PARTICIPANT HANDOUTS
“Lunchtime Learning” Professional Skill Development Distance Learning Series Event #5:
Caring for Difficult Patients in a Complex Healthcare System

Presented by:
Presented by William Robiner, Ph.D. A.B.P.P., L.P.
Professor, Departments of Medicine and Pediatrics
Director of Health Psychology
University of Minnesota Medical School

Live Broadcast Date/Time:
Wednesday, August 17, 2016
12:00–1:00pm Mountain Time / 1:00–2:00pm Central Time

Series Overview:
Join Community Health Association of Mountain/Plains States (CHAMPS) and Colorado Community Health Network (CCHN) for the “Lunchtime Learning” Professional Skill Development Distance Learning Series! These six one-hour webcasts will take place between April and September of 2016. Participants may attend any selection of events; all are designed to provide professional development and skills improvement as a component of a continuous process of advanced practice transformation, with the goal of positively impacting retention rates at Region VIII health centers. The events are primarily targeted at health center administrative and clinical support staff, although staff members from all levels of the health center are welcome.

Event Overview:
Patient care presents diverse challenges to health and social service professionals, including dealing with patients who may be considered “difficult” for a variety of reasons. The goal of this presentation is to provide an overview of characteristics of “difficult” patients and the complex systems in which they are seen which contribute to challenges in providing health care services. This presentation provides a framework for discussion and examples of practical approaches to dealing with “difficult” patients.

Learning Objectives:
Upon completion of this session, participants should be able to:
1. Identify attributes of “difficult” patients and their impact on health services.
2. Recognize the psychological comorbidities of “difficult” patients.
3. Recognize how providers and systems contribute to the problem of “difficult” patients.
4. Identify strategies of healthcare providers to manage “difficult patients more effectively.
SERIES TIMELINE
Event #1: Utilizing Mindfulness to Reduce Stress and Prevent Burnout (Archive Available)
Event #2: Creating a Productive Work Environment: Enhancing Teambuilding (Archive Available)
Event #3: Creating a Productive Work Environment: Decreasing Negative Attitudes (Archive Available)
Event #4: Creating a Productive Work Environment: Establishing Boundaries (Archive Available)
Event #5: Caring for Difficult Patients in a Complex Healthcare System; 8/17/16
Event #6: Interpersonal Considerations for Care of Elderly Persons; 9/21/16
Visit http://champsonline.org/events-trainings/distance-learning for complete details, including registration for upcoming events.

CHAMPS ARCHIVES
This event will be archived online and on CD-ROM. The online version will be available within two weeks of the live event, and the CD will be available within two months. CHAMPS will email all identified participants when these resources are ready for distribution. For information about all CHAMPS archives, please visit http://champsonline.org/events-trainings/distance-learning.

DESCRIPTION OF CCHN
Colorado Community Health Network (CCHN) is a non-profit organization representing the 20 Colorado Community Health Centers (CHCs) that together are the backbone of the primary health care safety-net in Colorado. CCHN is committed to educating policy makers and stakeholders about the unique needs of CHCs and their partners, providing resources to ensure that CHCs are strong organizations, and supporting CHCs in maintaining the highest quality care. For more information about CCHN, please visit www.cchn.org.

DESCRIPTION OF CHAMPS
Community Health Association of Mountain/Plains States (CHAMPS) is a non-profit organization dedicated to supporting all Region VIII (CO, MT, ND, SD, UT, and WY) federally-funded Community, Migrant, and Homeless Health Centers so they can better serve their patients and communities. Currently, CHAMPS programs and services focus on education and training, collaboration and networking, workforce development, and the collection and dissemination of regional data. For more information about CHAMPS, please visit www.CHAMPSonline.org.
SPEAKER BIOGRAPHY

William N. Robiner, PhD, ABPP, is Professor in the Departments of Medicine and Pediatrics at the University of Minnesota Medical School. He received his PhD in Clinical Psychology from Washington University. He is a board certified clinical health psychologist and is the Director of Health Psychology and the psychology internship at the Medical School with a busy clinical practice. He has discussed managing difficult patients with diverse professional groups including healthcare settings, professional organizations, and in corrections. He has published papers addressing diverse matters in psychology, healthcare, and education. Dr. Robiner’s awards include the Alfred M. Wellner Distinguished Career Psychologist Award from the National Register of Health Service Psychologists, the Joseph Matarazzo Award for Distinguished Contributions to Psychology in Academic Health Centers from the Association of Psychologists in Academic Health Centers, and the University of Minnesota President’s Award for Outstanding Service.
Caring for Difficult Patients in a Complex System

Wednesday, August 17, 2016, 12:00-1:00 PM Mountain Time
Lunchtime Learning: Professional Skill Development Distance Learning Series, Part 5 of 6

Interactive Poll

How often do you or someone on your staff encounter a patient who is perceived as “difficult”?

