patient techniques):
      1. Engage
      2. Empathize
      3. Educate
      4. Enlist — Biggest physician mistakes
   B. Challenge zone: Avoidance Distancing Emotional Enmeshment
      1. Acknowledge interpersonal problem with patient
      2. Increase control:
         a. Setting boundaries
         b. Extending the system
      3. Increase understanding
         a. Discover meaning
         b. Show compassion

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Working with boundaries
Most physicians set too tight boundaries in difficult relationships, but sometimes they need to loose. Need to experiment w/ changing boundaries

IV. ACKNOWLEDGE PROBLEM – Addresses Avoidance

A. Awareness of problem
   1. Global distress (something is wrong! I wish I weren't here!)
   2. Clues to potential difficulties (interruptions, repetitions, stereotyping by dr and/or pt – "this pt is a crock" "another uncaring dr")

B. Stop and think
   1. Act rather than react ("Don't just do something, stand there!")
      a. This helps avoid reflexive responses – shooting from the hip – repeats old behavior
      b. Allows for new behavior
   2. Assess how you are feeling
      a. Anxious, bored, frustrated, angry
      b. What is making you feel that way?
   3. Be curious about what is happening (interested objectivity)
      a. What is going on here? What is causing this problem? – something in me, something in patient, something in illness, something in system?

C. Assess the problem

D. Decide to accept or reject challenge of working with this patient
   1. What are other options?
   2. If accept, must work on relationship as well as medical issues

E. Start to build a therapeutic partnership by
   1. Acknowledging your difficulties with patient *"I'm wondering if we are working together as well as we might be able to"* OR *"I'm concerned I don't seem to be communicating as well as I'd like"*
   2. Acknowledging patient's difficulties *"Managing your diabetes seems hard for you to talk about. Is there some way I can make it easier?"* *"Your headaches are worse, you'd like more Percoset, and I'm telling you these aren't the best pills for you. No wonder you're frustrated"*
   3. Encouraging problem-solving: Basic message is, *"Even though we are having some difficulty, I would like to be your doctor and work with you. Do you think we can work together and find some common ground?"*

      "I want to solve this problem we seem to be having. My thoughts about the situation are___. What are your thoughts?"

      "Is there something that I can do to help us work together more effectively?"

Addresses both Distance or Enmeshment

V. SETTING BOUNDARIES/EXTENDING THE SYSTEM

Most – too tight, but sometimes too loose; experiment w/ where you've set the boundaries

A. Time: Opening and closing
   1. Clinician –
      a. Don't schedule when you are HALT (hungry, angry, late, tired) (opening) – Give diff. pt. prime slots – the best seat in the restaurant
      b. Don't attempt MARATHON resolution – improvement is gradual (closing)
      c. Stick to scheduled time boundaries (closing)

2. Patient –
    a. Respect patient time (don't be late for, avoid pts you don't like; opening)
    b. Negotiate agendas, help patients prioritize best use of time (closing)
    c. Use redirection to curtail repetitive or tangential statements (closing)

you worried about bump on finger, but I want to get more info on your chest pain

B. Roles/Expectations: Opening and Closing
    1. Clarify differences between you and the patient in terms of expectations – open boundaries to accomodate pt. expectations - alternative medicine
    2. Research shows pts have expectations in three areas:
        a. Treating symptoms as they arise
        b. Goals of cure or maintenance
        c. Specific requests w/ diff. pts, all of these can become problematic
    3. Physician may need to set limits in all these areas (closing)
        a. Symptoms: *"You want me to treat your blurry vision, your foot ulcer, your dizziness. But in order to do that, I need for you to talk with me about getting your diabetes under better control."*
        b. Goals: Patient's goal may be to obtain narcotics; physician's goal is to find a better treatment for her migraine headaches.
        c. Requests: Patient asks doctor to come to dinner; physician sets a boundary by saying: *"Thank you. Given my time constraints though it's my policy to spend all my free time with my family."*
    4. Specific situation of abusive patient:
        a. *"It's hard for me to take good care of you when you raise your voice and use profanity. I'm going to step out for a moment. When I come back, I expect us to be able to talk about this problem calmly."*

C. Agendas (Opening and Closing)
    1. Listen to what is important to patient in terms of ~~roles and expectations~~ their concerns, self-diagnoses and incorporate these into your interactions (opening)
    2. Set limits on low-priority patient agendas (closing)
    3. Open ~~boundaries~~ agendas you think are critical
        a. Screening tests, psychosocial issues, ~~avoiding~~ addressing unhealthy lifestyle behaviors
        b. ~~State as your rationale concern for pt health, and always ask permission~~ less likely to do this w/ diff. pt.

