Managing Difficult Encounters: Understanding Physician, Patient, and Situational Factors

ROSEMARIE CANNARELLA LORENZETTI, MD, MPH; C. H. MITCH JACQUES, MD, PhD; CAROLYN DONOVAN, DNP, PMHCNS-BC, FNP-C; SCOTT COTTRELL, EdD; and JOY BUCK, RN, PhD
West Virginia University School of Medicine–Eastern Division, Martinsburg, West Virginia

Family physicians commonly find themselves in difficult clinical encounters. These encounters often leave the physician feeling frustrated. The patient may also be dissatisfied with these encounters because of unmet needs, unfulfilled expectations, and unresolved medical issues. Difficult encounters may be attributable to factors associated with the physician, patient, situation, or a combination. Common physician factors include negative bias toward specific health conditions, poor communication skills, and situational stressors. Patient factors may include personality disorders, multiple and poorly defined symptoms, nonadherence to medical advice, and self-destructive behaviors. Situational factors include time pressures during visits, patient and staff conflicts, or complex social issues. To better manage difficult clinical encounters, the physician needs to identify all contributing factors, starting with his or her personal frame of reference for the situation. During the encounter, the physician should use empathetic listening skills and a nonjudgmental, caring attitude; evaluate the challenging patient for underlying psychological and medical disorders and previous or current physical or mental abuse; set boundaries; and use patient-centered communication to reach a mutually agreed upon plan. The timing and duration of visits, as well as expected conduct, may need to be specifically negotiated. Understanding and managing the factors contributing to a difficult encounter will lead to a more effective and satisfactory experience for the physician and the patient. (***Am Fam Physician*****. 2013;87(6):419-425. Copyright © 2013 American Academy of Family Physicians.)**

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Difficult encounters are estimated to represent 15 to 30 percent of family physician visits.[1,2] Factors contributing to these difficult clinical encounters may be related to the physician, patient, situation, or a combination. Physicians can recognize these visits as challenging by acknowledging their feelings of angst or helplessness generated during the conversation.[1-4] These encounters are also characterized by a disparity between the expectations, perceptions, or actions of the patient and physician.[5-7] The resulting frustration can be influenced by a variety of factors, including the physician's background, skill level, and personality. The situation may be compounded by the patient's complex medical needs, personality, health literacy, or communication style.[5,8-10] Other influences include aspects of the practice environment and health care system.[2,6,11-13]

Physicians who report the most difficulty with patient relationships also report lower job satisfaction and higher levels of professional burnout than their colleagues.[1] To handle difficult encounters more effectively, the physician must learn to recognize the many variables associated with these encounters, and adapt his or her approach to the patient, starting with enhanced communication skills.[7,12]

Physician Factors

Every physician brings his or her background, personality, and experience to each patient encounter. When the ability to improve a patient's condition is threatened or undermined, the physician's identity as a healer may be compromised.[14] Difficult encounters may occur in several ways. Internet-savvy patients who present the physician with a printout of information and demand specific diagnostic tests or treatments can surprise or threaten the physician. The physician might perceive that his or her knowledge or ability is being

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SORT: KEY RECOMMENDATIONS FOR PRACTICE

Clinical recommendation	*Evidence rating*	*References*
For challenging patients, set boundaries or modify your schedule if needed. This can improve your ability to handle difficult encounters.	C	6, 14
Try to be aware of your own inner feelings. This results in fewer patients being labeled as "challenging" and leads to better management of difficult encounters.	C	2, 3, 6, 11, 14, 20
Employ empathetic listening skills and a nonjudgmental, caring attitude during patient interactions. This will improve trust and adherence to treatment.	C	3, 6, 7, 11, 14, 21, 27
Use a patient-centered approach to interviewing, such as motivational interviewing. Motivational interviewing has been shown to improve the therapeutic alliance with the patient and effectively influence behavior change.	B	34, 37-39
Assess challenging patients for underlying psychological illnesses, and refer for appropriate diagnosis and treatment.	C	11, 12, 39, 40-42
Assess challenging patients with symptoms of functional somatic disorders for past or current sexual abuse or significant trauma.	C	22-24, 42, 44

A = consistent, good-quality patient-oriented evidence; B = inconsistent or limited-quality patient-oriented evidence; C = consensus, disease-oriented evidence, usual practice, expert opinion, or case series. For information about the SORT evidence rating system, go to http://www.aafp.org/afpsort.xml.

challenged and respond defensively.[15,16] Similarly, when patients present with recurrent symptoms related to lifestyle issues, such as smoking, despite receiving adequate counseling, the physician might question his or her ability to relate to patients or influence behavior change.[2,14,17] Another common scenario is a patient repeatedly "losing" prescriptions for controlled substances, thereby undermining the physician's trust.

