Strategies for dealing with the challenging patient

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Introduction

Although the challenging patient has been recognised for many decades, there is still significant frustration and burden for general practitioners (GPs) in managing such patients effectively. There are different ways of classifying challenging patients. The literature dates back many years to the psychiatrist Groves who described the 'hateful patient'[1] and defined four stereotypes: 'dependent clingers', 'entitled demanders', 'manipulative help-rejecters', and 'self destructive deniers'. Others refer to 'heartsink' patients[2] or 'difficult' patients.[3] Some types of medical problems are also more challenging for physicians. e.g. mental health, alcoholism, drug abuse, obesity and musculoskeletal disorders. Patients with somatisation disorder in particular may also be seen to be challenging. The prevalence of such challenging consultations is between 15%[4] and 30%.[5] In a study utilising in-depth interviews with 15 experienced Israeli GPs,[6] 'difficult' patients were reported to be those who were violent, demanding or rude and those who sought secondary gain, as well as those with psychosomatic problems (refer Table 1). It is important to note the setting of this study and that maybe in other contexts there are lower frequencies of presentations with aggression and violence as a dominant feature.

In trying to help physicians improve the quality of their interactions with challenging patients some authors have tried to define the characteristics of 'heartsink' patients in more detail. At the same time others have focussed on physician characteristics. As a result, most physicians now acknowledge that part of the problem is in the encounter and not just with the patients themselves.

In a UK study[7] of sixty GPs it was found that 60% of the variance in the number of 'heartsink' patients that the GPs reported could be explained by greater perceived workload, lower job satisfaction, lack of training in counselling and/or communication skills and lack of appropriate postgraduate qualifications. Other characteristics such as attitudes to psychosocial aspects of patient care have also been measured,[4] and it was reported that physicians with less interest in psychosocial issues were more likely to experience encounters as challenging (23% vs 8%).

It is important to acknowledge that there is some evidence that such encounters can have less than desirable outcomes for the patients. One study reported that patients presenting with physical symptoms who were perceived as 'difficult' by their physician were more likely to have poorer functional status, unmet expectations, reduced satisfaction and greater use of health care services.[4]

The earlier notion of 'heartsink' patients has recently been re-examined.[8] The authors concluded that the 'heartsink' phenomenon is a symptom of the tension between two different philosophical foundations underpinning general practice. Their question was should GPs confine their 'clinical attention' to 'scientific, biological medicine' or should they accept that medicine necessarily involves interacting in a helpful manner with *'those patients who seek salvation for psy-*

Table 1. Steinmetz and Tabenkin's 'types of difficult patients' (in descending order of relative frequency)[6]

1.	Violent, aggressive, verbally abusive
2.	Unresolved repeated complaints
3.	Multiple complaints – 'shopping list'
4.	Psychosomatic patients
5.	Complaining, never satisfied
6.	Seeking secondary gain
7.	Manipulative, lying
8.	'Everything hurts'
9.	Having a high anxiety level
10.	'Pain in the neck'
11.	Demanding, boundary-busting, exploiting the doctor
12.	Angry at the doctor
13.	Uncooperative
14.	Difficult psychiatric patient
15.	Drug addict

chological, social and spiritual problems at a biomedical level."[8]

Whatever GPs think of this question, most GPs are prepared to work with challenging patients. Therefore it may be helpful to share ways of managing these encounters more effectively. I will first examine some general techniques for dealing with challenging patients and then look specifically at strategies for dealing with the angry patient and breaking bad news.

General strategies for dealing with challenging patients

The authors of the Israeli study mentioned above[6] described a variety of strategies the GPs used to cope with the 'difficult' encounter (refer Table 2). These strategies included empathy, tolerance and non-judgemental listening. In findings similar to those of previous studies[7] they also reported that the more experienced the doctor was, the more he/she learned to accept the greater diversity of behaviours in their patients.

For those patients who present frequently with multiple unresolved symptoms, a more practical/structured approach has been proposed.[9] Gillette believes that although it appears burdensome, in his experience it has been shown that such an approach (refer Table 3)[9] in the long-term saves time, money and aggravation.

More recently another model has been proposed,[10] the CALMER approach (refer Table 4), which utilises the 'stages of change model' and other models including Gillette's, along with strategies derived from cognitive behavioural theory.[10]

Other ways of coping with challenging encounters include getting medical students/trainee registrars to form a relationship with the challenging patient, videotaping a difficult encounter and reviewing it with a colleague, talking in supportive peer groups, and learning relaxation techniques.

