Difficult doctor-patient relationships

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Background. Although difficult consultations constitute about 15% of general practice work, patients considered 'difficult' by one doctor, may not be thought 'difficult' by another. Rather than labelling and therefore dismissing patients, it is more helpful to consider that the relationships may be difficult rather than the patient.

Objective. To change the perspective from labelling a patient as difficult to considering the difficulties in the relationship between doctor and patient. This empowers the doctor to use communication skills to develop appropriate strategies for change.

Discussion. This article describes a method for managing difficult doctor-patient relationships that involves acknowledging the problem, settling boundaries, using additional communication skills and, when necessary, bringing in external resources to assist both doctor and patient.

You might agree intellectually that while it's OK to judge a behaviour, it's not OK to judge a patient, but do you follow that dictum in practice? For example, we condemn nicotine, alcohol and drug addiction but do we really support smokers, alcoholics and drug addicts in their attempts to stop their addictions? Or are they just too difficult?

Labelling, and thus dismissing, difficult patients, is easy but not helpful. Instead, it is more helpful to think of difficult relationships. Some of the patients that I couldn't stand, were found easy to deal with by my partner (and vice versa). Some of the patients found me to be a difficult doctor, some found my partner difficult. The differences were in the relationships. The differences and the difficulties are as much in us as they are in our patients.

There are now a number of different programs offered to both general practice trainees and established general practitioners to assist in the more effective management of difficult relationships. One such program was developed by the Bayer Institute for Health Care Communication in the USA, a not for profit foundation established in 1987 by, but independent of, Bayer Pharmaceuticals. To use the Bayer Institute's language, its Difficult Clinician-Patient Relationships Workshop addresses techniques to assist in those 15% of consultations that are in the 'challenge' zone. Its other workshop, the Clinician-Patient Communication Workshop, which is now offered throughout Australia by a number of RACGP medical educators, teaches techniques to enhance both patient and doctor satisfaction from the other 85% of encounters in the 'comfort' zone. In becoming the first Australian trained to conduct the 'Difficult Clinician Patient Relationships' workshop I discovered that managing difficult relationships is as easy as A, B, C, D and E!

An approach to the difficult relationship

Acknowledge

Some consultations get badly out of control and both you and the patient become more and more frustrated. As entrenched positions are fortified, the battle becomes more important than the outcome. Saving face becomes a higher priority than problem resolution. Stepping back to both acknowledge and verbalise the emerging difficulty gives both doctor and patient a chance to restart the relationship. A technique advocated in the Bayer course is to recognise when to say to ourselves 'Don't just do something, stand there!' We tend to plough on instinctively, getting deeper and deeper into trouble, when it would be far better to pause and reflect. 'Something's wrong'. 'What's going on?' Your own emotions can be used as diagnostic tools. 'I'm getting angry. Why?'

If in that situation:

➤ Review whether you 'engaged' properly with the patient at the beginning of the consultation. Did you begin aggressively, carrying into the new consultation anger and frustration lingering from the last patient (or the argument you just had with a staff member/your spouse/your partner...)?

➤ Then mentally run through the rest of the four 'Es' of effective communication to see if they have been fully used. After checking **engagement,** think whether you have demonstrated **empathy** (by making sure the patient knows he or she has been seen, heard and understood)? Has the patient received sufficient **education,** that is, been provided with enough information to understand what you are advising? Have you **enlisted** the patient - motivated them to accept your advice?

➤ Next, make a conscious choice whether you really want to try to work with that particular patient. If your honest and rational (ie, not based on anger) decision is that you do not want to be further involved in that patient's care, then carefully prepare him or her for referral or, rather, transferral. Ensure though that you make it clear that such referral is in the patient's best interests. In the USA doctors have been accused of a new form of negligence - abandonment!

If you decide to continue, then you will need to rebuild the relationship before you can proceed to manage the medical problem.

The first step is to share the relationship difficulty, by verbalising it. 'I'm finding it difficult to help you because...' Then build a partnership to solve the difficulty. 'How do you feel about that? Can you think of ways you can help me help you? Is there something I can do to help us work together better?'

Boundaries

It's honest, as much as a matter of practical importance, to define your boundaries and seek the patient's acknowledgement and agreement to them. Some will be rigid - a firm precondition for accepting that person as a patient. Some will be negotiable.

➤ 'While I will do everything medically I can to help addicts, I never prescribe drug of addition to support an addiction'.