- Regularly
- Occasionally
- Rarely
- Never

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Interactive Question

How many total people are watching this event at your computer (yourself included)?

Disclosures

- I have no financial relationships to disclose
- No discussion of off-label use of devices or pharmacological products
- Some slides were shared by Nadine Kaslow, Ph.D. who spoke at the APAHC Conference in February 2015 and from the Patient Centered Primary Care Collaborative.
Learning Objectives

At the end of the session, participants will be able to:

1. Identify attributes of “difficult” patients and their impact on health services
2. Recognize “difficult” patients’ psychological comorbidities
3. Recognize how providers and systems contribute to the problem of “difficult” patients
4. Identify strategies for healthcare providers to manage “difficult” patients more effectively

Self-Assessment- Your Motivation

- Did you become a health professional because you wanted to deal with "difficult" people?
- Did you think you would be insulated from “difficult” people if you became a health professional?
Self-Assessment- Your Experience

- Have you ever encountered a non-adherent patient?
- Have you ever encountered a "difficult" patient?

Interactive Question

- Have you ever been a difficult patient?
  - Yes
  - No
Self-Assessment - You as a Patient

- Have you ever been a non-adherent patient?
- Have you ever been a "difficult" patient?

Impossible People Exist!

- You will encounter them!
- You can’t avoid them!
- You can’t fix them!
- You can’t make them like you!
- You can’t beat them!
- They may not want your help!

**Friendly Advice:** Develop good boundaries with them and communicate effectively with them.
Interactive Question

How many people can you please?
- None
- Some
- All

You Can Please:

How many of the people how much of the time?

<table>
<thead>
<tr>
<th>People</th>
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<tbody>
<tr>
<td>None</td>
</tr>
<tr>
<td>Some</td>
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<tr>
<td>All</td>
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<tr>
<th>Time</th>
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<tr>
<td>None</td>
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<tr>
<td>Some</td>
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<tr>
<td>All</td>
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</tbody>
</table>
Who is a “Difficult” Patient?

Is it somebody who:

- Takes poor care of himself/herself
- Doesn’t follow your direction(s)
- Doesn’t get better
- Communicates poorly
- Is mean/belligerent
- Makes a mess of your office or schedule
- Is unintelligent/“clueless”

Who is a “Difficult” Patient?

Is it somebody who:

- Wastes healthcare resources
- Has chronic pain or doesn’t get better
- Wants prescriptions you question
- Complains to your boss/clinic manager/3rd party payer
- Wants to sue you
- Threatens to report you to the Board of Psychology/Medical Board
Definition of the "Difficult" Patient

- "patients who are medically challenging, interpersonally "difficult", psychiatrically ill, chronically medically ill, or lacking in social support." ¹
- A patient “whom most physicians would dread to treat.” ²
- Patients we don’t like or who don’t like us!”³

What is a “Difficult” Case?

- “Difficult patients are those who make us feel frustrated, uncomfortable, or ineffective”¹
- “Difficult" patients present some type of threat: They can reject us or harm us¹
- “Difficult” patients are those whose disorders don’t respond to treatment²


What is a "Difficult" Case?

“When we call a client difficult,…we really mean…we….are having difficulty working with him/her.”


“Difficult” Cases Are Characterized By:

- Multiple treatment failures
- Higher risk of abuse
- Higher risk of violence
- Higher risk of suicide
- Higher risk of legal action
- Demands for extra efforts
“Difficult” People Are Those Who Lead Us To Do/Be Things We Don’t Want To Do/Be:

- React in ways we are not happy with
- Do our jobs ineffectively
- Do our jobs inefficiently
- Do their share of the work
- Feel upset, used, exhausted, inferior, manipulated, threatened, burnt-out, etc.

