# TABLE OF CONTENTS

INTRODUCTION ................................................................. 2  
ACT ONE: IT’S YOUR FAULT .................................................... 5  
ACT TWO: IT’S THE SYSTEM’S FAULT ................................. 14  
ACT THREE: IT REALLY IS THE PATIENT’S FAULT .................. 25  
CONCLUSION ................................................................. 26  
WORKS CITED ............................................................... 28  
SCHOLASTIC VITA ........................................................... 29  
APPENDIX ................................................................. 30
INTRODUCTION

Most physicians and other practitioners will encounter difficult patients. For the purpose of this project I am not defining these “difficult” patients as those with elusive diagnoses or complicated therapies. I am instead using the word to denote those patients who have a difficult relationship with the physician, one characterized by conflict, compliance issues, and dread and disappointment on all sides. These difficulties are characterized by a lack or breakdown of communication, followed by a breakdown of understanding, and leading to dysfunction in the therapeutic relationship.

Communication is at the root of the therapeutic relationship, and failure of communication is most likely at the root of a failed therapeutic relationship. The clarity, timeliness, and sensitivity of human communication in health care is often critical to the physical and emotional well-being of all concerned. “In compiling a client’s case history the practitioner must be able to evoke clear, accurate and detailed information in order to diagnose the current state of health” (Kreps 2). These skills may not come naturally, but physicians must develop them in order to practice successfully. Training should help. Kreps notes that “skills and competencies are learned behaviors that have to be examined and practiced in order to be mastered” (3).

By examining communication issues in the physician-patient relationship, we can become aware of the stressors or potential breaking-points and try to find remedies. Physician-patient communication difficulties fall into three categories, which I will examine in detail in three acts of a slide show (see Appendix) in the
hope of providing ways for physicians to elude the illustrated pitfalls. This slide-show presentation is intended to be used as an educational tool for physicians-in-training as well as other providers. This thesis is intended to present a written account of the research that was done to prepare the slide show. The slide show has been prepared from my standpoint as a practicing physician. We providers are trained to work on challenging patients. Someone with a difficult diagnosis or complex treatment is a welcome challenge, encouraging us to use all our skills for our patient’s benefit. The purpose of this project is to create the same sense of challenge about encountering those “difficult” patients described earlier. When we react to this kind of difficulty as we do to a diagnostic challenge, we shift the focus from dread to professionalism and focus our problem-solving skills more appropriately.

Each of the “acts” of the slide show deals with a different aspect of communication breakdown. The boundaries are not always distinct, but I have created the divisions to provide a framework for discussion. Act One is titled “It’s Your Fault” and presents the argument that the physician can be the problem in the physician-patient dyad. Act Two, “It’s the System’s Fault,” discusses systemic problems, where communication issues result in problems but neither the physician nor the patient is really at fault. Act Three, “It’s the Patient’s Fault,” deals with those patients who truly are difficult.

There has been a great deal of research into physician-patient communication. Many of the works cited in this project are recently published, but they build on earlier theories. The field is still dynamic, with new wrinkles being added
to older strategies. The written part of this thesis is an enumeration of the re-
search. It is not intended as a synthesis of the research examined. Instead, the 
slide show synthesizes the cited research in an attempt to provide a coherent 
structure. In the slide show I have sometimes synthesized parts of different 
authors’ work in order to present a more easily understood example. Those 
authors’ individual theories are discussed in detail in the body of this work. The 
slide show will use case studies and other patient-centered examples to illustrate 
the theories I present in this thesis. In this way I hope to provide pragmatic dem-
onstrations of the ideas explored.

I use the word “fault” in an attempt to be brief. The show is not really in-
tended to find fault with anyone. The three act structure mimics the physician-
patient interaction, with the physician on one end, the patient on the other, and 
communication techniques forming the intermediary bridge. Just as the bounda-
ries between these three acts are blurry, the assignation of fault is also not abso-
lute. The concept of “fault” is a useful conceit for finding a starting point for the 
examination of those aspects of each of the three parts of the physician-patient 
interaction in order to improve them.
ACT ONE: IT’S YOUR FAULT

Physicians are expected to absorb a large amount of knowledge in a relatively limited time. To succeed in this task we learn shortcuts, mnemonics, heuristics. We also undergo training that is physically rigorous and can result in unclear thinking and emotional fragility. All of these factors can lead us into cognitive traps, resulting in poor diagnoses, ill-conceived therapies, and difficulties with communication.

Sometimes we ignore simple things. During an interview the physician should sit down, as Beeson explains: “When physicians sit during the course of an interview, it will significantly increase the patient’s perception of time spent with them compared to those who stand, without actually spending any more time” (28). It doesn’t take much effort to have an effect on our relationships with our patients, and the results can be remarkable. “Physician conduct and communication, and not necessarily untoward clinical outcomes, appear to be the principle [sic] predictors of malpractice risk” (Beeson 16). Relatively simple actions can have significant effects.

There are other ways that the physician can be at fault. The physician might make errors. “Medical errors in general, and diagnostic errors in particular, are common and of concern” (Berner S2). Medical errors are of special concern with an estimated rate of diagnostic error “approximately 15%” (Berner S3.) Because of time and other constraints, patient interviews are often truncated. “Physicians admit to having many questions that could be important ... but which they
do not pursue” (Berner S7). Overconfidence is also a pitfall, with many physicians believing that their practice “conforms to consensus recommendations when in fact it does not” (Berner S7). Finally, physicians can fall victim to their own autonomy. “Being a professional connotes possessing expert knowledge in an area and functioning relatively autonomously” (Berner S7). Collegial, cooperative oversight by other practitioners is the basis for peer-review, which attempts to provide a community that counteracts the pitfalls of the autonomous nature of many practices.

