What Mediators Can Teach Physicians about Managing 'Difficult' Patients

Between 10%-12% of patients are considered difficult by their treating physicians,[1] indicating a widespread problem. Many physicians report feeling at a loss to know how to effectively manage challenging patient interactions.[2] In extreme cases, physicians resort to refusing to treat hostile patients or dismissing them from their clinical practice.

But these last-resort measures rarely result in a satisfying resolution for either party. When a clinical relationship is severed, it is hard to escape lingering feelings of ill will, mistrust, resentment, or even job dissatisfaction. Clearly, if a breach in the doctor-patient relationship can be avoided and good rapport reestablished, it is better for all involved.

Mediators are specialists in conflict management. Their approach to conflict and the techniques they employ to resolve it have been identified as potentially useful in helping physicians navigate challenging patient encounters.[3] Yet short of formal mediation training for clinicians, there has not been much practical advice offered by mediators to clinical providers.[4] In the absence of a substantial investment of provider time to master mediation techniques, what insights can mediators impart to practicing clinicians that might help to ameliorate problematic patient interactions? Here I offer seven maxims of mediation that are applicable to the "difficult" patient and might prove helpful in clinical conflict management.

First, "difficult" patients should be viewed as a syndrome, not a species. Most of us can become difficult given the right conditions. If negative patient interactions are understood to be merely circumstantial,[5] then they will also be regarded as amenable to change. This simple re-orientation –

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[1] Hahn SR. Physical symptoms and physician-experienced difficulty in the physician-patient relationship. Ann Intern Med 2001; 134: 897-904.
[2] Hahn SR, Kroenke K, Spitzer RL, Brody D, Williams JB, Linzer M, et al. The difficult patient: prevalence, psychopathology, and functional impairment. J Gen Intern Med 1996; 11: 1-8.
[3] Bloche MG. Managing conflict at the end of life. N Engl J Med 2005; 352:2371-2373.
[4] Wasan AD, Wootton J, Jamison RN. Dealing with difficult patients in your pain practice. Region Anesth Pain M 2005; 30: 184–192.
[5] Fiester A. The "difficult" patient reconceived: An expanded moral mandate for clinical ethics. Am J Bioeth 2012; 12: 2-7.

what mediators call "reframing" – will go a significant distance in strengthening one's resolve to search for workable solutions without reifying a bad dynamic.

Second, anger is a reactive emotion, so the key is finding its source. Anger is a member of the class of "moral emotions," affective responses that testify to an individual's perception of having been wronged, offended or harmed. Along with resentment and indignation, anger is a reaction to a sense of being treated unfairly in some way – by the system, the providers, the receptionist, the insurance company, or maybe even the disease. If you find the source of the anger and address the underlying cause, then the symptoms of rude, aggressive or insulting behavior will usually resolve automatically.

Third, it takes mere seconds to escalate or deescalate a brewing conflict. It takes no more time to be the salve than the accelerant when someone is angry or frustrated. When teaching mediation, we often hear physicians say that clinical time pressures preclude getting mired in conflict management, but mediators know that many full-blown conflicts can be avoided with negligible time investment. With effective technique, anger can be abated in less than a minute. Alternatively, if a patient feels his or her concerns have been dismissed, feelings ignored, or blame deflected, a physician can turn up the dial on a person's anger just as quickly.

Fourth, calling someone out for bad behavior will inevitably make matters worse. No one wants to violate the standards of decorum. Rudeness, insults, and diatribes are the tools of the desperate who feel that they have exhausted all of the more civil avenues for being heard, having their needs met, or getting the acknowledgment they seek. Therefore, fingering wagging and scolding merely adds insult to injury to the party who already feels aggrieved. If shamed, patients will dig in their heels to protect both their dignity and their cause. As long as it is non-violent, ignore the verbal package in which the message is being delivered and hone in on the crux of what the person is trying to convey. This is admittedly hard to do: we have a natural predisposition to self-defense, so when attacked, our impulse is to fight fire with fire. Resist the urge to reproach.

Fifth, exercising neutrality ups the odds of successful conflict resolution. It is well-known that mediators are "neutrals" in a conflict – that is, they don't have a dog in the fight. That neutrality

enables them to fully invest their attention, analysis and problem-solving skills on the other person without the distraction of self-protection or self-defense. In managing the "difficult" patient, a physician is, of course, a party to the conflict, so neutrality is much harder to achieve. Yet, hard as it is, setting your own interests and ego aside in a heated encounter can pay large dividends. Until the conversational temperature is reduced, don't defend your own behavior, clinical practice, colleagues, or institution.

Sixth, naming the concern demonstrates alliance and avoids creating an adversary. Since invectives are maladaptive attempts to express one's real concerns – what mediators call "interests" – identifying and describing those concerns for the patient demonstrates that you are the patient's advocate without having to agree that the patient is in the right. This is why mediators place a higher premium on problem-diagnosis than on empathy: naming the problem is a very powerful tool in establishing trust and good will. If "difficult" patients could do the work of analyzing and explaining their needs without the heated or offensive language, they wouldn't need your assistance and they wouldn't be "difficult." Take one example. To the patient yelling and cursing about the two-hour wait, respond in a way that shows that you understand the underlying issue: "The delay in this appointment has wasted an enormous amount of your time, and it is incredibly frustrating to have to wait so long." But if you dismiss or ignore the concern or complaint – "Well I'm here now; let's get on with why you have come to see me" – you do so at your own peril. Unresolved anger festers and will put you and the patient at loggerheads.

Finally, a sincere apology or expression of consolation can go a long way in defusing a tense interaction. The apology ("I am sorry for…") and the statement of consolation ("I am sorry that…") are two of the most important tools in the mediator's arsenal. Physicians are sometimes reluctant to use them for fear of liability, but unless the situation involves malpractice, these expressions are harmless to the physician and very beneficial to the doctor-patient relationship. Use apology when there is even slight culpability and the expression of consolation when the circumstance is clearly beyond your

control. In the long wait-time example: “I am so sorry that you had to wait. We had an unexpected emergency.”

Mediation undeniably involves an extensive skill set that seven pithy axioms cannot fully capture. Although not intended as a panacea, perhaps these tools will be useful in reducing the acrimony and frequency of difficult patient encounters.