

DIFFICULT DOCTOR-PATIENT RELATIONSHIPS

Relationship difficulties emerge in about 15% of relationships. When stuck in a difficult relationship, think 'A, B, C, D and E':

- Acknowledgement, Boundary definition, Compassion and Determination of meaning to manage the relationship.
- Every relationship with a patient requires the use of both biomedical skills and communication skills of Engagement, Empathy, Education and Enlistment.

Perception of difficulty

Intellectually, there is a distinction between judging a behaviour that is unacceptable or dangerous and judging the person. Maintaining that distinction can be difficult in practice. For example, if you perceive behaviours that lead to or enable obesity (food addiction) in a negative way, does this impact on your ability to really support obese patients? If you disapprove of their behaviours, can you support smokers, alcoholics and drug addicts in their attempts to stop their addictions? Or are they just too difficult? It may be very easy to label and dismiss difficult patients but it is worth remembering that some of the patients your colleagues may find difficult, you will find easy to deal with and vice versa. The difficulties that can arise in the doctor-patient relationship will be created and/or affected by both parties to the relationship.

Acknowledge

Some consultations can get out of control with both you and the patient getting more and more frustrated. As entrenched positions are fortified, the battle becomes more important than the outcome. Saving face becomes a high priority before solving the problem. Stepping back to both acknowledge and verbalise the emerging areas of difficulty can give both the doctor and patient a chance to restart the relationship.

'Don't just do something, stand there!'

The first priority is to give yourself time to think, so you end up acting not reacting. Rather than having a tendency to act on impulse, getting deeper and deeper into trouble, it would be far better to pause and reflect – 'Something's wrong ... what's going on?' Reflecting on your own emotions and using them like a diagnostic tool – 'Why am I getting angry?' – to stop the situation from getting worse will require insight.

Four 'Es' of effective communication: Engagement, Empathy, Education and Enlistment.

When sensing difficulty with a patient, first review whether you have engaged properly with the patient. Did you begin aggressively? Did you bring anger and frustration into the new consultation from the last patient/a staff member/your partner? Then mentally run through the rest of the four 'Es' of effective communication and check if they have been fully used.

Check your **engagement** (have you connected properly with the patient?); think whether you have demonstrated **empathy** (making sure the patient knows they have been seen, heard and understood).

Has the patient received sufficient **education** and been provided with enough information to understand what you are advising?

Have you tried to **enlist** the patient (motivated them to accept your advice)?

Make a conscious choice whether you really want to try to work with that particular patient. Without anger or frustration, if your honest and rational decision is that you do not want to be further involved in this patient's care, then carefully prepare them for a referral or rather a transferral to another practitioner. Ensure that you make it clear that such a referral is motivated by the patient's best interests. You may wish to seek specific advice from Avant on how to end the doctor-patient relationship.

If you decide to continue, then you will need to rebuild the relationship before you can proceed to manage the medical problem the patient brought to you.

The first step towards rebuilding the relationship is to share the relationship difficulty with the patient, by verbalising it – 'I'm finding it difficult to help you because ...'

Then build a partnership to solve the difficulty – 'How do you feel about that? Can you think of ways you can help me help you? Is there something I can do to help us work better together?' And so on.

Boundaries

It is a matter of practical importance to define your boundaries and seek acknowledgement and agreement from your patient.

Some boundaries will be negotiable – for example, a practice sign may read '**The policy of this practice is:** Payment at the time of consultation. If adherence to this policy is difficult for you, please discuss this with your doctor.'

Some will be rigid – personal boundaries (not having a personal relationship with a patient) or professional boundaries (a firm precondition for accepting a person as a patient) – 'Whilst I will do everything medically I can to help drug dependency, I never prescribe drugs of addiction to support a drug dependency' or 'Mrs Smith, I've made a list of the eight things you've asked me to deal with today, but you did not book a prolonged consultation. I think we can deal with three of these today in the time we have. Would you like to say which three you'd like me to deal with today and which can be deferred to tomorrow?' This approach is subtle and sets a time boundary, leaving the patient empowered to make the choice as to what gets dealt with immediately.