Emotional Effects of “Difficult” Patients & Situations on Professionals

- Anxiety
- Feel behind
- Feel conned
- Guilt
- Sadness
- Anger
- Shame
- Powerlessness/responsible/defeated
- Uncertain

Interactive Question

- Have you felt any of these emotions in response to a difficult patient?
  - Yes
  - No

Pejorative Labels for “Difficult” Patients

- “Train wreck”
- “Hateful”
- “Turkey”
- “Nudnik”
- “Crocks”
- “Gomers”
- “Shpos”
- “Frequent flyer”
- “Heart sink” patients
- “Thick chart” patient
- “Slow load” patient (in EHR)
Mental Health Labels for “Difficult Patients”

- Personality Disorders
  - Cluster A: Odd or Eccentric
    - Paranoid
    - Schizoid
    - Schizotypal
  - Cluster B: Dramatic/Erratic/Emotional
    - Antisocial
    - Borderline
    - Histrionic
    - Narcissistic
  - Cluster C: Anxious/Fearful
    - Avoidant
    - Dependent
    - Obsessive-Compulsive

- Impulse Control Disorders
- Somatoform Disorders

Difficult Patients in Counseling

- Demanding
- Angry/Blaming
- Unlikable
- Treat others (e.g., partner/kids/staff) badly
- Defensive
- Unappreciative
- Others?

Descriptions of “Difficult” Patients

(Physical)

- Multiple symptoms involving multiple body systems
- Poor response to usual treatments
- Certain medical conditions
  - Chronic pain/fibromyalgia
  - Self-induced conditions
    - Obesity, tobacco-related/substance-related
- Terminal illness


Descriptions of “Difficult” Patients

(Behavioral)

- Rambling, unfocused
  - “Everything hurts”
- Raises new problems as visit ends
  - “Oh, by the way…”
- Self-destructive
- Medication-seeking
- Poor hygiene
- Demanding
- Manipulative, hostile, exploitative, rude, demanding, dissatisfied, controlling, lying, litigious
Descriptions of “Difficult” Patients (Behavioral)

- “Boundary-Busting”
  - Seductive (sexually or otherwise)
  - Dependent, clinging
  - Call a lot/demand extra time
- Resistant to health professionals’ recommendations
  - Under appreciative
- Poor adherence with treatment
  - Inconsistent drug use
  - Miss appointments/come late
- High healthcare utilization

Descriptions of “Difficult” Patients (Psychological)

- Unrealistic expectations of cure
- Difficult to communicate with
- Vague and shifting complaints
- Undue concern
  - e.g., about minor symptoms
- Excessive preoccupation with physical disease
Impossible People

- Play the “blame game”
- Confrontation may be fruitless
  - ...and may provoke denial and blame
- Are not swayed by reason
- Provide valuable life lessons
- May need to be treated like children

Patients Don’t Always Do What Health Providers Want them to Do

- The problem of non-adherence
  - Hint, it is not just Lindsay Lohan
Adherence is a Big Problem!

- Mean adherence rate for long-term medication use is over 50% in high-income countries
- Adherence to long-term medication treatment is a multifaceted challenge requiring consideration and improvement of several factors:
  - Trusting health worker–patient relationship
  - Negotiated treatment plan
  - Education on consequences of good and poor adherence
  - Family/community support
  - Simplification of treatment regimen
  - Managing side-effects

Patients Don’t Take Their Medications

“Drugs don’t work if you don’t take them.”

- So clinicians need to make it a practice to ask!
- …and keep asking

C. E. Koop, M.D.
Former Surgeon General

Why Don’t Patients Take Medications?

- Motivation
- Personality/temperament
- Don’t accept specific recommendation
- Not ready/denial
- Don’t like any medications
- Anxiety/fear/depression
- Forget/Disorganized
- Adverse effects/intolerance of drug
- Interpersonal factors/lack of support
- Cost

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Case Studies in Non-Adherence
Case 1

**Difficult patient?**

- Man in mid 80s with insomnia, can’t or won’t fall asleep until 4 AM, waking up after noon
- Unwilling to change bed time despite multiple health professionals’ advice
- Drinks moderately heavily- convinced he needs ETOH to sleep for self-medication
- Plays bridge on computer late at night
- Refuses to exercise
- Thinks he just needs the “right pill” or “good doctor”
- Mixes pills up; concocts own pill schedules
- Thinks the doctors are all incompetent for not giving him the “right pill”
- Forgets what doctors tell him

Case 2

**Difficult patient?**

- Woman in early 20s, unemployed, high school graduate
- Very passive presentation, little insight, says what she thinks provider wants to hear
- Received kidney transplant as a teenager
- Didn’t take immunosuppressants regularly
- Lost kidney, now depressed about being back on dialysis
- Comes to dialysis irregularly (e.g., late so doesn’t get full run)
- Drinks more liquids than has been instructed
- Wants a second kidney transplant

