Teaching medical learners to appreciate "difficult" patients

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During their training, medical students and residents will meet many types of patients, and not all of them will be easy to deal with. Some will be dependent, self-destructive, vague, or noncompliant. Each time our learners meet these patients, they will experience their own range of emotions, from anger to frustration to uncertainty. As teachers and experienced clinicians, we often take for granted that patients can be argumentative—at times even hostile—and that part of our job is learning how to effectively work with "difficult" patients.[1-3]

The aim of this paper is to provide a framework for teaching medical learners how to better appreciate the difficult patients they encounter by offering tools that will allow them not only to survive these visits, but to thrive in them.

Difficult patient or difficult encounter?

The language teachers use is very important. Labeling patients as *difficult* is not particularly useful or appropriate in most circumstances. It is fair to say that an encounter with a patient was difficult or that the series of life circumstances that led the patient to behave in the way he or she did were difficult, but the broad label applied to an individual is often unfair.

A key message to pass on to learners is that the attitude and behaviour of both the physician and the patient, as well as the patient's recent and remote life history, all affect how difficult an encounter will turn out to be.[4] The following are examples of key teaching strategies that physicians can apply when learners face difficult patient encounters.

Effective debriefing

Talking to learners about difficult encounters is essential to helping them understand that they are not alone—all physicians have visits that do not go well. As with any teaching encounter, the message will have greatest effect if the feedback is given immediately, with an opportunity for self-reflection on the part of the learner.[5] The following case description illustrates this point:

> You are a preceptor reviewing a case with a family medicine resident who has just had a heated discussion with the father of a 5-year-old girl. The father is demanding a dermatology referral for a benign skin rash. The resident has made a diagnosis of atopic dermatitis and suggested appropriate treatment for this condition. Although appropriate education has been offered, the father is insistent that a referral to a skin specialist be made. The resident becomes frustrated and angrily responds, "Part of my role as a physician is to serve as a gatekeeper to ensure that resources are not wasted in our system. Your daughter does not need a referral." The patient's father responds by demanding to speak to the resident's supervisor.

Discussion

An effective teaching moment will challenge the resident to explore his or her own emotional reaction to the patient encounter. For example, initiate the discussion by saying, "That seemed like a difficult encounter. Can you tell me how you are feeling right now?" The resident might respond by saying he or she feels angry, frustrated, or disrespected. Asking the resident to reflect on these emotions can yield a very rich discussion about counter-transference and suggestions about how this encounter could have ended differently.

Medical students and residents need to do more than evaluate the behaviour of the patient. They must also be able to effectively evaluate their own behaviour and emotions and understand how these can affect the outcomes of difficult encounters. It is important for the teacher to explain that while suppressing emotion is not necessary or advised, if these emotions are expressed in front of the patient, things should not be expected to end well. In this case, providing feedback about the resident's tone with the patient's father in a direct but nonthreatening fashion is crucial and could prevent such an outcome from occurring again.

Teaching learners to say no more effectively

There are many instances in medical practice in which saying no to patients is the right thing to do. Learning to say no in a way that makes the patient believe that they are still involved in the decision-making process can make even the most difficult patient encounters more manageable. In the case above, how could the learner have responded differently when the father repeatedly requested a referral?

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Discussion

Saying no right away to the request for a referral will almost certainly increase the father's frustration in this case. The learner should be certain to take a full history and complete a thorough physical examination before arriving at the decision to hold off on the referral.

When patients hear no before they have had a chance to be heard, they have every right to get annoyed and leave with a sense that the physician did not understand where they were coming from. An effective response to the demanding father in this case might be the following: "I appreciate that you are concerned about your daughter's skin condition and so am I. That is why I'm going to suggest a good effort with all of the treatments I have suggested today and a follow-up appointment in 2 weeks to review her progress. If things are not improving, we can certainly discuss the idea of a dermatology referral again at that time."

With this type of reflective statement, the medical learner has conveyed to the father that his concerns are understood and that the possibility of a referral is still on the table, although clearly not appropriate at this time. In effect, the learner has said no in a way that this previously "difficult" patient can now accept.