Whenever a physician's self-image as a competent health care professional is challenged, he or she is more vulnerable to professional burnout.[18] To sustain quality patient care, physicians need to be proactive in promoting and achieving their own self-care.[18,19] *Table 1* lists physician factors that can lead to difficult clinical encounters.[2,3,5,6,11-13,18,20] Physician self-awareness is the first step to facilitating a more successful encounter.

Table 1. Physician Factors That Can Lead to Difficult Clinical Encounters

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	**Skills**
Negative bias toward specific health conditions	Situational stressors	Difficulty expressing empathy
Perceived time pressure	Sleep deprivation	Easily frustrated
		Poor communication skills

Information from references 2, 3, 5, 6, 11 through 13, 18, and 20.

Patient Factors

Several studies have identified and evaluated characteristics of challenging patients.[1,3,6,21] In surveys of physicians ranging from residents to highly-experienced physicians, the common factor was the patient's ability to frustrate or trigger an emotional response from the physician.[2,3,11] Recognizing this characteristic in a patient is important in approaching a potentially difficult encounter.

Table 2 lists patient factors that can lead to difficult clinical encounters.[2,3,6,8-13,16,21-24] Contributing factors include common behavioral issues; significant medical issues or health conditions, including past or present trauma; underlying psychiatric diagnoses; and low literacy.[6,8-10,22-24]

A patient classification system developed about 60 years ago is still used by physicians to understand and plan responses to challenging patients.[3,12,25,26] *Table 3* provides methods to recognize and approach each of these types of patients.[3,6,11,12,20,25-27] Other classification systems include multiple patient types that can evoke a strong, instinctive reaction in the physician, including patients described as dependent,

Table 2. Patient Factors That Can Lead to Difficult Clinical Encounters

Behavioral issues
Angry/argumentative/rude
Demanding/entitled
Drug-seeking behavior
Highly anxious
Hypervigilance to body sensations
Manipulative
Manner in which patient seeks medical care
Nonadherence to treatment for chronic medical conditions
Not in control of negative emotions
Reluctance to take responsibility for his or her health
Self-saboteur
Conditions
Addiction to alcohol or drugs
Belief systems foreign to physician's frame of reference
Chronic pain syndromes
Conflict between patient's and physician's goals for the visit
Financial constraints causing difficulty with therapy adherence
Functional somatic disorders
Low literacy
Multiple (more than four) medical issues per visit
Physical, emotional, or mental abuse
Psychiatric diagnosis
Borderline personality disorder
Dependent personality disorder
Underlying mood disorder

Information from references 2, 3, 6, 8 through 13, 16, and 21 through 24.

angry, entitled, demanding, a chronic complainer, nonadherent, and self-destructive.[3,11]

Situational Factors

Modern office visits are often intensive, with priority given to pathophysiological issues rather than the patient's psychological needs.[7,26] The wider availability of medical knowledge to patients, including misleading information, can result in many patient questions and the need for more in-depth discussion.[15,26] The growing prevalence of patient-centered approaches that emphasize medical care tailored to patient preferences also exacerbates time pressures during difficult encounters.[7]

General Principles

The patient and physician each bring a frame of reference and set of expectations to an office visit. Empathy helps the physician suspend judgment and foster a relationship in which he or she is perceived as a healer and ally, not just a service provider.[6,17,19,20,28,29] Better health outcomes are achieved when the patient and physician have congruent beliefs about who is in control of necessary changes to improve health.[30] A focused assessment may reveal underlying, potentially treatable mental or psychiatric conditions; a history of abuse; or difficult family or social situations.[31-33] If controlled substances are necessary for treatment, screening the patient for potential substance abuse (and referral for treatment if necessary), implementing a pain contract, and checking with state substance registries are essential components of patient care.[31]

Following the principles of effective communication can help physicians prevent or manage difficult encounters.[7,11,13,28] Acknowledging that the patient's symptoms are valid is important to the potential effectiveness of treatment, as is demonstrating a willingness to work with the patient on a continuing basis. For an emotionally charged encounter, the physician must be able to redirect the situation *(Table 4)*.[11,12,14,20,27,34] The CALMER (catalyst for change, alter thoughts to change feelings, listen and then make a diagnosis, make an agreement, education and follow-up, reach out and discuss feelings) method is another approach to a difficult clinical encounter *(Table 5)*.[35]

