Managing Challenging Patient Encounters in the Pulmonary Ambulatory Clinic

Case related questions.

Scenario:
It is 4:00 PM in the clinic, and you are already running 45 minutes behind. You look at your schedule, and a sense of dread enters your mind: you anticipate this subsequent encounter will likely be difficult.

Mr. Daniels is a 75-year-old man with a history of severe chronic obstructive pulmonary disease (COPD) and non-small cell lung cancer, now in remission. He started following up with you three months ago for ongoing management of his COPD after having had a bad experience with his former pulmonologist (where there had been a delayed diagnosis of a malignant lung nodule). He is usually accompanied at his visits by his wife and two adult children, one of whom is a physician. He has been feeling more dyspneic recently, and your workup from the prior visit (CT scan, echocardiogram, and 6-minute walk test) was all unrevealing. His pulmonary function testing (PFT)showed a mild decrease in his forced expiratory volume in 1 second (FEV1) over the last five years. You explained that his worsening dyspnea is likely secondary to slowly worsening COPD and deconditioning, but he and his family are sure you must be missing something. His daughter demands that you explore further with a battery of suggested additional testing. They clarified that they sued their last pulmonologist for the delayed/missed diagnosis.

Question 1: What features of this case make the doctor-patient relationship challenging? What are examples of characteristics of the patient, physician, and situation that contribute to these difficult interactions? Discuss specific examples you may have encountered in your clinical practice of each subtype.

Question 2: What patient characteristics are most likely to contribute to a challenging encounter? What have you experienced in your practice?

Question 3: What are some strategies to overcome these challenging patient encounters? What have you tried in your practice? What has worked well? What has yet to be as successful?

Question 4: What physician characteristics contribute to challenging patient encounters? How can we address these issues either on a personal level or with our colleagues/clinical practices?

Question 5: How does the difficult relationship impact patient care?

Question 6: How does cultural competency impact these difficult encounters? What are some strategies and best practices for culturally competent communication?

Managing Challenging Patient Encounters in the Pulmonary Ambulatory Clinic

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Educational Objectives:

1. Discuss the different components that contribute to challenging patient interactions
2. Review common complex ambulatory patient-care team interactions and evidence-based approaches to mitigation

Scenario:
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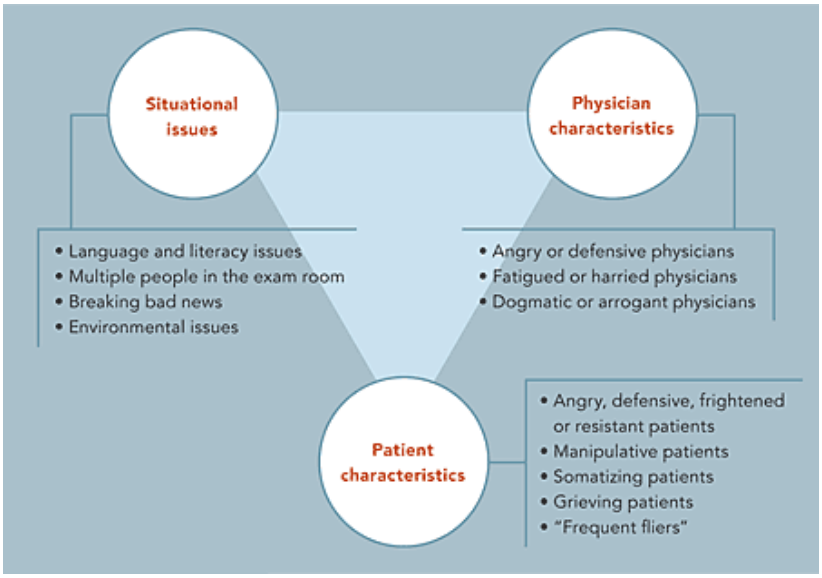
Mr. Daniels is a 75-year-old man with a history of severe chronic obstructive pulmonary disease (COPD) and non-small cell lung cancer, now in remission. He started following up with you three months ago for ongoing management of his COPD after having had a bad experience with his former pulmonologist (where there had been a delayed diagnosis of a malignant lung nodule). He is usually accompanied at his visits by his wife and two adult children, one of whom is a physician. He has been feeling more dyspneic recently, and your workup from the prior visit (CT scan, echocardiogram, and 6-minute walk test) was all unrevealing. His pulmonary function testing (PFT)showed a mild decrease in his forced expiratory volume in 1 second (FEV1) over the last five years. You explained that his worsening dyspnea is likely secondary to slowly worsening COPD and deconditioning, but he and his family are sure you must be missing something. His daughter demands that you explore further with a battery of suggested additional testing. They clarified that they sued their last pulmonologist for the delayed/missed diagnosis.