Autonomy and overconfidence result in cognitive errors. These “cognitive errors reflect problems gathering data, such as ... failure to recognize the significance of data, or ... failure to synthesize” (Berner S7). The cause of some of these errors may be related to reliance on heuristics. Heuristics are “powerful clinical tools that allow problems to be solved quickly and, typically, correctly” (Berner S8). For example, a sore throat with pus on the tonsils, accompanied by fever, headache and abdominal pain is usually strep throat. However, sometimes reliance on heuristics may result in premature closure, or “narrowing the choice of diagnostic hypotheses too early in the process” (Berner S8). Reliance on heuristics may also result in confirmation bias, which is “the tendency to seek out data that confirm” a diagnosis (Berner S8), and in context errors, in which other information creates a bias and the context of the problem is wrong (Berner S8). Our patient with strep throat may actually have mono, but we “lock in” the diagnosis before we examine the spleen (confirmation bias), or do not consider the diagnosis because our patient is not fatigued (context errors).
Reliance on heuristics can be a pernicious problem, because “as physicians gain experience and expertise, most problems are solved by some sort of pattern recognition process” (Berner S9). Reliance on heuristics can cause overconfidence precisely because heuristics are a valuable tool and work most of the time. Using heuristics gives us a false sense of expertise when in fact “expertise is characterized by the ability to recognize when one’s initial impression is wrong and to having back-up strategies readily available when the initial strategy does not work” (Berner S9). We may not use these back-up strategies (self-monitoring) and may not even realize that we should (complacency). If physicians are not trained well enough, they reach an intermediate state, where they are vulnerable to complacency, which “reflects a combination of underestimation of the amount of error, tolerance of error, and the belief that errors are inevitable” (Berner S9). Furthermore, complacent “physicians acknowledge the possibility of error, but believe that mistakes are made by others” (S10). We may acknowledge the possibility of error but believe errors are made by others. We may become overconfident of our diagnoses and unaware of our shortcomings. Most compellingly, according to Berner’s work, “physicians who were least expert tended to be most overconfident in their self-assessments” (S11).

To communicate effectively, the physician must be willing to participate in an engaged interaction, understanding her “patient’s biological functioning within the broader context of social and emotional well-being, family and community life, and cultural values” (Frankel 60). In other words, “action at the biological level is seen as mediated by social and psychological forces” (Frankel 61). A physician
must ignore conventional thinking that “the traditional positioning of providers and patients unifies their efforts toward finding patterns that fit a diagnostic category or medical model” (Geist 235). Medical communication is much more complex. The patient may have a significant level of non-medical concern that is having an impact on the medical complaint. The traditional model does not address this non-medical data. Geist and Dreyer argue for patient-centered medicine, where patients bring “essential” information to their encounter with their physician. This model espouses balanced communication, a form of dialogue that physicians may resist. Physicians may have learned to focus on technical maneuvers instead of their patient’s emotional state. Patients may be constrained by their perception of the physician as too busy or too aloof to be bothered by patient concerns. There is also a natural tension between those who have experience and those who are naive. The provider has handled a similar problem before, but the situation is new to the patient, resulting in a disconnect between time demands of the physician and the patient’s need for explanation (Geist 235-240).

Young and Klingel also argue for a different, more collaborative model. “Informed consent and public education do not guarantee that patients will be able and willing to actively participate in the medical encounter” (Young 30). “Many physicians believe that collaborative practice will jeopardize, rather than facilitate, the delivery of medical care” (Young 30), and so resent this collaboration. They fail to appreciate that “active patient participation in collaborative medical practice means shared responsibility and shared decision-making” (Young 32). Also, “communication exchanges between physicians and patients must contain some
component that leads to patient commitment in addition to patient education” (Young 33). Physicians may fail to realize that “patient participation decreases misunderstandings and unrealistic expectations” (Young 34) and that “cultural norms influence an individual’s ability to be assertive” (Young 35). “It is crucial that the patient be convinced that communication with the doctor is both helpful and achievable” (Young 38).

Interestingly, this model may explain the occurrence of some difficult patients. When a humanistic viewpoint is ignored, patients are marginalized as being “incapable of participating in the relationship” and described in pejorative terms: “disturbed, personality disorders, lacking knowledge, etc.” (Geist 237). “In this view of the relationship there is justification for not communicating” (Geist 238). So problem patients are said to have “personality conflicts” and “differences of opinion” (Geist 238) with their physicians. Since it is difficult to communicate in this situation, it is permissible for the physician to give up trying. Patient-physician interaction is devalued, and will not occur.

The physician’s mood may even affect an interaction. Slovic points out that “images, marked by positive and negative affective feelings, guide judgment and decision making” (400). He notes that our emotional response to a situation may be strong enough to override our cognitive functions. Also, “even very important attributes may not be used by a judge or decision maker unless they can be translated precisely into an affective frame of reference” (406). In other words, our emotional frame of reference has a strong influence on our thinking. If we can’t relate to an issue emotionally, we may not be able to process it correctly.
Slovic also notes that “emotional responses to risky situations ... often diverge from cognitive evaluations and have a different and sometimes greater impact on risk-taking behavior than do cognitive evaluations” (415). In other words, we physicians fail to note our lack of emotional connection, or that our emotions cause a bias in our reactions. We do not recognize that this emotional response colors our interaction with the patient and may not realize that our actions are ill considered, rash, or not appropriate to the medical situation, increasing the risk of difficulties in the physician-patient interaction.