Understanding the patient

If learners are going to understand why patients behave in certain ways, they must take the time to understand each visit in the context of the person's life. Difficult patients have often had difficult upbringings. Knowledge of meaningful life events (such as divorce, abuse, death of a friend, etc) can shed valuable light on who these people really are and why they have such a difficult time relating to other people, including their own physicians. This is exemplified in the following case:

> Jesse is a 45-year-old male prescription drug abuser with hepatitis C who presents with an acute flare-up of low back pain. One of your residents is seeing him for the first time today, and the visit begins with a rather gruff request for oxycodone. He is persistent, condescending, and loud, but your resident is handling things very effectively. She has learned to take a full history and perform a proper physical examination before giving treatment advice. She has asked the patient what he thinks the best treatment would be for his back pain at this time and what strategies have been tried in the past. She refrains from saying no immediately, even though she is quite certain that owing to this man's history of drug abuse and the nature of his apparent injury he will not be getting oxycodone today. Finally, the resident confidently and calmly reports that oxycodone is not effective therapy for his current condition, and a host of other appropriate treatment options are suggested. The patient becomes agitated and insults the resident, saying, "You have no idea what you're talking about. If you had my kind of pain, you'd be begging for someone to help you too!" He gets up and storms out of the office.
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> When debriefing this case with the resident, it is obvious she is quite distraught. She points out that she did everything right in her approach, yet the outcome still felt negative. Her opinion of the patient was that "he is a drug seeker who was just here for pills" and "I really don't want to see that guy again because I don't think we can help him."

Discussion

This patient would be a challenge even for the most experienced clinician. The debrief is an excellent opportunity to share more about the patient's history, or to challenge the resident to find out more on the next visit. Part of what the learner needs to understand better in such cases is global context. Who is Jesse? Who are the supports in his life? Did the resident know that a family member sexually assaulted him as a child? That Jesse never learned

to read or write? Or that the hepatitis C he acquired was not from intravenous drug use, but from a tainted blood transfusion?

In understanding more about who people really are and where they have been, physicians are not excusing poor or antagonistic behaviour, but rather are trying to understand it better. In this sense, it is fair to inform learners that every difficult patient encounter is an opportunity—an opportunity to gain insight into the human condition, to learn more about who patients are, and to effectively determine how to help.

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Competing interests
None declared

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TEACHING TIPS

- Medical students and residents can learn excellent practice skills from difficult patient encounters, enriching their practice experience, provided they learn to handle such situations appropriately.

- Learners should be challenged to evaluate their own emotions and behaviour as well as those of their patients, and use self-reflection to recognize how their feelings can affect patient encounter outcomes.

- Teaching learners to say no effectively, without silencing or alienating patients, is a key strategy in deflecting potential difficult encounters; encouraging learners to take a full history and physical examination before suggesting an alternative route to the one suggested by the patient is a way to show the patient he or she has been heard without compromising the physician's decision.

- Learners should be advised to uncover the patient's global context (eg, their background, their upbringing, factors leading to their condition, and any meaningful life events) in order to better predict and understand certain behaviour and more effectively provide care.

CONSEILS POUR L'ENSEIGNEMENT

- Les étudiants en médecine et les résidents peuvent acquérir d'excellentes compétences en pratique à la suite de rencontres difficiles avec des patients, en enrichissant leur expérience de la pratique, pourvu qu'ils apprennent comment gérer de telles situations de manière appropriée.

- On devrait inciter les apprenants à évaluer leurs propres émotions et comportements ainsi que ceux de leurs patients et à utiliser l'autoréflexion pour reconnaître comment leurs sentiments peuvent influencer l'issue des rencontres.

- Enseigner aux apprenants à dire non efficacement, sans clouer le bec du patient ou l'aliéner, est une stratégie importante pour désamorcer une rencontre difficile potentielle; il faut encourager les apprenants à faire une anamnèse et un examen physique complets avant de suggérer une autre solution que celle proposée par le patient pour lui montrer qu'on l'a bien écouté sans pour cela compromettre la décision du médecin.

- Il faudrait conseiller aux apprenants de chercher à connaître le contexte global du patient (p. ex. ses antécédents, son éducation, les facteurs qui ont mené à son problème et les événements marquants de sa vie) pour mieux prévoir et comprendre certains comportements et lui dispenser plus efficacement des soins.

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