Question 1: What features of this case make the doctor-patient relationship challenging? What are examples of characteristics of the patient, physician, and situation that contribute to these difficult interactions? Discuss specific examples you may have encountered in your clinical practice of each subtype.

Research shows that physicians consider approximately 1 out of 6 patient encounters complex or challenging.[1] Many have described the components of the difficult doctor-patient interaction in the ambulatory setting to fall into one of three categories: (1) situational issues, (2) physician characteristics, and (3) patient characteristics.[2] The chart below highlights important examples of each category. Recognizing the factors contributing to your challenging patient-doctor relationship can point you to possible solutions.

In this case, there are many situational issues as well as physician and patient factors contributing to this challenging patient interaction. These include (1) multiple people in the exam room, (2) threats of legal action, (3) angry/mistrustful/demanding patients and family, (4) physician fatigue/burnout, and (5) clinic time pressures. Grieving patients, somatization disorders, and patients viewed as "frequent fliers" are also often cited as patient characteristics that contribute to a difficult clinical encounter.

Figure 1. Components of a Difficult Clinical Encounter



Borrowed from Hull SK and Broquet K. How to manage difficult patient encounters. Fam Practice Manag 2007; 14(6):30-34.

In addition to the characteristics outlined above in the diagram, patients with depression/anxiety, severe symptoms, and multiple physical symptoms are all at risk for challenging encounters (see below). Physicians with poorer psychosocial attitudes (based on the previously validated 32-item "Physician Belief Scale" questionnaire designed to measure beliefs about psychosocial aspects of patient care in primary care physicians) portended the highest odds ratio for encountering a difficult patient. Physician factors may be a challenge to overcome, depending upon one's insight into their behavior and communication strategies.

Table 1. Independent Predictors of Difficult Encounters

Predictor	Odds Ratio (95% Confidence Interval)
Depressive or anxiety disorder	2.4 (1.5-3.9)
≥5 Physical symptoms*	1.9 (1.1-3.1)
Severity of symptom >6 (10-point scale)	1.6 (1.0-2.4)
Poorer physician psychosocial attitude score†	3.9 (1.6-9.5)

*On 15-item PRIME-MD (Primary Care Evaluation of Mental Disorders) symptom count.
†Physician Belief Scale score >70.

Table borrowed from Jackson JL and Kroenke K. Difficulty patient encounters in the ambulatory clinic. Arch Intern Med 1999; 159: 1069-1075.

Question 2: What patient characteristics are most likely to contribute to a challenging encounter? What have you experienced in your practice?

Edler et al. describe ***behavioral*** (subclinical mental health or personality disorders) and ***medical*** problems (chronic pain, psychiatric diagnoses, etc.) as two large sub-categorizations of the most cited types of "difficult" patients. Their findings were based on semi-structured interviews with family medicine physicians who served as clinic preceptors at 15 medical schools nationwide. The most commonly cited type of problem was the patient with multiple concerns.[1,3] Another cohort study demonstrated that visits with patients who found their symptoms to be worrisome or had severe symptoms were also associated with higher difficulty.[4]

Table 2. Patient Predictors of Difficulty

Patient predictors			
Characteristic	Difficult	Not difficult	P
Symptom severity	6.3	5.4	0.002
Number of Symptoms	5.5	3.7	<0.005
Functional status	20.6	23.1	<0.005
Mental disorder	28%	15%	<0.0005
Multi-somatoform disorder	21%	11%	0.02
Pre-visit serious illness worry	21%	13%	0.005

Table borrowed from Hinchey SA, Jackson JL. A cohort study assessing difficult patient encounters in a walk-in primary care clinic, predictors, and outcomes. J Gen Intern Med. 2011;26(6):588-594.

Question 3: What are some strategies to overcome these challenging patient encounters? What have you tried in your practice? What has worked well? What has yet to be as successful?

When you can visibly identify signs that a patient is angry, frightened, etc., addressing these issues early in the encounter is essential while avoiding escalating the conflict. Exploring why they are experiencing these emotions may be even more critical for building a therapeutic relationship than prescribing an albuterol inhaler. It is essential to use

statements such as "I understand why you might feel that way." to acknowledge and validate rather than dismiss their feelings.[2] For example, if you are running late in the clinic and the patient expresses frustration at your tardiness, apologizing up front and thanking them for their patience can go a long way.