Croskerry et al. also comment on the physician’s internal state as it affects the physician-patient encounter: “How doctors feel [is] a ... worthy topic for investigation, especially for any effects on clinical decision making and patients’ safety,” and “specific clinical situations provoke lesser or greater degrees of affective valence” (1205). In Croskerry’s model, “decision making occurs through one or a combination of two modes: Intuitive, which is fast, automatic, often involves an affective component, and uses few resources; and Analytical, which is slow, deliberate, affect free, and resource intensive” (1206). “Most errors of judgement occur in system 1 [the Intuitive system]” and “heuristics (mental shortcuts, maxims, rules of thumb) and biases also occur” (Croskerry et al. 1206). Also, “some patients will elicit affective responses” that could be “negative and lead to labeling, patients being referred to as complainers, difficult, high maintenance, or worse” (Croskerry et al. 1206). We should worry that “the best evidence might be degraded when it is unconsciously passed through an affective filter” (Croskerry et al. 1206). A patient who causes disgust because of intrusive
body odor may not get a thorough interview or exam because of the physician’s response to the odor. A patient whose actions seem strange or rude may be dismissed before valuable information can be gathered.

Communication failure may also be a result of physician failure. Physicians may rush through patient interviews or may be unskilled at taking a thorough history. According to Frankel, in “only 23% of visits was the patient provided an opportunity to complete his or her opening statement of concerns” (65). Despite the interruptions of the patient’s opening statement, which impair communication in order to save time, Frankel found “the cost of obtaining a full enumeration of problems at the outset of the visit is relatively small, two and one-half minutes at the most” (65).

Physicians can be insensitive to their patients’ lack of medical sophistication. When this happens, “physicians acknowledge patients’ lack of medical knowledge as an obstacle to effective communication” and “providers believe that patients’ passiveness mandates that they control the provider-patient relationship” (Geist 240). Physicians are prone to follow the “traditional ideology” that “it is ‘easy’ to treat diseases” rather than patients (Geist 241). However, “over half of all ambulatory care encounters ... involve conditions that are not disease-based, and thus fall outside the range of the traditional biomedical model” (Frankel 61). If we try to shoehorn these encounters into the traditional medical model, patients may resort to non-compliance out of frustration. We must remember Frenkel’s analysis: “When a medical practitioner reaches a firm diagnostic conclusion and develops a rational treatment plan, it is frustrating to find the
patient either dropping out of treatment or failing to get well” (63). “Non-
adherence may result from feelings of anger or helplessness created by an
overly narrow or strictly biomedical approach to problem solving” (68). We
should not forget that “patients who are not given a full opportunity to express
their concerns may respond by dropping out of treatment ... because they lose
confidence in their provider’s ability to assess and deal with all of their concerns”
(70).

Physicians should not be surprised by noncompliant patients. Frankel
points out that “20 to 80% of patients do not follow the recommendations of their
providers” (63). So why don’t patients follow our advice? Perhaps it is our atti-
tude. “Traditionally, non-adherence has been viewed either as a lack of patient
motivation, education, or knowledge, or as a failure on the part of the practitioner
to persuade” (63). If we consider the more modern interpretation of conversation
analysis where “speakers and hearers continually negotiate meaning in and
through conversational exchange and in so doing create social reality” (61), then
now we consider the “possibility that non-adherence might be linked to the dy-
namics of speech exchange during the medical encounter” (63), and we under-
stand that “leaving treatment as a consequence of not having one’s concerns
fully addressed is the most dramatic form of non-adherence” (65). “Non-
compliance ... illustrates how a shift in analytic focus can be useful in changing
our understanding of an existing problem” (62-3). “Unless treatment decisions
and regimens are negotiated with patients, non adherence may follow either be-
cause they are too difficult ... to undertake or because the patient disagrees with the recommendation” (70).

In addressing the range of cognitive errors that occur in the physician-patient interaction, Croskerry describes the “capricious nature of decision making” (776) and provides an encyclopedic list of “Cognitive Decisions to Respond” (775, 778-789) and “Debiasing Strategies,” including such things as insight, specific training, simulation and feedback (779). A thorough knowledge of the pitfalls of communication and strategies to avoid them will help the physician avoid error-producing behaviors.
ACT TWO: IT’S THE SYSTEM’S FAULT

We can view the interaction of physician and patient as a system. When this system fails, there are several possibilities. None of these requires blaming a part of the physician-patient dyad. Sometimes the system just doesn’t work:

Practitioners are often unaware of the ways in which their messages may frighten or confuse clients. Clients often fail to recognize how important it is for them to explain their symptoms clearly and fully to their health care providers in order to receive appropriate treatment. Both clients and practitioners report frustration and dissatisfaction in their health care encounters with others (Kreps 5). Failed communication is a system fault, not a personal one. There is a great deal of literature regarding the problems of communication and remedies for those problems. Most deal with models of systems that increase effective communication and decrease miscommunication. These rely on the benefit of cooperation: instead of viewing client noncompliance as a maladaptive client characteristic, it is more productive to view the problem as related to the kind of communication relationship established between the client and the practitioner” (Kreps 7).