For some patients, the physician may need to schedule more frequent focused visits, set appropriate boundaries for each visit, and agree on achievable goals.[6,14] If it is determined that a longer visit is needed for a more complex patient encounter, physicians can bill for face-to-face counseling time as long as it is adequately documented.[12] Whether the physician-patient relationship continues or ends, the patient must understand and agree with the decision.[6]

Approach to the Difficult Clinical Encounter

On a day when you are significantly behind schedule, your next patient is a 58-year-old divorced woman who smokes and has poorly controlled diabetes mellitus and hypertension. She is a college graduate and business executive. At every visit, she describes at least one new symptom, often with specific demands for testing or medication. Despite your repeated counseling on the importance of smoking cessation and controlling blood pressure and glucose levels, the patient remains nonadherent to lifestyle changes. You feel a sense of dread as you enter the room.

Although every difficult clinical encounter has unique aspects, recognizing several key components appears to be useful in managing these situations.

You feel a sense of dread as you enter the room. Physician awareness of inner feelings may result in fewer patients

Table 3. Suggested Approaches to Recognized Types of Challenging Patients

Patient type	*Characteristics of the clinical encounters*	*Approach*
Dependent clinger: insecure, desperate for assurance, worried about abandonment	Patient initially plays to physician's sympathies and praises him or her, making the physician feel special As the relationship develops, the patient becomes needy, wants/demands increasing personal time from the physician; the physician may feel resentful	Maintain a professional demeanor Establish boundaries early and consistently maintain them Involve the patient in decision making Assure the patient that you will not abandon him or her Schedule regular follow-up appointments
Entitled demander: often angry, does not want to go through necessary steps of assessment or treatment, may be reacting to fear and loss	Patient is aggressive and intimidating, forges a negative relationship with the physician Patient sees physician and health system as barriers to his or her needs Physician may feel anger, guilt, doubt, or frustration	Suspend judgment, and examine your own feelings Recognize that the patient's hostility may be his or her way of maintaining self-integrity during a devastating illness or other trauma If a specific emotion is evident, address it with the patient; do not react defensively when the patient expresses concerns Reinforce that the patient is entitled to good medical care, but that anger should not be misdirected at those trying to help
Manipulative help-rejecter: wants attention, has been rejected previously and has difficulty with trust, often has undiagnosed depression	Patient engages physician by subconscious manipulation Patient returns to the office often in cycles of help-seeking/rejecting treatment and does not improve despite appropriate advice Patient is confident that his or her health cannot improve Physician may be concerned about overlooking a serious illness	Recognize that the patient wants to stay connected to the physician, not necessarily to recover Engage the patient by sharing frustrations over poor outcomes Work with the patient to set limits on expectations Reformulate the health plan with the patient to focus on alleviating symptoms rather than curing the condition
Self-destructive denier: feels hopeless about changing the situation, unable to help himself or herself, fears failure, may have untreated anxiety or depression	Health problems persist despite adequate counseling and treatment Patient continues 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's behavior to identify causes of nonadherence (e.g., money, time, access to medical care or appropriate treatment) Celebrate each small success with the patient Offer/arrange for psychological support

Information from references 3, 6, 11, 12, 20, and 25 through 27.

being labeled as "challenging" and may lead to better management of difficult encounters.[2,3,6,11,14,20] Internal signals such as a sense of dread or negative feelings toward the patient, including anger or frustration, will influence the patient-physician relationship.[2,3,6] Strategies to help physicians identify personal factors that may contribute to a difficult encounter include self-reflection, recognizing biases, discussions with an experienced or trusted colleague, participating in Balint groups, or possibly seeking help from a psychotherapist.[18] The primary responsibility to address and resolve problems with the physician-patient relationship rests with the physician rather than the patient.[3]

You are significantly behind schedule. Environmental factors often contribute to a difficult encounter. The most common are extended wait times and negative interactions with office staff. A positive tone may be established by acknowledging a delay, thanking the patient for waiting, and giving an honest explanation.[36] Recognizing that the challenging patient requires more time and energy, the physician can plan for longer visits or schedule visits at the beginning or end of a clinic session. If the patient is new to the practice, frequent visits may be helpful to get to know the patient and to ensure that unresolved issues are addressed as soon as possible.[6,27]

Despite your repeated counseling on the importance of smoking cessation and controlling blood pressure and glucose levels, the patient remains nonadherent to lifestyle changes. Empathy requires understanding the patient's circumstances and perspective. Empathetic listening skills and a

Table 4. 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?"

