Managing Difficult Conversations with Patients

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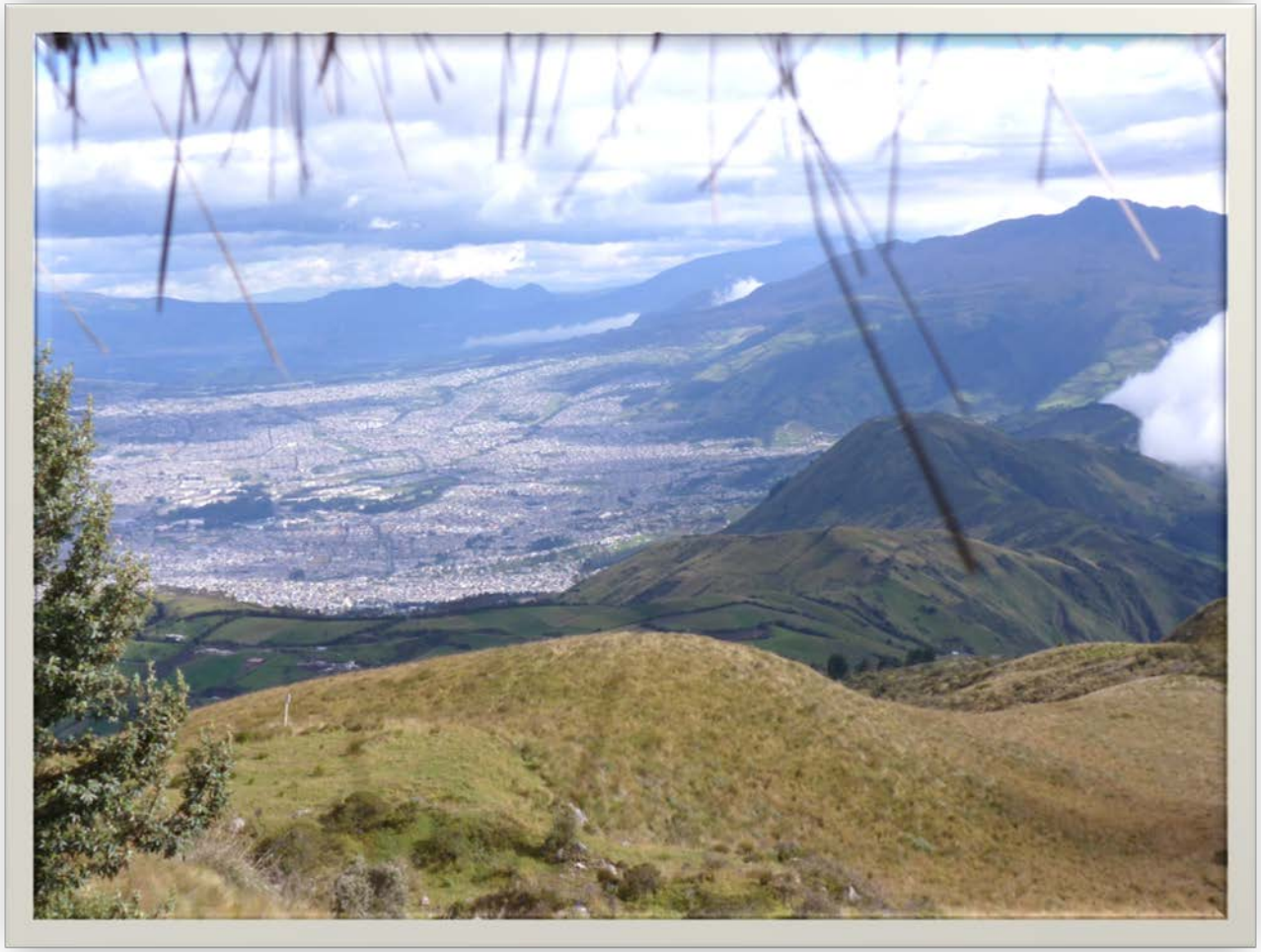
No Disclosures



Managing Difficult Conversations with Patients

- Rules of Engagement
- Confidentiality
- Safety in the Room

Case Scenarios

adapted from: Breuner et al. Pediatrics, Jan 2011.