➤ 'Mrs Smith, I've made a list of the eight things you've asked me to deal with today, but you did not book a long consultation. I think we can deal with three of these today in the time we have. Would you like to say which three you'd like me to deal with today and which can be deferred to tomorrow?'

The latter approach is subtle, it sets a time boundary but leaves the patient empowered by leaving her the choice of what gets dealt with today.

Boundaries are commonly temporal (how much time you are prepared to give) and physical (agree to a request for a home visit or ask the patient to come to the surgery; accept or avoid a kiss) but more subtly, they may define a role limit. 'I know you've come to get me to give you a workers' compensation certificate, but I don't think I can do that. I'm very happy though to provide a detailed medical report to whomever you nominate so you can make a claim for compensation'.

Boundaries can even be behavioural. 'Mr Smith, please calm down. I'm going to step outside for a moment. If, on my return you persist with your aggressive behaviour and foul language, I will have to ask you to leave'.

Sometimes, it's the patient who seeks to impose the boundary.

Compassion

Compassion starts with empathy (acknowledging the patient's emotion and making sure he or she knows you see, hear and understand them) to which is added practical, helpful action. At its simplest it may just be passing a box of tissues when you notice the patient's eyes fill with tears (as opposed to not acknowledging the patient's distress - because you don't know how to, or don't want to, manage that distress). The next level might be to give practical help in making appointments, finding contacts and resources. Sympathy is passive; compassion is active. In short, compassion is 'feeling plus doing'.

Determine the meaning

People do things for a reason. For example, the teenage girl perceives a positive, immediate benefit from smoking (peer acceptance) and perceives the negative, health risks as

remote, both in frequency and age.

Every patient comes to you with a pre-set belief about what could be the problem and what might be the solution. Your skill is not just to come up with your solution to the patient's problems but to find out what they are thinking. Sometimes their expectations appear irrational. That usually means there's a piece of the jigsaw you haven't found. A flat refusal to contemplate a caesarian section may flow from 'I'm redheaded. Red heads always bleed a lot. My redheaded great aunt had a caesarian and nearly died from haemorrhage'. The science may be wrong, but the logic is impeccable. Unless you look behind the apparent unwarranted fear or unrealistic expectation to understand its meaning to the patient, the relationship will remain stuck.

It's sometimes helpful not to ask: '**Why** did you come to see me today?' which is directly interrogative but rather: '**How** did you come to see me today?'

Some concrete thinkers as well as some jokesters will say 'by car' but most patients will understand the question to mean: 'How did you come to decide you wanted to see me today?' which invites information as to the patient's thinking. The 'Why' question will be answered: 'Because I need a Pap smear'. The 'How' might be answered: 'My best friend has just had a breast cancer diagnosed and my Aunt Maude got her cancer of the uterus at my age'. The meaning of the request for a Pap smear is revealed.

Extend the system

There will be many occasions when you will want to scream 'Help!' Relationship problems are as much a reason for seeking help as are technical problems. Help can be obtained by referral or transferral but can also be obtained by co-assistance. In my own practice we often (ie, two or three times a year) swapped heart-sink patients. One of us would 'wear' the patient for a while and then usually when the partner was on holiday, the other would take on the patient and then keep seeing the patient for a time after the vacationing partner returned.

If you see a 'battered wife', the external help you might seek will include resources (accommodation, financial assistance), legal advice (what legal obligations are you under to report?), support/advocacy (support groups, legal aid) and more expert medical help.

The one caveat is to ensure that the patient does not think you're trying to get rid of him or her. Conversely, if you are indeed referring to another doctor or agency for complete management, make sure the patient understands why.

Summary

These techniques for assisting in the management of difficult doctor-patient relationships satisfy the Gestalt test - any experienced general practitioner will have an instant sense that they sound right. But have they been proven effective? Over 20.000 doctors have attended one or other of the Bayer Institute's courses in the USA. Assessment forms collected at the end of each

workshop and follow up 5 weeks afterwards indicate the attendees perceived clear benefits were obtained from attendance. But that does not prove that the workshops produced behavioural change in the attendees or improved outcomes for both doctor and patient. With the assistance of Bayer Australia, an Australia wide program of workshops is proposed for the year 2000, with pre- and post-workshop attendance clinical audits, conducted in accord with RACGP protocols.

Insight into the problem is the necessary first step to solving it. Making the paradigm shift away from thinking of difficult patients to thinking of difficult relationships is the first step to managing such relationships better.