Information from references 11, 12, 14, 20, 27, and 34.

nonjudgmental, caring attitude are necessary to improve patient trust and adherence to treatment.[3,6,7,11,14,21,27] This approach may decrease unnecessary diagnostic testing and reduce the risk of malpractice accusations.[36]

A patient-centered approach to interviewing is important for the physician to appreciate the patient's perspective.[28] Motivational interviewing is an increasingly common and studied technique, in which the physician explores the patient's desire, ability, need, and reason to make a change. Motivational interviewing has been shown to improve the therapeutic alliance with the patient and effectively influence behavioral change.[34,37-39] Identifying and clarifying the patient's expectations may allow him or her to more easily express dissatisfaction, or provide insights into appropriate treatment strategies. Asking patients to offer causes and potential solutions for their problems fosters a more collaborative relationship for care. Mutually agreed upon strategies offer better opportunities for patient adherence to treatment.[30,35]

At every visit she seems to describe at least one new symptom, often with specific demands for testing or medication. Appropriate treatment

Table 5. 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.

of psychological conditions is important in the successful care of challenging patients.[40,41] Some patients express vague symptoms and are frustrated that a cause cannot be diagnosed or treated. These patients may have underlying depression, anxiety, or personality disorder.[11,12,39,42] A previous article in *American Family Physician* addresses the care of patients with personality disorders in the primary care setting.[43]

Patients with symptoms of functional somatic disorders should be screened for previous or current exposure to violence or to physical, mental, or psychological abuse.[22-24] Functional somatic syndromes may be a result of intense bodily responses of varying organ systems to overwhelming stress. Targeted therapies may be beneficial.[44] Family physicians should be familiar with behavioral and psychiatric health care professionals and community services in their area so that they can make appropriate referrals. Patients with addiction, personality disorders, or significant psychosocial conditions require a team approach to care.

Factors contributing to difficult clinical encounters may be related to the physician, patient, situation, or a combination.

Data Sources: We searched the Cochrane Database of Systematic Reviews, CINAHL, PubMed, EBSCO Host, and Essential Evidence Plus. Search terms were difficult patient encounters, challenging patients, anger, noncompliance, physician-patient relations, physician-patient communications, heartsink patients, demanding patients, patient satisfaction, motivational interviewing, literacy, abuse, somatoform disorders, and chronic pain. We also searched the bibliographies of previously identified studies and reviews, the ClinicalTrials.gov registry, the U.S. Preventive Services Task Force, and UpToDate. We included only English-language publications. Search dates: November 30, 2011, and October 5, 2012.

The Authors

ROSEMARIE CANNARELLA LORENZETTI, MD, MPH, is a professor and interim chair of family medicine and an associate dean of student services and academic achievement at West Virginia University (WVU) School of Medicine in Martinsburg. She is also director of the Interdisciplinary Communication Curriculum for WVU's Eastern Division Campus.

C. H. MITCH JACQUES, MD, PhD, is a professor of family medicine and is the former dean and associate vice president for health services at WVU's Eastern Division Campus. He is also a faculty member with the Interdisciplinary Communication Curriculum for WVU's Eastern Division Campus.

CAROLYN DONOVAN, DNP, PMHCNS-BC, FNP-C, is an assistant clinical professor in WVU's School of Nursing and a clinical instructor in the Department of Family Medicine. She is the former director of behavioral health education at the Harpers Ferry Rural Family Medicine Residency in West Virginia, and is a faculty member with the Interdisciplinary Communication Curriculum for WVU's Eastern Division Campus.

SCOTT COTTRELL, EdD, is an associate professor in the department of medical education and an associate dean for student services at WVU's School of Medicine. He is a faculty member with the Interdisciplinary Communication Curriculum for WVU's Eastern Division Campus.

JOY BUCK, RN, PhD, is an associate professor of nursing and adjunct associate professor of family medicine at WVU's School of Medicine. She is a faculty member for the Interdisciplinary Communication Curriculum for WVU's Eastern Division Campus.

Address correspondence to Rosemarie Cannarella Lorenzetti, MD, MPH, West Virginia University–Eastern Division, 2500 Foundation Way, Robert C. Byrd Health Science Center, Martinsburg, WV 25401 (e-mail: rcannarella@hsc.wvu.edu). Reprints are not available from the authors.

Author disclosure: No relevant financial affiliations.

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