- Case 1:
  - Mr. A. is a 45 year old man who was diagnosed with cyclic vomiting, after a long series of evaluations and consultations. He is an attorney who specializes in medical negligence and was enraged with this diagnosis. He sought treatment from many specialists and refused to accept the nature of his illness; the threat of lawsuit was always imminent. He continuously demanded more and more tests and consultations. Eventually his doctors did not return his calls and acknowledged fear, frustration and even anger.

Objectives

- Participants will:
  - Review concepts of countertransference, empathy and apology
  - Understand physician, patient and situational factors that lead to difficult conversations
  - Learn to recognize common patterns of difficult patients encounters

Different Types of Difficult Conversations

- Breaking Bad News
- End of Life Conversations
- Error Disclosure
- Assessing Readiness for Behavioral Change
- Patient is Angry or Challenges Physician's Expertise
- Elusive Diagnoses

Relationships are Complicated!

- Patient clinician relationships ought to be sustainable for the clinician and healing for patients.
- Encounters are most challenging for providers when strong emotional responses are triggered.
- Most literature on managing difficult conversations with patients is physician centered.

Countertransference

- Definition utilized in medical encounters:
  - unconscious or incompletely recognized emotional reactions a physician has toward a patient or his/her circumstances.
- Not pathology
- Recognizing countertransference is helpful to understanding framework of difficult patient-doctor relationship.

Marshall et al., *Am J Gastroenterol, Jan 1995.*

Empathy

- "The capacity to share or recognize emotions experienced by another…"

- In clinical medicine, it has been described as:
  - The ability to understand the patient's situation, perspective, and feelings and to communicate that understanding to the patient.

Coulehan et al. Let Me See if I Have This Right…": Words that Help Build Empathy. *Ann Intern Med* 2001; 135(3):221-227.

Elements of Empathic Communication

Element	Example
Reflection	"You're really feeling overwhelmed by these problems."
Legitimization	"It must be upsetting to have these problems."
Respect	"You've been doing your best to cope."
Support	"I'd like to help."
Partnership	"Maybe we can work on these together."

Time and the Patient–Physician Relationship

David C. Dugdale, MD, Ronald Epstein, MD, Steven Z. Pantilat, MD

Apology

- Apology is an important tool with ownership when appropriate!
- Apology by itself does not acknowledge or assign fault.
- Ownership of a mistake is helpful in the patient-clinician relationship.

Clinician factors in difficult encounters

- When the ability to improve a patient's condition is threatened or undermined, the physician's identity as a healer may be compromised.

- Physician Self-Awareness is the first step to facilitating a more successful encounter.

Cannarella Lorenzetti, et al. *Am Fam Physician*, March 2013.

Clinician factors in difficult encounters

Cannarella Lorenzetti, et al. *Am Fam Physician*, March 2013.

Attitudes	Conditions	Knowledge
Emotional burnout	Anxiety/depression	Inadequate training in psychosocial medicine
Insecurity	Exhaustion/overworked	Limited knowledge of the patient's health condition
Intolerance of diagnostic uncertainty	Personal health issues	
Negative bias toward specific health conditions	Situational stressors	Difficulty expressing empathy
Perceived time pressure	Sleep deprivation	Easily frustrated
		Poor communication skills

Patient factors in difficult encounters

Cannarella Lorenzetti et al., *Am Fam Physician*, March 2013.

Behavioral Issues	Conditions
Hypervigilance to bodily sensations	Addiction to alcohol or drugs
Highly anxious	Belief system foreign to clinician's frame of reference
Non-adherence to treatment	Physical, emotional or mental abuse
Not in control of negative emotions	Conflict between patient and clinician's goals for the visit
Angry	Chronic pain syndromes
	Psychiatric diagnoses: Borderline, Dependent PD

Situational factors in difficult encounters

- Office scheduling
- EMR
- Language barriers
- Outside noise
- Multiple individuals present in the room

Common patterns of difficult encounters

Cannarella Lorenzetti, et al. *Am Fam Physician*, March 2013.

Clinician's experience of patient	Characteristics of the clinical encounter	Approach
Insecure, worried about abandonment, dependent	Patient initially praises clinician. As relationship develops, patient's needs become greater, more personal time required of clinician, clinician can become resentful.	Maintain professional demeanor, establish boundaries early and consistently maintain them. Involve patient in decision making. Schedule regular follow-up appointments. Assure non-abandonment.