The angry patient

Patient anger is uncomfortable for the doctor and can lead to poor communication within the consultation, dissatisfaction, and therefore patients who are more likely to make a complaint.[11,12] Strategies to defuse anger are important. Simple steps include:

1. Allow the patient to vent their anger.
2. Acknowledge the anger 'I can see you are really angry about this.'
3. Validate the anger 'understandably you are very angry as this is a very frustrating situation you are in.'
4. Offer to explore the situation in more depth – it is often found that there are many layers to the anger and frustration the patient is experiencing.

During the interchange keep calm, utilise a neutral tone of voice, adopt an open body posture, move back from the patient so there is plenty of space for the patient, do not become defensive (do not take it personally) and be aware of the position of the door or any emergency button should you require it.

In a novel study[13] 130 patients undertook to evaluate four different responses (apology, explanation, self-disclosure and acknowledgement) by physicians to patient anger (due to a long wait) by observing video trigger tapes. The approach evaluated as most important and satisfying was an apology combined with a short explanation e.g. 'I apologise for your long wait. It's been a hectic morning. Some of the patients have needed extra time.'

Table 2. Steinmetz and Tabenkin's means of coping with the difficult patient or encounter (in descending order of relative frequency)[6]

1. Empathy
2. Non-judgemental listening
3. Patience and tolerance
4. Direct approach
5. Defining limits of time and content in advance
6. Referral to various consultants, lab tests, alternative medicine and mental health services
7. Confrontation with the patient
8. Recommendation for transfer to another doctor
9. Use of humour
10. Involving the patient's family

Table 3. Gillette's approach to 'problem patients'[9]

1. Recognise problem behaviour when it exists.
2. Obtain the patient's perspective – this may need a follow-up visit to fully explore the patient's story, their ideas, feelings and expectations of the doctor.
3. Take a structured history –including a psychosocial review.
4. Do a routine physical exam and screening lab work – this will enable you to identify any coexisting medical problems and assure the patient you have been thorough. Touch the part that hurts!
5. Complete any indicated testing promptly – do not fall into the trap of ordering new tests every time the patient describes a new symptom.
6. Give the patient a timely report of your conclusions and plan.
7. Set limited objectives.
8. Schedule regular visits – then gradually increase the interval between visits.
9. Keep visits short and focussed.
10. Touch the patient.
11. Give the patient something to do – prescribe exercise or dietary modifications.
12. Use medicine selectively.
13. Work with family and friends.
14. Work with colleagues and staff – they need to understand and support the plan. Discourage pejorative descriptors that promote negative attitudes.

Saying 'I apologise for your long wait' was ranked higher than 'I am sorry you have been kept waiting', because the first response means the doctor is taking more personal responsibility for the situation. Most participant patients preferred the doctor then to move along in the interview by using a follow-up question like 'shall we get started' and not utilising questions that explored the patient's feelings in more depth. Limitations of this study include the fact that videos were used and the anger the patients were observing was only related to the one scenario of being kept waiting by the doctor. Obviously offering an apology for things within the doctor's control is a helpful strategy.

Delivering bad news

Delivering bad news is difficult and a continuing challenge for any GP. Bad news can be defined as a situation *'where there is either a feeling of no hope, a threat to a person's mental or physical well-being, a risk of upsetting an established lifestyle, or where a message is given which conveys to an individual fewer choices in his or her life.'*[14] Context is critical as many cultures have differing views on bad news. Some cultures believe it is harmful to the patient. However many patients do wish to be fully informed, for example *'92% of patients with mild dementia wished to be informed and 98% of the same patient sample reported wanting disclosure of a hypothetical diagnosis of cancer'*[15] and there is evidence that disclosing the truth does not harm the patient.[15] When bad news is delivered badly we can make people feel less well than when delivered skilfully. It was found that women with early breast cancer who felt the information they received was adequate were only half as likely to be depressed or anxious one year later.[16]

Delivering bad news can be stressful because it may evoke strong feelings in the physician such as a sense of personal failure, fear of not being able to handle the emotions, fear of causing harm, feelings around their own mortality and possibly shame in asking for support. There are often other constraints such as time, and institutional barriers such as lack of support and poor role-modelling that adds to the difficulties. Doctors clearly remember their first experiences of giving bad news because they were unpleasant and they felt inexperienced.[17]