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Tracking Adherence

Wireless Medication Event Monitoring System

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Case 3

**Difficult patient?**
- Married man in late 60s, retired, pleasant personality
- Current weight close to 300#
- Obese since adolescence
- Awaiting 3rd bariatric surgery
- Currently having multiple GI problems, so can only eat a little at a time; frequent nausea and vomiting
- Unwilling to change diet to lower fat content
- States intention to exercise but doesn’t
- States intention to eat fewer calorie dense, fatty foods but doesn’t
- Agrees he needs to be more accountable, but doesn’t make behavior changes, says he has “no willpower”

**Costs of Not Addressing Behavior**

- Adverse outcomes, such as rejection of transplanted organs, is more common among less adherent patients
  - Nonadherence is estimated to be associated with 15%–60% of late acute rejection cases and 5%–36% of graft losses in kidney transplant recipients
  - Medically ill patients with behavioral co-morbidities have up to 100% higher medical costs

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What Do Patients Want?

Somebody who brings good news

But what kinds of news are there?
And What Do They Want?

If it is *bad* news?

What Do Providers Want From Patients?

If it is *bad* news *DON’T*
Scope of the “Difficult” Patient Problem

- Older, more often divorced or widowed, more acute problems, chronic problems, chronic & medications¹
- Of primary care patient encounters ($n = 722$):²
  - ≈ 30% were troubling to physicians
  - Psychosocial problems & lower social class patients were associated with greater frequency of difficulty

Prevalence and Impairment

- In a study of 4 primary care settings, 15% of patients were judged to be “difficult” ($n = 627$)
- “Difficult” vs. non-difficult patients had:
  - More functional impairment
  - Higher health care utilization
  - Lower satisfaction with care
- “Difficult” patients did NOT differ from non-difficult patients in:
  - Demographic characteristics
  - Physical illnesses
Underlying Reasons Patients can be “Difficult”

- Feelings of fear, guilt, worthlessness, incompetence, shame
- Loneliness, social isolation
- Fear of abandonment
- Life stress
- Concern about personal safety:
  - At home, school, work, in clinic/hospital, in general, etc.
- Past abuse (i.e., emotional, physical, sexual)
- Disorganized, chaotic life, limited resources
- Earlier adverse medical experiences

Underlying Reasons

- Rational need for medical information/treatment
- Irrational need for medical information/treatment
- Involvement with tort law or Worker’s Compensation or disability systems
- Mentally Altered/Neurological Disorders
  - Strokes
  - Traumatic brain injury
  - Developmental/organic disorders

Underlying Reasons

- Mental Disorders
  - Somatoform disorders
  - Personality disorders
    - Borderline, dependent, ASPD, OCPD, etc.
  - Anxiety disorders
  - Mood disorders
  - Substance use disorders

Psychology’s Importance in Healthcare

- 28% of Americans have a mental disorder\(^1\)
  - Only \(\frac{1}{2}\) of those receive treatment (14%)
  - \(\frac{1}{2}\) of those treated receive treatment only through primary care providers (i.e., no MHP) (7%)
- 26% of patients in primary care have a bona fide mental disorder\(^2\)
- 25-80% of ambulatory medical patients have some psychiatric morbidity\(^3\)

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Psychology and Primary Care

- 7 of the top 10 health risk factors are lifestyle or behavior factors\(^1\)
- 60\% of visits to primary care involve behavioral health issues\(^2\)
- “100\% of medical visits involve a psychological or behavioral component”\(^3\)


Mental Disorders & “Difficult” Patients

- “Difficult” patients (67\%) were much more likely than non-difficult patients (35\%) to have a mental disorder \((p < .0001)\)
- Mental disorders account for a substantial proportion of the excess functional impairment and dissatisfaction in “difficult” patients

### Depression and Medical Illness

<table>
<thead>
<tr>
<th>Illness</th>
<th>Estimated Prevalence of Depression (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>5–50% (most studies: 20–25%)</td>
</tr>
<tr>
<td>Diabetes</td>
<td>14–22%</td>
</tr>
<tr>
<td>Fibromyalgia</td>
<td>20–71%</td>
</tr>
<tr>
<td>Myocardial Infarction</td>
<td>18–25% (40–65% sx)</td>
</tr>
<tr>
<td>Alzheimer’s Dementia</td>
<td>15–57%</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>25–75%</td>
</tr>
<tr>
<td>Stroke</td>
<td>10–40%</td>
</tr>
<tr>
<td>Multiple Sclerosis</td>
<td>34–40%</td>
</tr>
<tr>
<td>Parkinson’s Disease</td>
<td>40%</td>
</tr>
</tbody>
</table>

