Difficult Patients/Difficult Situations 4

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INTRODUCTION

Whenever and wherever health professionals congregate, it does not take long for them to bring up the topic of difficult patients. Patients and families we experience as difficult often increase the frustration and decrease our satisfaction with work. They make it difficult to deliver the person-centered care that is at the heart of high-quality, satisfying, and effective health care. Why, we ask, would someone come to the office, emergency department, or hospital and harass, abuse, demean, or lie to us?

Fortunately, most difficult interactions are both diagnosable and repairable. Apart from the rare patient who seems determined to be difficult, most problematic situations are created by unsatisfactory communication between practitioners and patients or by personal issues the practitioner or patient unknowingly bring into the visit. Such issues can mirror similar problems within the practitioner's own world and provoke negative reactions to an inherent or overt aspect of the patient's physical condition, sexual orientation, personality, or lifestyle.

At times, practitioners consider patients difficult based on their similarity to family members or others with whom they have had a close relationship or interpersonal problems. For example, a physician whose uncle used anger to control her may now have problems with an older male patient who responds angrily when she refuses to prescribe an antibiotic for an upper respiratory infection. Another common situation is the practitioner who is unusually intolerant of patients who will not stop smoking. This practitioner may well have had a close relative whom he or she could not convince to stop smoking, who later died from lung cancer. Developing the self-awareness to separate one's own past experiences and relationships from the current clinical interaction can significantly moderate one's aversive response and reduce difficult interactions. The key to dealing with such situations is to carefully examine how visits are progressing while monitoring one's own responses to the patient and the interaction. Greater self-awareness about their own feelings, experiences, and beliefs can help practitioners approach the clinical interaction with more self-reflection and less judgment and frustration. The case illustrations that follow focus on some of the more common challenging patients and situations that practitioners will encounter, and offer specific approaches to dealing with them. Table 4-1 summarizes some general guidelines for working with difficult patients. Table 4-2 recommends practical strategies for approaching specific situations.

THE ANGRY PATIENT

CASE ILLUSTRATION 1

Dr. Swanson enters the room to see her fourth of the 12 patients scheduled for her Thursday morning session. Her patient, Ms. B., a 35-year-old social worker, is sitting with arms crossed, refusing to make eye contact. Dr. Swanson greets the patient by asking, "Ms. B., how are you?" She responds, "I've been waiting 35 minutes! This is no way to run an office." The doctor, who is emotionally drained after spending the last 50 minutes talking with a patient about breast cancer, wonders why she's chosen medicine as a career. She follows up by saying, "I apologize for being late. Besides that, are there other things that are upsetting you?"

Ms. B. replies, "You said that when I went to the Emergency Room last week with back pain, you would call and tell them I was coming. When I got there, no one knew why I was there or anything about my medical history. It was very embarassing."

Table 4-1. General guidelines for working with difficult patients.

- Seek broader possibilities for the patient's emotion or problems
- Respond directly to the patient's emotions
- Solicit the patient's perspective on why there is a problem
- Avoid being defensive
- Seek to discover a common goal for the visit

Diagnosis

It is generally easy to recognize an angry patient. Even without the explicit expression of anger, harsh non-verbal communication, such as rigid posturing, piercing stare, a refusal to shake hands, gritting the teeth, and confrontational or occasionally abusive language, provide unmistakable evidence. More subtle behaviors that may indicate anger include refusing to answer questions; failing to make eye contact; or constructing non-verbal barriers to communication, such as crossed arms, turning away from the provider, or increasing the physical distance between them.

All too often, practitioners assume that the patient is angry with *them*, and, as a result, feel blamed for something they must have done or forgotten to do.

Table 4-3. Possible causes of patient anger.

- Difficulty in getting to the office
- Problems with the office staff
- Anger toward the illness from which the person suffers
- Anger at the cost of health care
- Problems with consultants to whom the practitioner referred the patient
- Unanticipated problems from a procedure or medication recommended by the practitioner
- Previous unsupportive or condescending treatment by a physician
- Absent or miscommunication between members of the healthcare team
- Other significant news or problems unrelated to medical service, such as work- or family-related conflicts

Although that certainly is one possibility, other important reasons must be considered as the cause for a patient's or family member's anger. These include, but are not limited to, those listed in Table 4-3.

Psychological Mechanisms

Many patients come to rely on the special relationship they develop with their medical practitioners. When successful, these relationships are anchored in trust and safety.

Table 4-2. Tips for approaching difficult situations or patient behaviors.