D. Avoid unintentional barriers in time and space with patients with whom you're having difficulties
    1. Don't let charts, desks function as unconscious boundaries
    2. Maintain eye contact as appropriate and don't tower over patient (more likely to avoid eye contact, remain standing with pts we don't like)
    3. Don't avoid contact: use touch when and where appropriate

E. EXTEND THE SYSTEM (opening a boundary)
    1. Difficult patients demand resources of time and energy
    2. Often useful to "share the wealth"
    3. Identify what help is needed

1. Support, understanding
2. Advocacy
3. Expertise (information)
4. Skills (parenting, communication etc.)

B. What are potential sources of help?
1. Family members, friends, coworkers
2. Other health professionals
3. Social service professionals
4. Clergy
5. Support groups

C. How to extend and get help
1. Inform patient of
   a. Need for involvement of others
   b. Options and consequences
   c. Confidentiality
2. Involve patient in process of resource identification
   a. Who does pt usually turn to for help?
   b. Are these people available?
   c. Consider other options
3. Responsibilities for extending the system
   a. What will the patient do?
   b. What will the clinician do
   c. What will the family do?
4. Referral vs collaboration
   a. Avoid indirect communication of abandonment (pt dump)
   b. Make sure patient knows when will see or hear from you again

draws closer to pt — Addresses Distance — of the pt's behavior as a function of the meaning of the illness: What makes this patient act this way

VII. DISCOVER MEANING

A. Discovery of meaning increases physician understanding of patient, and patient understanding of him/herself

B. Uncovering meaning reduces frustration because it explains the previously inexplicable

B. The illness has meaning for the patient

Very angry pt — emergency surgery to remove ruptured ovarian

1. Functional meaning (limitations on daily life – *"Yes, I'm grateful the surgery to remove my infected ovaries probably saved my life, but now I can't have children")*

Disengaged pt — erectile dysfunction due to diabetes

2. Symbolic meaning *("Could guilt over my affair have caused impotence rather than diabetes?")*

Uncooperative, noncompliant

3. Illness occurs within context of personal and family history *("There's nothing I can do about my weight- everybody in my family is heavy")*

C. Visit itself has meaning for the patient
1. Why did patient come now? (Anniversary reaction; can't stand pain of sore throat any longer)
2. What meaning does the patient wish to gain from this visit? *("I don't have cancer like my mother;" "Someone will help me"* agenda)

-take-him message if can figure out, pt. will be satisfied

C. Illness may have meaning for the clinician
    1. Success or failure may be predicted based on past experience and medical knowledge diagnosis of liver CA may be depressing to Dr.
    2. Clinician can be challenged, bored by particular disease ("another diabetic," but it's a unique and frightening ~~experience~~ diagnosis for the patient)
    3. Disease may have personal meaning for the clinician

D. Seek a shared, constructive meaning
    1. Make explicit patient and clinician perceptions
    2. Establish mutual therapeutic goals explanations of
    3. ~~Seek out options and alternatives~~
    4. ~~When patient refuses treatment, try to understand why~~

VIII. SHOW COMPASSION

A. Experiencing compassion for patient
    1. Reduces anger and frustration
    2. May allow new solutions to emerge
    3. Empowers patient to create his/her own solutions

B. Communicating empathy – ratchet up the empathy – more than in comfort zone
    1. Try to really understand pt's experience and point of view
    2. Review and summarize what's happened
    3. Name the pt's thoughts and feelings
    4. Verify with the pt
    5. Legitimize the thoughts and feelings
    6. Respect efforts to cope
    7. Offer support and partnership