The AAFP suggests the "CALMER" approach to the problematic clinical encounter, which is included Table 3.[5]

Table 3. The CALMER Approach to Difficult Clinical Encounters

Element	*Approach*
Catalyst for change	Identify the patient's status in the stages of change model*
	Recommend how the patient can advance to the next stage
Alter thoughts to change feelings	Identify the negative feelings elicited by the patient
	Clarify how these feelings influence the encounter
	Strategize how to reduce your own negativity and distress
Listen and then make a diagnosis	Remove or minimize barriers to communication
	Improve working relationships
	Enhance probability of accurate diagnoses
Make an agreement	Negotiate, agree on, and confirm a plan for health improvement
Education and follow-up	Set achievable goals and realistic time frames, and ensure follow-up
Reach out and discuss feelings	Ensure a strategy for your own self-care

**—Stages include precontemplation, contemplation, preparation/determination, action, maintenance, relapse.*

Information from reference 35.

Table borrowed from Lorenzetti RC et al. Managing difficult encounters: understanding physician, patient, and situational factors. American Family Physician 2013

In addition, collaborating with patients through prioritization, teamwork, and goal setting are frequently mentioned coping strategies for these challenges. Administrative solutions such as scheduling more extended office visits and setting clear boundaries (explained to the patient and made clear to your office staff) are also important. For example, a patient who calls frequently or uses an online medical web portal to send frequent messages may benefit from understanding that you will respond only once daily. You may also need to remind yourself to limit your time and refrain from constant back-and-forth dialogue. In extreme circumstances, the therapeutic relationship may need to be terminated, but this should be viewed as a strategy of last resort. Table 4 outlines other commonly employed strategies cited in the Edler et al. study.[3]

Table 4. Management and Coping Strategies Given by Physician Participants (N=101)

Encounter Component	Management and Coping Strategy	Examples of Strategy	Frequency of Mentions
Collaboration	Priority setting	Prioritize patient concerns	20
	Diagnostic skills	Thorough history, physical and testing	13
	Decision making	Explain fully	13
		Be consistent and objective	12
		Facilitate patient decision making	12
		Be honest and fair	11
	Teamwork	Use referrals (mental health, pain, etc)	12
		Enlist/see family	2
		Provide quality care	1
	Coaching	Set small, achievable goals	8
		Short term symptom relief	2
Appropriate use of power	Set clinical management rules	Schedule patient frequently, longer visits	26
		Clinic time management	1
		Good documentation	1
		Allow a tincture of time	1
	Set boundaries and limits	Make explicit rules	19
		Limit number of patient concerns	10
		Set general limits	9
		Limit time at each visit	4
Empathy	Empathy	Understand patients psyche and emotions	9
		Be compassionate and firm	8
		Be patient centered	1
		Reinforce positives	1
		Keep professional distance	1
Consistently unsuccessful patient encounter			
Opposition, misuse of power, compassion fatigue	Termination	Dismiss patient, make them want to leave	11
		Ignore problems	1
		Charge more	1

Borrowed from Edler N, Ricer, R, and Tobias B. How respected family physicians manage difficult patient encounters. JABFM, 2006; 19 (6): 533-541.

Table 5. Communication Strategies to Redirect an Emotionally Charged Clinical Encounter

Strategy	*Physician actions*	*Examples*
Active listening	Understand the patient's priorities, let the patient talk without interruption, recognize that anger is usually a secondary emotion (e.g., to abandonment, disrespect)	"Please explain to me the issues that are important to you right now." "Help me to understand why this upsets you so much."
Validate the emotion and empathize with the patient (understanding, not necessarily sharing, the emotion with the patient)	Name the emotion; if you are wrong, the patient will correct you; disarm the intense emotion by agreement, if appropriate	"I can see that you are angry." "You are right—it's annoying to sit and wait in a cold room." "It sounds like you are telling me that you are scared."
Explore alternative solutions	Engage the patient to find specific ways to handle the situation differently in the future	"If we had told you that appointments were running late, would you have liked a choice to wait or reschedule?" "What else can I do to help meet your expectations for this visit?" "Is there something else you need to tell to me so that I can help you?"
Provide closure	Mutually agree on a plan for subsequent visits to avoid future difficulties	"I prefer to give significant news in person. Would you like early morning appointments so you can be the first patient of the day?" "Would you prefer to be referred to a specialist, or to follow up with me to continue to work on this problem?"

