REVIEW ARTICLE

MANAGING DIFFICULT ENCOUNTERS

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KEYWORDS

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ABSTRACT

Difficult doctor-patient relationships are a recognized aspect of modern healthcare, but the actual incidence, risk factors, ethical issues, and management strategies are less well-known. The author queried PubMed, ScienceDirect, and the Education Resources Information Center. The inclusion criteria consisted of the free-text terms "difficult patient" and "difficult client" and the Medical Subject Heading terms "patient participation" and "professional-patient relations" with searches further refined by focusing on adults, management, screening, and incidence among review and research articles published in academic journals in English. The author excluded articles focused on children, adolescents, and anger management. This study condenses a body of research spanning two decades and can help clinicians understand factors that contribute to difficult encounters, employ simple screening instruments, and implement management approaches that can minimize difficult encounters and maximize their successful resolutions. Based on the collected evidence, most doctor-patient relationships are trouble-free, but some, ranging between 10% and 20%, are dominated by difficulties of varying degrees and types.

INTRODUCTION

There is no such thing as a difficult patient—a bold statement that seemingly contradicts clinical experience. Focusing on the encounter moves the spotlight off the patient and in its place illuminates a bidirectional relationship. Viewed in this manner, all the complexities of human communication may culminate in a difficult encounter.

The earliest literature defined difficult encounters almost exclusively as arising from problematic patients. Labeling an individual as a "difficult patient" effectively absolves the clinician's role in a difficult encounter, either as a contestant or a conciliator. Over roughly the past decade, researchers broadened their inquiries and focused on the clinician-patient relationship, and through the process identified the clinician's potential contributions to a difficult encounter.

This review examines the published literature that studied the actual incidence of difficult encounters, examines factors that both patient and providers may contribute to a difficult encounter, ethical issues, and clinical management of difficult encounters.

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While not infallible, this study condenses a body of research spanning two decades and can help clinicians understand factors that contribute to difficult encounters, employ simple screening instruments, and implement management approaches that can minimize difficult encounters and maximize their successful resolutions.

METHODS

In constructing this narrative review, this study queried three quality academic search systems, PubMed, ScienceDirect, and the Education Resources Information Center (ERIC) in June and July 2022. All three systems are suitable for extensive exploration of scientific literature.[1]

In each case, the search method began with the terms "difficult patient" and "difficult client" and, depending on the features of the search system, the search was refined by adding the inclusion/exclusion criteria. After retrieving the results, the search strategy further refined the outcome with a manual review to ensure compliance with the criteria.

The inclusion criteria consisted of the free-text terms "difficult patient" and "difficult client" and MeSH terms "patient participation" and "professional-patient relations" with searches further refined by focusing on adults, management, screening, and incidence among review and research articles published in academic journals in English. Excluded were articles that focused on children, adolescents, and specialty-specific topics (such as

anesthesiology), each of which was outside the adult scope of this review. Articles addressing solely anger management were also excluded as being beyond the scope of this review.

To best capture the evolution of the research, this study conducted a 20-year PubMed search, which resulted in 19 relevant abstracts from a pool of 86 retrievals. A query of ScienceDirect using the terms "difficult patient" and "difficult client" produced 631 results (from a broader range of article types) from 2002–2022, with nine meeting the inclusion criteria after a manual review. A 20-year search of ERIC using the terms "difficult patient" and "difficult client" produced 47 responses with nine of them meeting the inclusion criteria. The search strategy also used citation chaining from the included articles to identify additional pertinent articles. This review did not involve human subject research and is exempt from Institutional Review Board review.[2]

REVIEW

Screening instruments for predicting difficult encounters

The development of the Difficult Doctor-Patient Relationship Questionnaire (DDPRQ) represented one of the first efforts to move beyond subjective characterizations and describe the difficult patient with a 30-item screening instrument. The DDPRQ organized the 30 questions across five themes: the demanding irritating patient, physician dysphoria, compliance and communication, the self-destructive patient, and the seductive patient. After validating the instrument, the researchers conducted a study, coupling the DDPRQ with medical and mental health diagnostic screening questionnaires. The study results endorsed the DDPRQ's reliability and classified 10% to 20% of the patients as difficult based on the intensity of their somatization, personality disorders, and psychopathologies such as depression or anxiety. In different terms, difficult patients in this sample were demanding, had unrealistic expectations, were non-adherent to treatment, and accepted minimal responsibility for self-care. DDPRQ scores did not correlate with either the patient's or physician's demographics.[3]