"*Mr. Jones, let me make sure I've got this right. You were recently and hospitalized for this leg ulcer. You had a hard time in the hospital, you were in a lot of pain and felt no one understood what you were going through.* You were angry and frustrated, because you *Is that right? I think your feelings are very understandable, being in a great deal of pain is hard for all of us. Now you are here to get the wound packed, and you want to make sure I understand how much pain you're in. You're doing the right thing by talking with me about what happened. I would like to work with you to make this procedure as painless as possible. Let's talk over what can be done.*"

C. Compassion is empathy reflected in action
    1. Acts of consideration – making sure pt is comfortable, explaining carefully when and how pt can get help
    2. Availability
    3. Active helping (making arrangements, connecting people with resources)

Sets boundary by separating pt. from her omnipresent symptoms and extending compassion by being willing to listen to her story

DIFFICULT CLINICIAN- PATIENT RELATIONSHIPS

THREE PREMISES

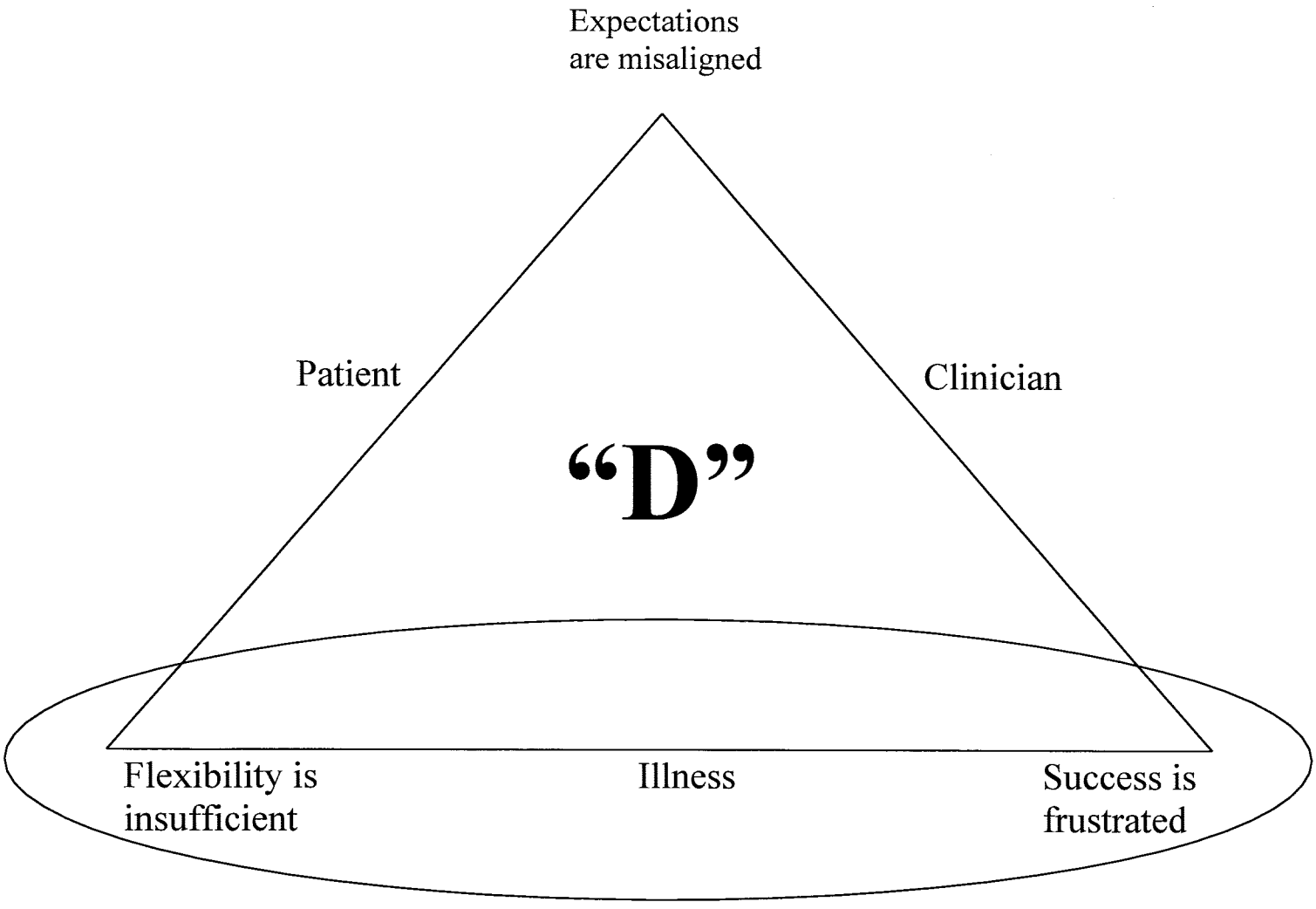
- **Label "difficult" is subjective**

- **Paradigm shift from**
  - **"Difficult Patient" to**
  - **"Difficult" is function of relationship between doctor and patients, and their interactions.**

- **Change is possible**

A THEORETICAL MODEL OF "DIFFICULT" CLINICIAN PATIENT RELATIONSHIPS

Relationship difficulties develop when …



A MODEL FOR CLINICIAN BEHAVIORS IN "DIFFICULT" CLINICIAN-PATIENT RELATIONSHIPS.

DIFFERENT SITUATIONS CALL FOR DIFFERENT RESPONSES

ZONE ONE

"Comfort"

Engage	Educate
Empathize	Enlist

ZONE TWO

"Challenge"

Acknowledge Problems
Increase Control
Increase Understanding

PROCEDURES TO IMPROVE RELATIONSHIPS

- **Acknowledge problems**
- **Increase Control**
  - Set Boundaries
  - Extend the System
- **Increase Understanding**
  - Discover Meaning
  - Take Compassionate Action

DIFFICULT CLINICIAN- PATIENT RELATIONSHIPS

INCREASING CONTROL