Boundaries are commonly temporal (how much time you are prepared to give) and physical (agree on a request for a home visit or ask the patient to come to the surgery; accept a hug or just a hand shake from a grateful patient). More subtly, they may define a role limit – 'I know you've come to get me to give you a workers compensation certificate, but I don't think I can do that. I'm very happy though to provide a detailed medical report to whomever you nominate so you can make a claim for compensation.'

Boundaries can even be behavioural: 'Mr Smith, please calm down. I'm going to step outside for a moment. If on my return you persist with your aggressive behaviour and inappropriate language, I will have to ask you to leave.'

Sometimes, it's the patient who seeks to impose the boundary – 'I want you to fix my xxxx, but I don't want surgery' or 'I want a repeat script for the pill, but I don't want a pap smear today'.

Establishing and maintaining boundaries is a key part of maintaining a healthy doctor-patient relationship.

Compassion

Compassion is empathy expressed through action.

Compassion starts with empathy (acknowledging the patient's emotion, making sure they know you are seeing, hearing and understanding them) to which is added practical and helpful action. At its simplest, it may just be passing a box of tissues when you notice the patient's eyes fill with tears, as opposed to not acknowledging the patient's distress because you don't know how to or don't want to manage their distress.

The next level might be to give practical help in making appointments, finding contacts and resources. Sympathy is passive, compassion is active. In short, compassion is feeling plus doing – picking up a phone and making a call, rather than just writing a referral.

Determine meaning

People will resent being treated as if they are stupid and will not be receptive to advice or information given in a condescending way.

People do things for a reason. For example, the teenage girl perceives a positive, immediate benefit from smoking (peer acceptance) and perceives the negative health risks as remote, both in frequency and age saying – 'Lung cancer is relatively uncommon and happens mainly to old men.' The teenager perceives her smoking habit outweighs the potential health risk for many years to come.

Every patient comes to you with a pre-set belief about what could be the problem and what might be the solution. Your skill is not just to impose your solution to the patient's problems but to find out what they are thinking. Sometimes their expectations appear irrational. This usually means there's a piece of the jigsaw you haven't found. For example, a flat refusal to contemplate a Caesarean Section may flow from – 'I'm red headed. Red heads always bleed a lot. My red headed great aunt had a Caesar and nearly died from haemorrhage.' The science may be wrong, but the logic is impeccable. Unless you look behind the apparent unwarranted fear or unrealistic expectations and understand its meaning to the patient, the relationship will remain stuck.

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It's sometimes helpful not to ask-'Why did you come to see me today?' which is directly interrogative, but rather-'How did you come to see me today?' While some jokesters will say 'by car' most patients will understand the question to mean 'How did you come to decide you wanted to see me today?' This way of questioning makes the patient think deeper. The **Why** question will be answered - 'Because I need a Pap smear'. The **How** might be answered - 'My best friend has just had a breast cancer diagnosis and my Aunt Maude got her cancer of the uterus at my age'. The meaning of the request for a pap smear is revealed.

It is often through understanding the background or rationale for the patient's decisions that you have a greater chance of effecting change in their behaviour or addressing the problem.

Extend the system

Relationship problems are as much a reason for seeking help as technical problems. Help can be obtained by referral or transferral. Be cautious and sensitive in this process to ensure that the patient does not think you're trying to get rid of them. In the case of referral, you might explain it saying you are bringing new instruments into the orchestra which you will continue to conduct. Conversely, if you are indeed ending the doctor-patient relationship and transferring the patient to another doctor or agency for complete management, make sure the patient understands why.

References

1. Difficult Clinician-Patient Relationships workshop.
Website: www.healthcarecomm.org

Bibliography

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