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### Psychiatric Disorders in “Difficult” Patients

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Odds ratio [OR]</th>
<th>95% confidence interval [CI]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Somatoform</td>
<td>12.3</td>
<td>5.9 - 26.8</td>
</tr>
<tr>
<td>Panic</td>
<td>6.9</td>
<td>2.6 - 18.1</td>
</tr>
<tr>
<td>Dysthymia</td>
<td>4.2</td>
<td>2.0 - 8.7</td>
</tr>
<tr>
<td>Generalized Anxiety Disorder</td>
<td>3.4</td>
<td>1.7 - 7.1</td>
</tr>
<tr>
<td>Major Depression</td>
<td>3.0</td>
<td>1.8 - 5.3</td>
</tr>
<tr>
<td>Alcohol Abuse/dependence</td>
<td>2.6</td>
<td>1.0 - 6.7</td>
</tr>
</tbody>
</table>

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Doctors and “Difficult” Patients

- Evidence suggests that the “problems do not lie exclusively with the patient” ¹
- Patients are labeled “difficult” by physicians because of their frustration with the relationship or because of how the patient sought healthcare ²


It Takes 2 to Tango

- A “difficult” patient for one doctor is not necessarily “difficult” for another ¹
- Doctors with poorer attitudes about psychosocial problems perceive more of their medical encounters as difficult ²

Dealing with “Difficult” Patients

- The patient “whose problems will not go away...is an uncomfortable reminder of the doctor’s inadequacy and impotence...”¹

- Providers’ internal reactions can include:²
  - Anger, depression, frustration, resignation, repugnance, disgust, etc.


“Surveys of hospital staff members...blame badly behaved doctors for low morale, stress and high turnover.”

Provider/System Contributions to “Difficult” Patient Interactions

- Provider Personality and Beliefs
  - Judgmental, perfectionism, stubborn, responsibility
  - Depression, self-esteem
  - Anxiety, approval-seeking
  - Need for control, defensiveness

- Work Stressors
  - EMR, tasks
  - Hours, # of patients on panel
  - Limited support

- Work Style

- Time
  - Limited time/patient

August 5, 2016

“...Recent studies suggest that spending time inputting patient records into a computer has slashed patient face time to just 10% of the workday...EHRs create a bureaucratic burden that feels more like secretarial work than practicing medicine,” according to a Medscape article on the findings of an expert panel on physician burnout. One of those findings cites the introduction of EHRs as a major contributor to burnout.
Contextual Contributions to “Difficult” Patient Interactions

- Environment
- System (e.g., complexity, access)
- Culture
- Rules
- Architecture
- Economics
- Litigation risk
- Compliance

What Do “Difficult” Patients Want?

“Difficult patients and difficult families want to be heard and understood…If you reach out and help them understand that you want to make them happy, comfortable, and help them get well, you will diffuse most conflicts before they even start.”

“From ancient times, physicians have recognized that the health and well-being of patients depends upon a collaborative effort between physician and patient…The patient-physician relationship is of greatest benefit to patients when they … work with their physicians in a mutually respectful alliance.”

“The patient has the right to courtesy, respect, dignity, responsiveness, and timely attention to his or her needs.”

Each Patient Encounter is a Chance to Show Professionalism

- Be on time
- Dress appropriately
  - Name tag
- Be welcoming/disarming
  - Warm tone of voice, eye contact, shake hands
  - Convey concern and safety
- Be prepared- read medical record/notes first
Be Mindful of Professional Ethics

Be Mindful of Colleagues’ Ethics
Strategies for Dealing With Difficult Patients

Four Aspects of Decision Making

- Risk Management
- Legal Considerations
- Ethical Considerations
- Clinical Decision Making
Risk Management

■ Safety/Threats
  • Patients
    - Risk of violence/harm to self/others
  • Staff
  • Safety plans/drills

■ Identify known and unknown risks
  • Risks of action/inaction

■ Resources
  • Alert Staff
  • Security/Police
  • Community/institutional

Legal/Regulatory Considerations

■ What laws and regulations are applicable?
  • HIPAA
  • Tarasoff
  • Mandatory Reporting
    ◆ Vulnerable adults
    ◆ Child Protection