Emanuel and Emanuel provide an excellent overview of the types of interaction between physician and patient. They note that the patient’s role in medical decision making has become “a conflict between autonomy and health, between the values of the patient and the values of the physician” (2221). This conflict has impact on “the ethical and legal standards for the physician’s duties, informed consent, and medical malpractice” (Emanuel 2221). In other words, if there is disagreement on goals of treatment, or even appropriateness of certain
tests or therapies, whose opinion rules? Do our patients have the right to demand any test, even if not appropriate, or any therapy, even if futile? If the disagreement cannot be resolved may we providers discontinue the therapeutic relationship without being guilty of abandonment? The Emanuel’s models--the paternalistic, informative, interpretative, and deliberative--are related to autonomy and values, with the goal of finding the most appropriate integrated interaction and the prevention of dilemmas like those outlined above.

In the Emanuels’ Paternalistic Model there is the assumption that there are “shared criteria” (2221) for improving the patient’s situation. There is little patient autonomy, and the assumption is that the physician always knows best. Although physician training is evolving, many of us have been trained in the Paternalistic Model (PM) of medicine. In the PM, a physician-patient encounter goes like this: A patient presents to his physician with a complaint. After appropriate questioning, examination, and testing, the physician tells the patient what is wrong and what to do to make it better. There are many objections to the Paternalistic Model. It does assume that the physician has the best interests of the patient at heart and is trying to help (beneficence). However, the physician is assumed to have a narrow focus and may neither explore all the necessary psychosocial factors (Can the patient afford the treatment? Is there a culturally more palatable plan?) nor consider the patient’s input into the treatment plan.

Rather than abandoning the Paternalistic Model, I would argue for an expanded definition. Since the PM springs from the ideal of beneficence, can we not expand paternalism to include some of the techniques outlined in the more
“enlightened” models discussed? In other words, is my physician not able to expand the exploratory part of the encounter to include more of what other models desire? Can she not then maintain her authority while still being collaborative? Collaboration and cooperation are beneficial, but at some point there needs to be an authority, even if that authority is guiding rather than prescribing. Otherwise, a failure to reach a plan may result.

In the Emanuels’ Informative Model, the physician provides all relevant data and the patient selects the appropriate intervention (2221). In their Interpretive Model, the physician and patient interact, then “elucidate the patient’s values ... and [work to] help the patient select the available medical interventions that realize these values” (2221). Finally, in the Deliberative Model, physician and patient interact to help the patient “choose the best health-related values that can be realized in the clinical situation” (2222).

In all models, Emanuel and Emanuel discuss autonomy, focusing on specific interventions that allow the selection of values, and result in choices that stem from those values. They note that “freedom and control over medical decisions alone do not constitute patient autonomy. Autonomy requires that individuals critically assess their own values and preferences” (2225). In their ideal interaction, disagreements result in discussions of values (2226). These discussions result in a more integrated interaction:

The essence of doctoring is a fabric of knowledge, understanding, teaching, and action, in which the caring physician integrates the patient’s medical condition and health related values, makes a recommendation on
the appropriate course of action, and tries to persuade the patient of the worthiness of this approach and the values it realizes” (2226).

Geist and Dreyer provide definitions that are helpful in the discussion of autonomy versus cooperation: “The false unity of self is represented in the view of the patient as an intact unity formed before entering a relationship” (234).

Each part of the physician-patient dyad may have unrealistic expectations. “Absent from the dialogic perspective is the naive view of the patient as an unbiased reporter of biological facts and the view of the provider as an unbiased listener objectively constructing scientific truth” (Geist 235). Instead, “the traditional ideology of medical care and the role that providers and patients idealize in their relationship is represented in the interpretations of this relationship” (Geist 237). As we have seen earlier, the physician may bring biases to the physician-patient interaction. Geist and Dreyer are saying that patients also bring biases, are sometimes unreliable (not on purpose), and fall into the role of patient that has been promulgated as the “traditional” patient. This “traditional” patient will not get the full benefit of the more enlightened models outlined above.

Resistance to these enhanced models and to the abandonment of the PM may occur: “Patients may be reluctant to participate ... for any number of reasons” (Geist 236). This systemic failure can be bilateral: “Rather than embracing the differentiation inherent in a relationship, typically providers and patients communicate in ways that define their participation as static, fitting the roles prescribed by the traditional medical ideology” (Geist 236). Physicians talk to patients and patients respond. The patterns are well established, entrenched in
models like the PM. Achieving a more flexible communication model may require an expedition outside the comfort zone of both physician and patient. Encouraging this more flexible model may require more effort and courage than many physicians and patients can muster.

There is also the problem of miscommunication. “Miscommunication does not mean that communication has not occurred. It means that often the meanings that communicators create in response to messages sent to them are very different from the meanings that were intended” (Kreps 7), and “miscommunications and missed opportunities are rooted in mismatched expectations on the part of both the provider and the patient” and in “a failure to see the patient-provider interaction as a rhetorical knowledge-building event” (Young 69). We fail to see “the medical encounter as a complex rhetorical interaction, where both parties must negotiate needs, expectations, interpretations, and goals ... based on mutuality and autonomy, or shared values and shared decision making” (Young 71).

Young and Flower propose a different model, Collaborative Interaction (CI). CI builds on the concept of collaboration and cooperation. It “includes dialogue, problem solving, and knowledge building” (71). CI expands the rhetorical model, including argument, empathy, and shared agency, and relies on the autonomy of patients. These patients bring their own perspective and logic to the effort of problem solving (75-79)

Collaborative Interaction addresses non-compliance, explaining that it results from “competing interpretations” and is countered by shared knowledge and
empathy. Shared knowledge improves patient-provider relationships, and empathy improves understanding by moving beyond emotion (75-78). Arguing that “situational constraints, including time factors, language barriers, and gaps in cultural understanding, perpetuate the social norm that patients are passive recipients of a ‘sterilized’ medical expertise that ignores their real-life situation” (78), they focus instead on “reciprocal, problem-solving relationships” (79) that “allow patients to represent their medical problems in the context of their life experiences and to define, both for themselves and for the provider, the logic that directs their health care decisions” (79).