Common patterns of difficult encounters

Cannarella Lorenzetti, et al. *Am Fam Physician*, March 2013.

Clinician's experience of patient	Characteristics of the clinical encounter	Approach
Entitled, demanding, often angry. Does not want to go through necessary steps of assessment or treatment. May be reacting to fear and loss.	Patient sees physician and health system as barriers to his/her needs. Physician may feel anger, guilt, doubt, frustration. Patient might feel intimidating or aggressive and negative feelings arise in the patient doctor relationship.	Recognize that the patient's hostility may be his or her way of maintaining self-integrity during illness. If specific emotion is evident, address it with the patient. Do not react defensively. Suspend judgment, examine your own feelings.

Common patterns of difficult encounters

Cannarella Lorenzetti, et al. *Am Fam Physician*, March 2013.

Clinician's experience of patient	Characteristics of the clinical encounter	Approach
Manipulative, wants attention, difficulty with trust, rejects suggestions for symptom improvement, ? undiagnosed depression	Patient returns frequently in cycles of help seeking/rejecting treatment, does not improve despite good advice. Patient does not believe his/her health could improve. Clinician may be concerned about missing serious illness	Patient may want to stay connected to clinician, not necessarily to recover, engage patient by sharing frustration over poor outcome, work with patient to set limits on expectations, focus on alleviating symptoms rather than curing condition.

Common patterns of difficult encounters

Cannarella Lorenzetti, et al. *Am Fam Physician*, March 2013.

Clinician's experience of patient	Characteristics of clinical encounter	Approach
Patient appears hopeless about changing situation, unable to help him/herself, fears failure, feeling of self-destruction or denial, may have untreated anxiety or depression	Health problems persist despite adequate counseling and treatment, self destructive habits, physician may feel ineffective and responsible for lack of progress	Recognize that complete resolution of issues is limited, set realistic expectations, redirect patient to identify causes of non-adherence (money, time, access to care), offer to arrange for psychological support, celebrate each small success with patient.

Case Scenarios

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- Case 2:
  - Ms. M. is a 39 year old woman who presented with fatigue and a rash. Her physician was eventually able to make the diagnosis of lupus. Her illness appeared mild. She responded to the diagnosis with thoughtful questions and eventually asked her Primary Care physician whether he would follow her long term for this chronic illness. Flattered, he vowed to do so. Later that day, she telephoned briefly to thank him. In the following week, she emailed twice, concerned that she would die, and also thanked him again for taking care of her. As weeks passed, the patient's calls and visits became more frequent and the gratitude diminished. After 2 months, she was calling the physician daily, both at the office and at home.

Case Scenarios

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- Case 3:
  - Ms. D. is a 24 year old woman referred for headaches. She walked confidently into the examination room and declared: "I have a nightmare headache since forever!" Patient said she had a constant right frontal headache since the age of 12, 2-10 on the pain scale. She missed between 5 and 15 days/month of school when she was in college. The headaches seemed worse at the time of her menses. As the doctor asked questions, Delores interrupted: "You know, this is getting really irritating. All you doctors do is ask questions and do nothing. I'm telling you, nothing works. My regular doctor is a total idiot, he has no idea what's going on. I saw a neurologist, and I thought she was smart, but she was also a total loser." While the doctor explained the treatment options to Ms. D., she summarily shot down each one saying "Tried that, didn't work."

Case Scenarios

adapted from: Breuner et al. *Pediatrics* Jan 2011.

- Case 4:
  - Mr. J. is a 49 year old man with obesity. He was eating French fries and drinking a large soda in the doctor's office. Mr. J. had no showed the past 3 times for his nutrition appointments. His weight during the appointment was 316 lbs. He laughed and said: "I expected it to be much higher after all the eating I did this past week!" It had become common knowledge that the more the team tried to help the patient, the more he would resist. When the patient relocated, the clinical team was relieved.

Conclusions

- Take time to reflect on what kinds of encounters are difficult for you.
- Elements of Empathic Communication: Reflection, Legitimization, Respect, Support, Partnership.
- Acknowledge countertransference feelings.
- Apology is an important tool, with ownership when appropriate.

Thank You!