In a setting familiar to many clinicians, researchers explored difficult patients in an ambulatory clinic. The study included 500 patients and 38 clinicians, the former completing health-related questionnaires and the latter completing a modified 10-item DDPRQ and the Physician Belief Scale. Factors contributing to a difficult visit included the patient's depression or anxiety, at least five physical symptoms endorsed on the PRIME-MD checklist, and symptom severity of seven or greater on a 10-point scale. Physician demographics and experience did not contribute to a difficult encounter, but clinicians who scored greater than 70 on the Physician Belief Scale reported 23% of their encounters as difficult.[4]

The Physician Belief Scale is a 32-item self-report questionnaire that pioneered an objective assessment of physicians' attitudes about their knowledge and comfort with psychosocial aspects of treatment. Researchers incorporated the scale in studies to measure the clinician's contributions to a difficult encounter. A sample of the items on the Physician Belief Scale include "I am too pressed for time to routinely investigate psychosocial issues … Patients will become more dependent on me if I open up psychosocial concerns … I am intruding when I ask psychosocial questions."[5]

Clinicians can now choose from a variety of questionnaires that measure different qualities of the doctor-patient relationship. A sample of those available includes the Trust in Physician Scale, an 11-item questionnaire completed by patients. The Trust in Physician Scale includes items such as "My doctor is usually considerate of my needs and puts them first and I trust my doctor to tell me if a mistake was made about my treatment."[6,7] A systematic review of seven instruments measuring trust concluded that the Trust in Physician Scale is the most studied among the group, but all seven would benefit from further research.[8]

Researchers developed the Jefferson Scale of Physician Empathy as a brief instrument to measure empathy and settled on a 20-item questionnaire following a series of successive trials. Of note, the study participants included 55 faculty physicians, 41 internal medicine residents, and 193 medical students, which positioned the instrument's role in academic medicine. A sample of the items includes "A physician who is able to view things from another person's perspective can render better care, physicians' sense of humor contributes to a better clinical outcome, and understanding body language is as important as verbal communication in physician-patient relationships."[9] A systematic review of 59 published articles supported the structural validity and internal consistency of the Jefferson Scale of Physician Empathy, but in terms of reliability, measurement error, and cross-cultural validity the authors suggested further study.[10]

A cohort study enrolled 750 patients to understand the dynamics of difficult encounters using a mixture of health-related questionnaires for the patients while clinicians completed the DDPRQ and the Physician Belief Scale. Health care providers graded 17.8% of their encounters as difficult. Clinicians with less than 10 years of experience and scores greater than 70 on the Physician Belief Scale had more difficult encounters. Patient characteristics defining a difficult encounter included a previous week of heightened stress, more than five somatic complaints, and a mood disorder. Interestingly, the authors noted that difficult encounters negatively affected patient care with the presenting symptoms worsening and health care use increasing over the subsequent 6 months.[11]

Factors influenced by patients and providers that may contribute to a difficult encounter

Health care providers must take the lead in recognizing and repairing difficult encounters, but part of the recognition is an admission that, despite the clinician's best efforts, not every encounter can be rescued. With that in mind, a starting point would consider a provider's attributes that increase the likelihood of a difficult encounter.

An early step in that direction involved a survey of 1,391 physicians conducted as a secondary analysis of the Physician Worklife Survey. This study concluded that physicians expressing the most

frustration in clinical encounters were less than 40 years old, had higher personal stress, practiced in a medicine subspecialty, worked more than 55 hours a week, and treated more patients with mental health and substance use disorders.[12]

Authority can stifle communication, and there are two broad examples where this encumbers the doctor-patient relationship. Researchers conducting a qualitative study involving 48 focus group members discovered that some physicians were more authoritarian than authoritative, a brash style that hindered patient-centered care. Other participants admitted deferring to the physician's expertise and surrendering their autonomy and assuming a passive role, in part to avoid being labeled a difficult patient. In both cases, the study emphasized the importance of encouraging the patient's unfettered communication.[13]

A person's socioeconomic class is another variable affecting communication. Social inequities affecting the doctor-patient relationship occur on both ends of the spectrum. Among individuals in lower socioeconomic strata, patients may not understand the treatment and providers may lack familiarity with their patient's environment and how it may influence behavior.[14]

The dynamic is different with affluent patients, otherwise referred to as Very Important Patients (VIPs). In a telling reassessment, the acronym "VIP" is reimagined as Very Intimidating Patients, which emphasizes the adverse influence on the doctor-patient relationship. While benefiting from greater access and attention, an encounter with a VIP may be warped when the clinician strays from the standard of care. A combination of the VIP's persona, be it demanding, condescending, or flattering, along with the clinician's corresponding adulation, fear, or grandiosity heightens the risk.[15]