“CI rejects the paternalistic model, which poses the physician as ‘guardian’ and the informative model, which poses the physician as ‘competent technical expert’ ” (Young 83). CI promotes the physician as “counselor or advisor” and a “friend or teacher” working with the patient to develop shared values or goals. Patients make choices and take action. Sometimes those choices and actions are not effective in promoting their health status. Sometimes interactions are hampered by “a mismatched frame of reference for the medical problem” or a “lack of understanding of each person’s role in the medical interaction” (Young 85-88). Young and Flower provide an important definition of the encounter we hope to have:

An optimal medical encounter is an experience that validates the expertise of both patient and provider and that dignifies the patient’s needs through out the entire sequence of treatment. In a problem solving relationship,
patients and providers concentrate on negotiation and shared agency, rather than compliance (89).

They also explain problems with control: “A patient’s sense of control is compromised when the patient and providers have different goals and expectations for a particular visit or regimen of care” (92). If a patient wants a test or treatment that is not medically appropriate, then conflict can result. Negotiations that give the patient a sense of control over her treatment can prevent a breakdown of the physician-patient relationship.

Kreps is helpful in defining those problems that may sabotage our system of communication. He notes that unrealistic expectations can be one source of sabotage: “Studies have indicated that health care professionals and clients tend to stereotype one another” (8), and reminds us that these expectations “are based on over-generalized perceptions and stereotypes of the people involved in the health care system” (10). He also mentions lack of sensitivity, which “causes people to communicate callously with one another, and precipitates the breakdown of health care relationships” (10), and calls for improved intercultural communication: “In a society in which one in four people are people of color, none of us can afford to remain ignorant of the heritage and culture of any part of our population and therefore understanding both differences and similarities is important (159).

Smith and Pettetegrew propose a slightly different model. They caution that “the role of the healer has involved exercise of authority and power. That role has
been misused from time to time” (127). In their model, “communication is also a
pragmatic necessity” (128), and

when persuasion is viewed in the context of mutuality and when it is based
on the ethic which has traditionally distinguished rhetoric from sophistic, it
provides a way of balancing individuality and interdependence in the
physician-patient relationship (128).

Smith and Pettigrew conclude that “three concepts are prominent: paternalism,
autonomy, and shared decision-making” (128). With regard to paternalism they
note that “the exercise of physician authority through paternalism can be charac-
terized as in conflict with the patient’s desire to exercise self-determination and to
maintain autonomy” (128). Furthermore, it is “only in the mutual participation
model that the mutuality of influence by physician and patient is recognized”
(129). They note that “patient participation ... leads to better outcomes” (129),
while paternalism does not “involve talk about the patient’s values” (131) and
“compliance necessitates a dominant-submissive relationship” (133). They argue
instead that “stable, secure relationships are likely to feature more candor and
directness, not less” (137). They do admit that “the positive side of paternalism is
beneficence” (137), but we need additional positives, including free choice, which
is “based on ideas, values, arguments, and information” (139). With free choice,
“the patient’s decisions are influenced by proper discourse” (139). Patients do
not enter into the physician-patient relationship without their own agenda, and
“no patient seeks medical care without a desire to influence the physician” (140).
In this model the physician must persuade, rather than dictate, and persuasion “requires an ethical concern” (Smith 141).

The medical interview is another place where the physician-patient communication system is vulnerable. The mechanics of the interview system can be problematic. In “The Demise of Dialogue,” Geist and Dreyer provide an excellent overview of the problems they perceive in traditional medical interviewing. This concept of the problematic traditional interview is important, since all the information that bears on the subsequent interaction is obtained during the medical interview. Geist and Dreyer stress the global nature of those issues brought into any encounter:

Recognizing that the medical encounter is essential to attaining health care and that it is embedded in a context of social and economic issues that impinge upon the provider-patient relationship, it becomes crucial to examine the interpretations that providers and patients form (233).

They emphasize the individuality of the participants, noting that “through communication, providers and patients form a unity of understanding in conversation, but only through two clearly differentiated voices” (234). Both voices are heard, but communication requires synthesis, each hearing the other and reaching consensus and understanding, followed ultimately by agreement.

The failure of dialogue does not just affect the physician. The relative inexperience of the patient creates its own systemic difficulties. The physician is experienced, having participated in many physician-patient interactions before, while the patient is naive. The time demands of the physician and the need of the
patient for explanation will result in a level of conflict (Geist 238). The patient’s naive can seem inexplicable. Geist and Dreyer give an example of a patient who doesn’t like her doctor because he is “controlling,” yet admits “He knows what’s better for me” (239). Physicians are cautioned to remember that in the hospital “patients find themselves in a strange, complex, and frightening environment” (Geist 239). In this situation, patients require more time for reassurance and explanation, and may not seem to understand because they are overwhelmed by the environment.

Geist and Dreyer stress understanding as the essence of communication: dialogue “create[s] something that never existed before--something absolutely new and unrepeatable, and it always has some relation to value” (244). To achieve this understanding it is essential that “interviewers, through dialogue, must encourage respondents ... to tell their stories” (245). Young and Flower provide some practical means of achieving this improved communication. They suggest “Collaborative communication ... a rhetorical practice that generates building blocks for a more complete and coherent diagnostic story ... by situating patients as problem solvers” (69).