Borrowed from Lorenzetti RC et al. Managing difficult encounters: understanding physician, patient, and situational factors. American Family Physician 2013

Question 4: What physician characteristics contribute to challenging patient encounters? How can we address these issues either on a personal level or with our colleagues/clinical practices?

Burnout and stress are a reality of clinical practice within wards or ambulatory clinics. The time it takes to address challenging patient encounters is the most often cited reason for physician frustration (see Table 6).[3] Solving these systemic issues requires a multidisciplinary approach; a physician may unduly feel individually responsible. Delegating non-physician tasks in a pre-clinic meeting can be one way to alleviate time constraints that can lead to harried clinics. Discussing clinic efficiency and patient scheduling issues with your fellowship or clinic director is another way of addressing systems issues that may impact your stress level and, inadvertently, patient care. Acknowledging that a clinic's quality improvement endeavors must get to the root causes of burnout is essential. If a physician is experiencing signs/symptoms of burnout, they should seek care and support while sharing the work of organizational change.

Table 6. Reasons for Perceiving the Encounter as Difficult: (N = 101)

Physician Characteristic	Reason Given by Physician	Frequency of Mentions
Professional identity	I am unable to make better	41
	Conflicts with my professional standards	21
Personal qualities	Feel taken advantage of	21
	Difficulty making relationship with patient	21
Time management	Takes too much time	24
Comfort with patient autonomy	Patient sets the agenda	6
Confidence in skills	Too hard to solve	6
Trust in patient	Lose trust in patient	5

* Participants could mention more than one reason.

Borrowed from Edler N, Ricer R and Tobias B. How respected family physicians manage difficult patient encounters. JABFM, 2006; 19 (6): 533-541.

It is also important to recognize that a physicians' emotional reactions to a patient contribute significantly to how challenging an encounter may be. Empathy is an emotion that is positive, if not crucial, in a healthy physician-patient relationship. A study of generalist physicians from Japan that used a self-assessment of physician empathy based on the Jefferson Scale of Empathy (JSE) showed that empathetic physicians were less likely to experience patient encounters as difficult.[6] However, there are negative emotions that can be detrimental. Countertransference and projective identification are two psychodynamic concepts that commonly affect patient encounters.[7] Both concepts describe subconscious tendencies to project personal issues or emotions onto another person. Once the physician becomes aware of these emotions, they can react appropriately and minimize their effect on the patient encounter.

Question 5: How does the difficult relationship impact patient care?

According to the study by Jackson et al.,[1] although there were no differences in visit costs or amount of testing ordered, patients who had challenging encounters with physicians were more likely to be "somewhat" or "very dissatisfied" with the physicians' technical competence (9% vs. 1%, $p<0.001$), bedside manner (7% vs. 0.7%, $p<0.001$), explanation of what was done for them (12% vs. 3%, 0.001) and time spent in the visit (13% vs. 3%, $p=0.002$) in a study of 463 patient encounters in primary care walk-in clinic. Of note, these were patient-reported perceptions. To our knowledge, no patient-level outcomes data have been tracked in previous studies.

Question 6: How does cultural competency impact these difficult encounters? What are some strategies and best practices for culturally competent communication?

Lack of culturally competent communication is recognized as a barrier to effective doctor-patient relationships, often leading to patient dissatisfaction, poor adherence, and adverse outcomes.[8] Teal and Street describe a model of culturally competent communication that focuses on four critical elements[9]:

1. **Communication repertoire** must include attitudes of empathy, caring, and respect. It is important to listen actively, pay attention to socio-cultural aspects of the patient illness, elicit the patient's perspectives, and empower patients to make decisions.

2. **Situational and Self-Awareness** picking up on patient cues, expectations, and interaction nuances are key. Recognizing even subtle misunderstandings can aid in resolving confusion and reconciling points of disagreement. For example, patient tone of voice, word choice, facial expressions, or silence can be essential to recognize.

3. **Adaptability** to individualized communication strategy based on a patient's beliefs, cultural background, and behavior requires the ability to "think on your feet," recognize verbal or non-verbal cues, and consider that in real-time during the encounter. For example, if a patient's body language may signal discomfort, the physician may refocus the discussion or take a moment to pause and ask the patient what concerns they have.