Difficult encounters arise from a complex interaction between the clinician, patient, and healthcare systems but certain mental disorders are particularly challenging such as individuals with borderline or paranoid personalities. Their tumultuous, demanding, and fractious nature requires considerable patience and therapeutic neutrality.[16] Ambiguous medical complaints that defy diagnostic categorization and treatment may also affect the doctor-patient relationship. In these and myriad other examples that descend into a difficult encounter, the clinician's initial focus is geared toward repairing the communication, a step that may benefit from a consultation with a mental health professional.[17]

Management of the difficult encounter

Frederick W. Platt and Geoffrey H. Gordon's *Field Guide to the Difficult Patient Interview* is a classic introduction full of tips and strategies engagingly offered through concrete clinical examples. The book is organized by first describing a problem, the principles that guide a response, the procedures for tackling the tricky situation, the pitfalls that clinicians should avoid, and a concluding gem.[18]

In the section "Dealing with the Difficult Relationship," framing the issue begins with a list of "dreaded phrases" uttered by patients that almost immediately darken the clinician's behavior, such as "no doctor has ever been able to help me," "you're the only doctor who has ever understood me," or "only Demerol helps my headaches." Clinicians may interpret the comments as setting unrealistic expectations, making demands, or being obsequious, illustrating the principle that requires "conversation repair." According to the authors, the clinician should refrain from reacting defensively by pausing and reflecting before responding. Pitfalls to avoid include ignoring the patient, getting angry, or failing to listen and understand the patient. With a concluding pearl, clinicians are reminded that empathy is the best intervention.[18]

Factors intrinsic to managed health care, such as time-limited sessions, may stress the doctor-patient relationship with both parties watching the clock. Sensing the looming closure, the patient may anxiously unload their concerns, overwhelming the clinician. The too-brief encounter leaves both participants unsatisfied. In these situations, the clinician can schedule an additional appointment or even consider a telephone call, video conference, text, or chat to follow up. Even if it is unbillable, reaching out to the patient signals the clinician's interest and empathy.[19]

Repairing a difficult encounter relies on five principles: an empathetic attitude, normalizing the patient's emotional experience, providing support, being respectful, and working toward a shared decision-making partnership. These five principles help the clinician de-escalate the difficult encounter by providing respectful, supportive comments that reflect the patient's concerns and avoid counterproductive arguments. [20]

In another study, researchers examined the results of a customer service program specifically designed to improve patient satisfaction. Clinicians and support staff received training that addressed "patient perceptions of staff and telephone access, frequency of returned phone calls, staff empathy and responsiveness, and overall patient experience." The 4-year program randomly surveyed patients every 3 months with a structured instrument while monitoring formal complaints throughout the study period. A total of 611 patients participated, and researchers reported that patient satisfaction scores increased from 80.3 to 91.2, with formal complaints decreasing by 40.5%. Factors associated with patient satisfaction consisted of returning calls promptly; taking extra time to explain treatment plans; cheerful, optimistic providers; soliciting the patient's contributions to a treatment plan; and the staff's professionalism and civility.[21]

There are two broad approaches to managing a difficult encounter, with one focused on prevention by emphasizing the clinician's communication skills and the other exploring practices that may mitigate a fully fractured relationship. Prevention highlights empathy and mindfulness, but when the relationship deteriorates, mitigation strategies may limit the damage.

Conversation analysis as it specifically applies to medical encounters asserts that "there is evidence that how physicians solicit patients' concerns can have consequences for patients' perceptions of physicians' competence and credibility, and thus for patient outcomes, such as satisfaction." For example, medical encounters are of three types: the initial visit, a follow-up visit, and a visit with an established patient with routine or chronic problems. The research suggests that "What can I do for you? How are you feeling? and What's new?" are reasonable open-ended questions

respectively matching the patient's status. Mismatches, such as asking an established patient "What can I do for you?" might be interpreted as insensitive.[22]

A clinician's sensitive and focused style of communication is a crucial step toward preventing difficult encounters. A systematic review identified five evidence-based clinical practices that strengthen the doctor-patient relationship: prepare with intention, listen intently and completely, agree on what matters most, connect with the patient's story, and explore emotional cues.[23]