To summarize, the rhetorical (mutual persuasion) model would “emphasize persuasion of another choosing freely on the basis of reasons “ and “Per-suasion takes ... an acceptance of the beliefs and values of the other” (Smith 143). Increasing the physician’s rhetorical skills will allow her to achieve the goal of patient involvement. Many of these models look to this ultimate result. The physician helps the patient to achieve understanding of whatever problem has
been presented, and strives to understand the patient needs that ensue from the basic problem. The patient then explores solutions to the problem, using the physician’s expertise and counsel. Both the physician and the patient then arrive, through negotiation and consensus, at the treatment plan that is best for the situation.
In his 1978 article, Groves provides insight into the difficulties we encounter when taking care of “hateful patients.” Groves is reassuring, validating those feelings that we all have, noting that “a few patients kindle aversion, fear, despair or even downright malice in their doctors” (883). We are reassured to be told that “emotional reactions to patients cannot simply be wished away, nor is it good medicine to pretend that they do not exist” (Groves 883). What is important about Groves’s work is that we are given not only insight into the causes of this hatefulness, but also strategies for dealing with these unfortunate souls.

Groves notes that hateful patients have “insatiable dependency” (883). Reactions to these patients “constitute important clinical data that should facilitate better understanding and more appropriate psychological management” (883). This is a remarkable and helpful shift of viewpoint. Instead of dread and avoidance, we are now presented with clinical problems--they can be categorized and sorted--and they can be treated like any other illness. This lets us rise to the occasion of a clinical challenge. If we are doing our jobs well, we analyze and treat a difficult patient in the same manner we do an undiagnosed anemia. This response is not one that is taught in traditional curricula. “Nowhere does [Osler] allude to personal feelings that the difficult patient may stir up” (Groves 884).

Groves describes four different archetypes of hateful patient. The first, dependent clingers, “escalate from mild and appropriate requests for reassurance to repeated, perfervid, incarcerating cries for explanation, affection, analgesics, sedatives and all forms of attention imaginable” (Groves 884). In doing so, they
reveal a “self perception of bottomless need and their perception of the physician as inexhaustible” (Groves 884) When the physician makes an attempt to address this neediness they exhibit “genuine gratitude, but to an extreme degree” (885). Because they are insatiable, any attention from the physician is, ultimately, not enough. Boundaries must be established in order to maintain some sort of therapeutic relationship. The “clinger ... must be told that the physician [is only] human” (Groves 885) and limits to the clinger’s demands can be set.

Groves’ second archetype is the entitled demander. This patient exhibits a “profundity of ... neediness but ... use[s] intimidation, devaluation and guilt induction” (885) to achieve his goals. This is the patient who will wear down the physician with endless arguments, interspersed with threats and attempts to blame. To avoid these extraneous arguments and discussions, the physician should use “tireless repetition of the theme of acceptance that the patient deserves first-rate medical care” (Groves 885). We can agree that the patient is entitled to care, without agreeing that the care requested (or demanded) is appropriate.

The third archetype is the manipulative help-rejecter. These are the patients we characterize as “crocks,” who resort to “pessimism and tenacious naysaying” (Groves 885). The physician may suggest several treatments for what are expressed as extremely troubling ailments, only to have them all rejected as being “not right” or “not for me.” The most effective treatment for these manipulative help-rejecters is “gentle, simple reasoning” (Groves 886).
The final archetype is the self-destructive denier. These patients are frequently most troubling because they “display unconsciously self-murderous behaviors” (Groves 887). This type includes patients whose non-compliance may be severely damaging, such as diabetics who don’t take their insulin, despite several previous hospitalizations. Optimal care “entails a psychiatric consultation for the patient to ascertain whether treatable depression” (Groves 887) is part of the diagnosis.

Groves notes that “the physician routinely helps most patients establish better contact with reality, better adaptation to painful illnesses and better relations with families, friends and other caregivers” (887). Hateful patients seem to find a way to sabotage caring behaviors. This sabotage results in physician frustration, depression and, when turned outward toward the patient, hateful feelings. We should note that “disavowal of hateful feelings requires less effort than bearing them. But such disavowal wastes clinical data that may be helpful in treating the ‘hateful patient’ ” (Groves 887).
CONCLUSION

We can see many pitfalls in the physician-patient relationship. Whether physician-centered, patient-centered, or related to the process of interaction, effective communication is the thread that runs through all the possible permutations of and remedies for maladaptive interactions. I have tried to demonstrate the theoretical basis for the points I will emphasize in the slide show. The slide presentation attempts to take this basic research and make it speak to those who are, or will be, in clinical practice. I will take these basic principles and illustrate them with simple examples, including case studies that speak to the basis of the main talking points. I hope to humanize this research and, by doing so, make it relevant and easy to relate to, encouraging a wide range of responses. Difficult patients need care, too, and their very nature puts them at risk of not receiving what they need. As physicians we must not succumb to frustration and deny care to those who need it. That is the message of this project.
BIBLIOGRAPHY


CHRISTOPHER W. GRONER

BORN:  
June 20, 1951, Kansas City, MO

UNDERGRADUATE STUDY:  
Dartmouth College  
Hanover, New Hampshire  
B.A., English Literature, 1973

GRADUATE STUDY:  
University of Kansas School of Medicine  
Doctor of Medicine, 1976

POSTGRADUATE STUDY:  
Bowman Gray School of Medicine, Wake Forest University  
Residency in Family Medicine, 1979

SCHOLASTIC AND PROFESSIONAL EXPERIENCE:

Chief of Staff, Hugh Chatham Memorial Hospital

Board of Trustees, Hugh Chatham Memorial Hospital

Medical Staff, Active Member, Hugh Chatham Memorial Hospital

PROFESSIONAL SOCIETIES:

Board Certified: American Academy of Family Physicians

Fellow: American Board of Family Medicine
Dealing with Difficult Patients

Christopher W. Groner, M.D.