SET BOUNDARIES

Clinician Time(Opening and Closing)

- Physician: Avoid HALT
- Avoid MARATHON sessions
- Stick to boundaries

Patient Time

- Respect patient time
- Negotiate agendas; prioritize
- Redirection

Roles/Expectations(Opening and Closing)

- Patient
  - Symptoms
  - Goals
  - Requests

Agendas

- Patient
- Physician

Avoid unintentional barriers

DIFFICULT CLINICIAN- PATIENT RELATIONSHIPS

ACKNOWLEDGE THE PROBLEM

Awareness of Problem

- ♦ Global distress
- ♦ Interruptions
- ♦ Repetitions
- ♦ Stereotyping

Stop and Think

- ♦ Assess your feelings
- ♦ Be curious about what is happening

Assess the Problem

- ♦ What is the reason for the difficulty
- ♦ Is it the patient's problem, your problem, a problem due to illness; a system's problem?

Decide to accept or reject challenge of this patient

Build a partnership

DIFFICULT CLINICIAN- PATIENT RELATIONSHIPS

INCREASING CONTROL

EXTEND THE SYSTEM

Identify type of help needed

- ♦ Support, understanding
- ♦ Advocacy
- ♦ Expertise
- ♦ Skills

Identify potential sources of help

- ♦ Formal
- ♦ Informal

How to extend and get help

- ♦ Involve patient
- ♦ Identify respective responsibilities
- ♦ Address abandonment issues

DIFFICULT CLINICIAN- PATIENT RELATIONSHIPS

INCREASING UNDERSTANDING

DISCOVER MEANING

Meaning of illness for patient

- Functional
- Symbolic
- Family History

Meaning of visit

Meaning of illness for physician

Seek shared, constructive meaning

DIFFICULT CLINICIAN- PATIENT RELATIONSHIPS

INCREASING UNDERSTANDING

SHOW COMPASSION

Compassion

- ♦ Reduces anger and frustration
- ♦ Allows new solutions to emerge
- ♦ Empowers patient to create own solutions

Communicate Empathy

- ♦ Understand patient's experience
- ♦ Review and summarize what's happened
- ♦ Name the patient's thoughts and feelings
- ♦ Verify with the patient
- ♦ Legitimize thoughts and feelings
- ♦ Respect patient efforts to cope
- ♦ Offer support and partnership

Compassion in Action

- ♦ Acts of consideration
- ♦ Availability
- ♦ Active helping