Situation	Recommended Techniques
Angry patients	Elicit the patient's reason for being angry: *You seem angry; tell me more about it.* Empathize with the patient's experience: *I can understand why you would be angry.* Solicit the patient's perspective: *What can we do to improve the situation?* If appropriate, apologize: *I'm sorry you had to wait so long.*
Silent patients	Point out the problem: *You're being very quiet.* Elicit the patient's reason for silence: *Why are you being so quiet?* Explain the need for collaboration: *For me to help you, I really need you to talk to me more about your problem.* Respond to cues of hearing impairment or language barriers: *Are you having trouble hearing or understanding me?*
Demanding patients	Take a step back from the demand: *You seem adamant about the MRI. Why do you think it's so important?* Solicit the goal of the demand: *Is there a particular problem you think the MRI will help us diagnose?* Acknowledge emotions unexpressed at the time of the demand: *It must be very frustrating that your back still hurts.* Solicit the patient's perspective: *What do you think is causing your problem?* *In what way had you hoped I could help you?*

It is, therefore, quite common for patients to share emotions they would never consider revealing or discussing with others. Patients want to have their concerns evaluated with compassion and interest. Any perception that their concerns are not taken seriously or are viewed as mundane, may be considered a violation of their trust and result in their feeling violated, vulnerable, and angry.

Patients have lofty expectations of practitioners. They expect timely service, relevant and up-to-date information about evaluations and treatments offered, and advice on how to cope with their illness. From their point of view, interactions that fall short can result in feelings of shame and rejection. The resulting humiliation can easily turn to anger.

From the practitioner's point of view, the patient's expression of anger may trigger feelings as diverse as guilt at having failed the patient, or feeling insulted by the patient's disrespectful behavior. As a result, practitioners may become defensive. This expresses itself as a reciprocal anger, a withdrawal from the relationship, or a denial of the practitioner's own behavior that may have prompted the anger in the first place. The difficulties are magnified if the expression of anger is or has been problematic in the practitioner's own family. After recognizing the contributions of one's own experiences, openly exploring a patient's anger can help create a more honest relationship, define the problem more explicitly, and facilitate an accurate and timely response.

Management

In most anger situations, evaluation and understanding should begin the therapeutic process. Responding calmly without judgment or projection with "You seem angry" tests whether the practitioner has correctly identified the emotion of the patient. (At times, it may be more effective and less threatening for patients to label the behavior with a less powerful emotion, for example, "You seem upset"). Failing to confront anger informs the patient that the practitioner is impervious to or unsettled by anger, discourages any meaningful sharing of feelings, and ensures eliciting superficial information. However, constructively acknowledging and working with the anger is both efficient and medically appropriate.

Although many patients in this situation respond with, "You bet I'm angry," some deny their anger. Nonetheless, their body language or tone of voice betrays the denial. In this case, the practitioner can address the denial: "Maybe 'angry' is too strong a word. It seems to me that you're upset by something; if you'd like to tell me about it, I might be able to help." This invitation to explain offers patients the opportunity explicitly to express their feelings. As a result, the practitioner develops a more complete understanding of the patient's point of view, and both can reach a deeper agreement on the nature and magnitude of the problem. At this point in the encounter there is usually a reduction in the patient's anger, relief on the part of the practitioner, and the restoration of a positive collaboration that facilitates a solution to the identified problem. Understanding the particular cause of the anger will help manage the problem in the future.

CASE ILLUSTRATION 1 (CONTD.)

The doctor apologizes, saying that the office had gotten busy and that she had simply forgotten to make the call. She explains that to prevent problems like that in the future, the staff decided at a recent meeting to put up a "follow-up" board so that process errors could be reduced. Ms. B. feels better understood, accepts the apology, and ends by saying, "I hope this doesn't happen again; I have enough stress at work as it is." Remembering the same patient's earlier complaint about waiting 35 minutes in the office to be seen, the doctor says, "I should have asked the receptionist to tell you that I was running late—I'm sorry about that. We're really trying hard to make sure that we communicate more effectively with our patients and our consultants." The whole exchange takes 50 seconds—time that is certainly well spent.

Patient Education

It is important for patients to understand that it is not only permissible but also important for them and their families to express their feelings. Encouraging the expression of anger helps to identify unresolved conflicts that can interfere with providing appropriate care. Encouraging patients and their families to express concerns or disappointments actually offers the practitioner an opportunity to become more effective by identifying and then removing significant barriers to effective, honest collaboration. Encouraging the hospital, emergency department, or office staff to use this approach can do the same.

Summary

Too often we assume that angry patients are angry with us. Sometimes this is so, but often there are much more complex reasons for the anger. The patient's reasons must be sought directly before mistakenly projecting our own beliefs onto the patient. By working hard to avoid being defensive, practitioners can acknowledge and then constructively resolve the cause of the anger. Confronted with such a responsive approach, most angry people are satisfied and resume an effective collaborative relationship with their practitioner.