The first component, "prepare with intention," encourages clinicians to preview the patient's medical record or gather quick updates from office staff followed by a moment of uninterrupted mindful, reflection. The second recommendation requires the clinician's patience, listening attentively to the patient's narrative while minimizing distractions and probing questions. Active listening emphasizes the importance of nonverbal cues such as sitting down, good eye contact, leaning forward, and gestures such as head nodding. The third suggestion, "agree on what matters most," encourages patient participation in treatment planning, clarifies reasonable expectations, and concludes by summarizing the discussion and inviting disclosure of any unaddressed concerns. Clinicians can also demonstrate a personal, nonclinical interest in the patient, for example, by observing and commenting on their tattoos or asking about the person's hobbies or other interests. The fifth practice, "solidifying the clinical relationship," explores emotional cues by extending active listening to closely monitoring the patient's nonverbal communication, such as posture, mannerisms, and vocal tone, and then validates the observations with empathetic inquiries, such as "this seems upsetting."[23]

Repairing difficult encounters requires a bit of juggling on clinicians' parts in order to preserve the relationship—but not at the expense of providing substandard care. A useful strategy considers the ROAR approach, with the clinician's encounter structured by being "Reflective" and "Objective" and by providing the patient an updated "Assessment" and offering "Reassurance." By being reflective, the clinician recognizes and articulates the patient's frustration, de-escalating an emotion that can easily transition to anger. Being objective resets the clinical process as the clinician once again solicits the patient's history, shares entries from the medical record, and, most importantly, invests time in listening and answering any questions that arise. An assessment of the medical condition follows, during which the clinician ideally monitors the patient's reactions and empathically recalibrates in response to questions or concerns. Reassurance is the next and perhaps most important step. Through words and actions, the clinician's future availability is stressed, cementing the relationship's bond.[24]

Sometimes all that is needed is an apology, a simple solution encumbered with controversy. Medical apologies can run the gamut from a clinician's appointment tardiness to a bona fide medical error, but sincerity is key in every instance.[25] Proponents of medical apologies argue that the clinician's declaration of "I am sorry" without admitting guilt, along with "explanations, an expression of regret and empathy and the offer of redress" may restore trust and salvage the difficult encounter. In terms of suspected adverse events, however, the clinician should always pursue consultation before expressing contrition.[26]

Opponents of medical apologies point to studies showing their negligible impact on malpractice litigation. With high hopes, 38 states revised their tort laws making medical apologies inadmissible in malpractice trials; the reasoning was that apologies were good faith efforts by clinicians that would result in less litigation. In a study that examined 8 years of malpractice claims against 90% of physicians in America, the study concluded that "on balance, apology laws increase rather than limit medical malpractice liability risk."[27] In terms of disclosing medical errors in hopes of restoring a relationship, apologies "do not facilitate the type of communication that would improve physician transparency and overall patient satisfaction."[28]

DISCUSSION

Regardless of specialty practice, osteopathic physicians will eventually have a difficult patient encounter. Even though most doctor-patient relationships are trouble-free, a minority are dominated by difficulties of varying degrees and types. Many of these difficult encounters are behaviorally expressed in a cascade that may initially include silent frustration and then progress to problems with the patient's medical adherence, overt complaints, and even litigation. Prevention is the optimum approach, a strategy that requires the doctor's self-awareness, active listening, empathy, boundary setting, and management of expectations. Resurrecting a difficult encounter is in the physician's interest because damaged relationships negatively affect health care and may encourage grievances and legal actions. When difficult encounters between a doctor and a patient erupt repeatedly during each visit, it may be appropriate to issue an apology along with a commitment to improve communication and resolve misunderstandings. However, in cases where medical errors are suspected, physicians should wait for the results of internal reviews before responding and coordinate their responses with the guidance the facility provides.

Limitations

The selection of search terms used in this study may have excluded relevant literature. For instance, to broaden the scope of the publications searched, this study employed the terms "difficult patients" and "difficult clients." These two terms were represented in nearly all of the articles retrieved, although it is possible that different professional terms could have affected the study's findings. Another potential limitation could be articles available in nonsearched databases. Selection bias could be a limitation, but this study mitigated that by searching three databases.

CONCLUSION

Difficult encounters are an inevitable aspect of modern health care, but this concise review of the published literature provides evidence that can help physicians. Physicians can use simple, evidenced-based screening instruments to identify potentially troublesome relationships. This study also identified both physician and patient behaviors that contribute to difficult

encounters. The cumulative research presented in this study offers management approaches that can help prevent or repair difficult encounters. Not every troublesome relationship can be prevented or repaired, but as this study demonstrates, combining awareness of risk factors with clinical management can reduce and potentially mitigate difficult encounters.

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