Definition of difficult, as a patient who is vexing, causing an emotional reaction such as dread.
Remember Why We’re Here

Remember what a privilege we have.  
Tell the story of my first patient.  
What makes a difficult patient.  
Differentiate between challenging and difficult
Patient One

- 67 year old female.
- Recent 20 pound weight loss.
- Abdominal pain
- Swelling in left supraclavicular fossa.

Ask for possible diagnoses, implications.
Patient Two

- 67 year old female.
- Recent ten pound weight loss.
- Normal physical exam.
- Mental status exam shows extreme anxiety, depression, neediness and hostility.
- Brings a list of twelve complaints to the visit.

Possible diagnoses and implications.
Which one would you prefer to care for?
➢ Which one will be alive in five years?

Discuss which patient will require more care over time.
The Basic Question

- How can we make our experience with patient two as exciting and challenging as our experience with patient one?
Goals

- Make caring for difficult patients as rewarding as it can be.
- Eliminate the stigma from these patients.
- Increase comfort for the providers.
- Provide a framework for reacting appropriately to these patients.
- Review the literature, especially regarding communication theory.
Remember

- They might be right.
➤ They might be right.
Patient Three

- 32 year old female.
- Complaint: I’m afraid I have cancer.
- HPI: slowly enlarging tumor in lower abdomen, constipation, pain.
- PMH: G1P1, told after her delivery she had premature ovarian failure, put on HRT.
- Stopped HRT after several years. “Too much trouble.”
Patient Three

- Physical Exam: 24 week uterine fundus with audible fetal heart tones.
- Delivered at term a healthy male infant.
Patient Four

- The son of patient three.
- Now 11 years old.
- Healthy, has had problems with hyperactivity, treated with behavioral methods and school accommodation.
- Mother complains that he is more “hyper” than usual, and has lost 4 pounds in the last few months.
- Wants thyroid testing.
Patient Four

- Physician is skeptical but agrees to testing.
- Results: FTI and T4 elevated. TSH suppressed.
- Patient responds well to thyroid suppression therapy.
Act One: It’s Your Fault

➢ Sit down.
Act One: It’s Your Fault

- Sit down.

- “When physicians sit during the course of an interview, it will significantly increase the patient’s perception of time spent with them compared to those who stand, without actually spending any more time.”
Act One: It’s Your Fault

➢ Touch your patient.
Act One: It’s Your Fault

- Touch your patient.

- The sad hilarious story of my first patient.
Act One: It’s Your Fault

➢ Be aware of your mood.
Act One: It’s Your Fault

- Be aware of your mood.
- “Some patients will elicit affective responses” that could be “negative and lead to labeling, patients being referred to as complainers, difficult, high maintenance, or worse.”

Croskerry, et al. (1206)

Our emotional response may affect how we respond to our patients. Patients who are physically offensive or behaviorally difficult may not get the full benefit of our time and energy.
Act One: It’s Your Fault

➢ Be aware of your prejudice.
➢ Everyone is somebody’s grandmother.

No matter what the patient seems like, they are and have family. We can all relate to our “outlier” family members who are still loved and cared for, even when they are difficult.
Act One: It’s Your Fault

- Listen to your patient.
Act One: It’s Your Fault

- Listen to your patient.
- In “only 23% of visits was the patient provided an opportunity to complete his or her opening statement of concerns.”

Frankel (65)
Act One: It’s Your Fault

- Listen to your patient.
- “The cost of obtaining a full enumeration of problems at the outset of the visit is relatively small, two and one-half minutes at the most.”

Frankel (65)
Act One: It’s Your Fault

- Listen to your patient.
- “Patients who are not given a full opportunity to express their concerns may respond by dropping out of treatment … because they lose confidence in their provider’s ability to assess and deal with all their concerns.”
  
  Frankel (70)
Act Two: It’s the System’s Fault

- You may have learned the wrong things in school.
Act Two: It’s the System’s Fault

➢ You may have learned the wrong things in school.

➢ Beware the Paternalistic Model.
  • Emanuel and Emanuel, JAMA, 1997.

In the PM the doctor evaluates the patients complaint, formulates a treatment, and prescribes it without much feedback. The patient’s contribution to the ultimate plan of therapy is quite limited.
Act Two: It’s the System’s Fault

- You may have learned the wrong things in school.
- Informative Model
- Interpretive Model
- Deliberative Model

Informative—physician provides all relevant data, patient selects intervention.
Interpretive—physician and patient work to help the patient select intervention that matches patient’s values.
Deliberative—best intervention in the entire clinical situation.
Act Two: It’s the System’s Fault

- Collaborative Interpretation as described by Young and Fowler.
- “Shared knowledge is the key to more effective patient-provider relationships” (76).
- Empathy is “a cognitive process that moves beyond emotion” (78).