There is a paucity of good research on what patients' and families' needs are in relation to the delivery of bad news, but a recent, detailed summary of the literature exists.[18] As these authors report, most studies are based on recall months to years later; as many researchers believe it to be unethical to question recipients of bad news immediately after or close to the event. In one retrospective study of parents after the death of their child (majority due to road traffic accidents) they wished physicians to show distress and concern rather than cold detachment.[19] Retrospectively 54 family members, of 48 patients, who had died in an intensive care/emergency setting, were asked to evaluate the importance of different elements related to receiving bad news. The most important features were reported to be the: *'attitude of the news-giver (ranked most important by 72%), clarity of the message (70%), privacy (65%), and knowledge/ability to answer questions (57%).'*[20]

An Australian study was undertaken to compare the views of oncologists, nurses and breast cancer patients on the importance of 15 general principles and 12 recommended steps to guide clinicians in breaking bad news.[21] It was reported that *'Giving the patient the diagnosis and prognosis honestly and in simple, but not blunt, language was ranked highest by all three groups. Giving the news in a place that is quiet and private ranked second among patients, fifth among nurses, and eighth among doctors.'*[21] A study of patients with head and neck cancer reported that they wanted their physicians to be caring, compassionate, and truthful and to use simple and direct language.[22] These authors also reported that 75% of the participants did not want their physi-

Table 4. Pomm et al.'s CALMER approach[10]

1. **C**atalyst for change - identify where the patient is on the stages of change and then act as a catalyst for moving them onto the next stage.
2. **A**lter thoughts to change feelings – physicians need to identify their own feelings in response to the patient, ask how they are affecting the relationship, explore possible reasons for the patient's behaviour and then ask 'what can I tell myself about this situation that will make me feel less angry/disgusted?'
3. **L**isten and then make a diagnosis.
4. **M**ake an agreement – to continue in the relationship, having a clear agreement on the need to work on the problem together. This will increase perceived control for both the physician and patient.
5. **E**ducation and follow up.
6. **R**each out and discuss your feelings – ask yourself how you now feel about the patient. Identify how you will care for yourself. Discuss it with a trusted colleague.

Table 5. Baile et al.'s SPIKES six step protocol for delivering bad news[23]

1. **Setting up** the interview
2. Assessing the patient's **Perception**
3. Obtaining the patient's **Invitation**
4. Giving **Knowledge** and information to the patient
5. Addressing the patient's **Emotions** with empathetic responses
6. **Strategy** and **Summary**

cian to touch them when giving the bad news.[22]

There have been many published guides on how to deliver bad news.[21,23-26] There are many similarities between the guidelines, but context must always be considered and there needs to be some awareness about how to learn and implement skills effectively.

In most of the guides an emphasis is placed on preparing for and setting up the consultation. This will involve arranging a private room, dealing with any time constraints, involving family members if desired by the patient, rehearsing what you might say, and being prepared emotionally and also with any factual information you may need.

Once the consultation starts, sitting down in a relaxed way is helpful and signals to the patient that you have time for them. It is then important to assess the patient's understanding of the situation so far by asking an open questions such as 'What is your understanding of what has been happening to you?' You can then correct information and gauge how much information the patient may wish to receive. You then ask the patient whether they wish for more information and how they would like to receive it. Giving a warning that difficult information is coming is critical.

When sharing the information, use simple, non-technical words and repeat important points. As much as possible relate your explanation to your patient's framework and match their vocabulary. While giving information constantly monitor and check for the patient's comprehension and reactions. The emotional reactions of patients to receiving bad news will vary a great deal depending on the individual. Support needs to be offered in an empathic way by noticing the emotions, identifying them and reflecting/validating them. Giving permission to the patient to express feelings is important.

Finally it is crucial to identify and deal with any further patient concerns and make a plan of action. It may be that the plan initially is to return within a certain timeframe to discuss in detail treatment options. It is vital before concluding the consultation to ensure that there is a good support network for the patient and clear safety nets.

Conclusion

It is evident from the amount of literature on challenging patients and delivering bad news that not all the problems have been solved, and that these consultations continue to be difficult for most GPs. As there is significant variability in what patients desire for their bad news consultation, and in what strategies work for individual challenging patients, GPs need a wide repertoire of helpful skills. Finally it is clear that ongoing specialised skills training is required to continually refine skills in managing these challenging consultations.

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