4. **Knowledge about core cultural issues should focus** on the patient's beliefs rather than a stereotype of the patient's racial, ethnic, or socioeconomic group. Knowledge of beliefs regarding gender roles, physician authority, family roles, death and dying, and religious beliefs regarding disease may be beneficial in guiding discussions moving forward.

Table 7. Sample Behaviors for Each Skill in the Culturally Competent Communication Model

Culturally competent communication skills	Application to each function of clinical encounter	Useful sample behaviors
Non-verbal behavior skills	*Applicable to all functions*	■ Be on time; Don't rush the patient. ■ Be attentive; Be an active listener – Allow silence; do not interrupt; – Use body positioning to indicate interest – Do not read the chart or write notes while patient is talking – Limit touching; respecting preferences for physical space; providing explanation for intruding into personal space – Make eye contact but do not stare or force prolonged eye contact ■ Limit gestures ■ Mirror patient's facial expression to indicate empathy; ■ React with non-judgmental expressions ■ Make facilitative responses (nodding, minimal verbal expressions)
Relevant references *for non-verbal skill*		(Barrier, Li, & Jensen, 2003; Coulehan et al., 2001; Epstein, 2006; Shapiro et al., 2002)
Verbal behavior skills	*Establishing relationship*	■ Utilize title and last name unless invited to do otherwise ■ Indicate concern/interest for patient as an individual; – "Tell me about yourself." – "How's your work at XXX going?" ■ Indicate concern/interest for individual as patient; – "How have you been feeling?" ■ Use non-judgmental verbalizations; (not "why?" but "how," "what," etc.) ■ Ask for and reflect observed patient emotion ("How are you feeling about your symptoms?" "You seem sad [tired, frustrated, unsure].")
	Gathering information	■ "What brings you in today?" ■ Reflect what the patient shares (e.g., "Sounds like you think…" ■ Summarize; Request feedback ("Did I get that right?") ■ "What else do you want to talk about?"
	Managing the problem	■ Invite questions about your perception of diagnosis and treatment – "Do you understand or have questions?" – "Stop me if you're not sure what I'm saying."

Recognition of potential cultural differences	*Establishing relationship*	■ Attend to patient discomfort ■ Recognize negatively-perceived behavior and assess cause ■ Acknowledge others accompanying patient
	Gathering information	■ Explore changes in the patient's life, especially for immigrants ("How is medical care different here than in your country?") ■ Assess the patient's explanatory model for the disease and treatment ■ Ask about tangible and community resources ■ Learn about core issues for the patient's cultural group (e.g., "Does anyone else need to be involved in your decisions?") ■ Assess factors that contribute to understanding (education, knowledge about disease) ("Are you familiar with X?") ■ Assess social context that can influence ability to care for self (e.g., SES, physical living environment), social stressors, literacy and languages ■ Elicit patient preferences for information and decision-making. "Are you the type of person who – wants to know everything, good and bad?" – prefers to make your own decisions, or do you feel more comfortable following my recommendations?"
	Managing the problem	■ Ask for the patient's perception of recommended treatment. ■ Reflect the patient's perspective; Request feedback ■ Acknowledge differences in your perception and the patient's perception of problem or treatment. ■ Invite questions "Do you understand?" "Do you have questions?" ■ Attend to body language and facial expression, silence, and other cues that a patient disagrees or is uncomfortable with diagnosis or treatment
Incorporation of cultural knowledge	*Establishing relationship*	■ Utilize previously learned knowledge to: – guide appropriate non-verbal behavior – determine familiarity (e.g., title/last name vs. first name, greeting style) – include others who are present; and according to earlier assessment of their role – determine probing questions about medical and socio-cultural context ■ Adapt behaviors that created unease to increase patient comfort ■ Adapt provision of information to patient's preference ■ Include patient in decision-making to the degree he/she prefers
	Gathering information	■ Assess degree of difference in patient explanatory model and physician's biomedical model ■ If necessary, assess patient's flexibility to broaden explanatory model to include biomedical aspects ■ Determine aspects of treatment that you can be more flexible about
	Managing the problem	■ Discuss diagnosis or treatment options in ways that are consistent with the persons' education, medical knowledge or experience, and explanatory model ■ Acknowledge implications of differences in patient's explanatory model and a biomedical perspective ■ As possible, incorporate socio-cultural aspects into biomedical explanations of illness and its treatment ■ Creatively develop options/plans for treatment that reflect the patient's preferences and needs. ■ Provide written information that is language/literacy appropriate ■ Monitor patient's understanding of and affective response to information, and reconcile potential misunderstandings.

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