CI employs knowledge building, empathy, and shared agency. In other words, the physician and patient cooperate to form a problem-solving relationship.
Act Two: It’s the System’s Fault

- Collaborative Interpretation as described by Young and Fowler.
- Physician is counselor or advisor and friend or teacher “who works with the patient to develop shared values or goals” (83).
Act Two: It’s the System’s Fault

- Collaborative Interpretation as described by Young and Fowler.
- “An optimum medical encounter is an experience that validates the expertise of both patient and provider and that dignifies the patient’s needs throughout the entire sequence of treatment. In a problem-solving relationship, patients and providers concentrate on negotiation and shared agency, rather than compliance.”
  
  (Young 89)
Act Two: It’s the System’s Fault

- The essence of doctoring is a fabric of knowledge, understanding, teaching, and action, in which the caring physician integrates the patient’s medical condition and health related values, makes a recommendation on the appropriate course of action, and tries to persuade the patient of the worthiness of this approach and the value it realizes.

  Emmanuel and Emmanuel (2226)

Not all encounters are the same. Some simple encounters are best served by the PM. A good physician will get the feel for when a different strategy is needed. Knowing these other methods is necessary to knowing when to employ them.
Act Two: The Future

➢ The Kalamazoo Conference
Act Two: The Future

➢ The Kalamazoo Conference

Build a Relationship

- Patient-centered or relationship-centered approach to care, emphasizing the patient’s disease and his or her illness experience.
- Requires an awareness that ideas, feelings and values of physician and patient influence the relationship.
- The relationship is a partnership.
Open the Discussion

- Allow the patient to complete his or her opening statement.
- Elicit the patient’s full set of concerns.
- Establish/maintain a personal connection.
Gather Information

- Use open-ended and close-ended questions appropriately.
- Structure, clarify, and summarize information.
- Actively listen using nonverbal (e.g., eye contact) and verbal (e.g., words of encouragement) techniques.
Understand the Patient’s Perspective

- Explore contextual factors.
- Explore beliefs, concerns, and expectations about health and illness.
- Acknowledge and respond to the patient’s ideas, feelings and values.

Contextual factors: family, culture, gender, age, socioeconomic status, spirituality
Share Information

- Use language the patient can understand.
- Check for understanding.
- Encourage questions.
Reach Agreement on Problems and Plans

- Encourage the patient to participate in decisions to the extent he or she desires.
- Check the patient’s willingness and ability to follow the plan.
- Identify and enlist resources and supports.
Provide Closure

- Ask whether the patient has other issues or concerns.
- Summarize and affirm agreement with the plan of action.
- Discuss follow-up (e.g., next visit, plan for unexpected outcomes.)
Act Three: It’s the Patient’s Fault

- Bad Chemistry
Act Three: It’s the Patient’s Fault

- Bad Chemistry
- “As he walked across the parking lot, the bad chemicals in Dwayne Hoobler’s head made him think the asphalt was as soft and spongy as marshmallows.”
  - Paraphrased from Kurt Vonnegut
Act Three: It’s the Patient’s Fault

- Bad protoplasm.
Act Three: It’s the Patient’s Fault

- Bad protoplasm.
- Patient Five: 58 yo female, with symptoms of depression, very resistant to therapy, failed several psychotropics.
- Finally agreed to psychiatric consultation.
Act Three: It’s the Patient’s Fault

- Bad protoplasm.
- Patient Five: 58 yo female, with symptoms of depression, very resistant to therapy, failed several psychotropics.
- Psychiatric consultant found significant depression, also markedly decreased functional status that precluded insight psychotherapy.
- What is the lesson here?

The lesson is that we have prejudices about functionality. A patient who appears in the office, well dressed and on time is assumed to have a certain functional status. This may not be true. Just because everyone in your neighborhood is functioning well, doesn’t mean that it’s that way all over.
Act Three: It’s the Patient’s Fault

- “A few patients kindle aversion, fear, despair or even downright malice in their doctors” (883)
Act Three: It’s the Patient’s Fault

- “Insatiable Dependency”
Act Three: It’s the Patient’s Fault

- Dependent Clingers
- Entitled Demanders
- Manipulative Help Rejecter
- Self-Destructive Denier
Act Three: It’s the Patient’s Fault

- Dependent Clingers
- “Escalate from mild an appropriate requests for reassurance to repeated, perfervid, incarcerating cries for explatation, affection, analgesics, sedatives and all forms of attention imagineable” (884).
- Treatment: set limits and reinforce that the physician is only human.
Act Three: It’s the Patient’s Fault

- Entitled Demanders
- “Profundity of … neediness but … use intimidation, devaluation and guilt induction” (885)
- Treatment: Agree that the patient is entitled to care, without agreeing that the care requested (or demanded) is appropriate.
Act Three: It’s the Patient’s Fault

- Manipulative help-rejecters:
  - These are the “crock”s and pessimists, who reject all treatments.
  - Treatment: “Gentle, simple reasoning.”
    (Groves 886)
Act Three: It’s the Patient’s Fault

- Self-Destructive Denier: “display unconsciously self-murderous behaviors.
- Treatment: psychiatric consultation for treatable depression

Groves (887)
Parting Thoughts

- Be self-aware.
- Be aware of how you interact.
- Be aware of how your patients interact.
Parting Thoughts

- Patient Six: 68 yo male, severe generalized atherosclerosis.
- Refused to quit smoking, would not follow dietary advice.
- Was very pleasant, self-aware, acknowledged his self-destruction.
- Died from CVA, cardiac complications.
Parting Thoughts

- Included his physician in his will.
- One bottle of premium Scotch whiskey every year at Christmas.
Parting Thoughts

- We must take care of everyone.
- Some days it’s hard to tell the angels from the rest.