■ Documentation

■ Applicable regulations/policies
  • Board of Psychology/Medical Board
  • Health Department

■ Is legal consultation necessary?
Ethical Considerations

- What ethical concerns exist?
  - Autonomy
  - Beneficence
  - Nonmaleficence
  - Fidelity
  - Justice

- Consult *Ethical Guidelines*

- Are ethical consultations necessary?
  - Consult ethics resources (e.g., hospital biomedical ethics committee, professional organizations)

Clinical Decision Making

- Assessment

- Treatment options
  - Clinical Efficacy
  - Clinical Effectiveness
  - Clinical Guidelines/pathways/standards

- Cost
  - Cost Effectiveness

- Expertise/resources/staffing

- Resource allocations/referrals

- Involvement of collaterals
  - Family, community, other systems
Clinical Management of Violence

10 Items From the Historical, Clinical and Risk Management (CR-20) Violence Assessment Scheme

<table>
<thead>
<tr>
<th>• Violence</th>
<th>• Major mental disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Other antisocial behavior</td>
<td>• Personality disorder</td>
</tr>
<tr>
<td>• Relationships</td>
<td>• Traumatic experiences</td>
</tr>
<tr>
<td>• Employment</td>
<td>• Violent attitudes</td>
</tr>
<tr>
<td>• Substance use</td>
<td>• Treatment or supervision response</td>
</tr>
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Relationship Building Techniques

<table>
<thead>
<tr>
<th>Partnership</th>
<th>Let’s work together</th>
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</thead>
<tbody>
<tr>
<td>Empathy</td>
<td>That sounds hard...</td>
</tr>
<tr>
<td>Apology</td>
<td>I’m sorry for...</td>
</tr>
<tr>
<td>Respect</td>
<td>I appreciate your...</td>
</tr>
<tr>
<td>Legitimization</td>
<td>Anyone would be...</td>
</tr>
<tr>
<td>Support</td>
<td>I’ll stick with you ...</td>
</tr>
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</table>

NYU Macy Initiative on Health Communication
CCHN & CHAMPS 8/17/16
When Using Confrontation

PEARLS

- Choose power struggles carefully
  - Enter only those that are worth having
  - Enter mainly those that you can win
  - Avoid Win-Lose situations
  - Avoid Lose-Lose situations
  - Take a long view
    - Seek to “win” wars, not battles
- Be diplomatic
- Have only a few priority goals

Coping with “Difficult” Patients-Communication

- Avoid being judgmental
- Be patient, tolerant
- Get good history to understand patient
- Use direct communication
- Use humor… carefully
- Selective personal disclosure
Managing “Difficult” Patients

- Set limits for time and content
- Referral for tests, labs, specialists, alternative health, mental health
- Develop treatment plan/contract
  - Set limited objectives
  - Schedule for addressing needs
- Involve others- family/friends (with consent)
- Steer focus away from emotional issues when necessary

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Schedule Appointments Regularly

- Make patients feel cared for and understood
- Address small concerns before they overwhelm patient
  - May gradually lead patient to more mature thought patterns
  - Reduce or eliminate unnecessary telephone calls, tests, admissions, ER visits

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Coping with “Difficult” Patients
Stress-Management

- Prepare for the encounter
  - Breathe deeply/catch breath
  - Check labs/chart in advance
  - Spread out “difficult” encounters

- Accept the situation
  - “It’s life; this is part of my job”

- Approach situation gingerly
  - Choose words carefully
  - Find things to appreciate in him/her

Neutralizing Impossible People

- Greet each patient respectfully
- Maintain/protect your self-esteem
- Avoid letting your anger take hold
- Sidestep accusations/complaints
- Don’t be defensive
- Don’t absorb their “impossibleness”
- Use silence
- Use appropriate touch
  - (e.g., handshake, pat on back)
Responding to the “Difficult” Patient

Steps in Managing “Difficult” Patients

1. Understand yourself
2. Understand your patient
3. Think before you act
4. Form an alliance
5. Treat whatever is treatable
6. Avoid the traps
7. Get help
8. Handle your emotions

Step 1 in Managing “Difficult” Patients

Understand yourself

- Be aware of your own biases and responses
- Understand why certain types of patients upset you
- You’re not a “bad” doctor/professional if you have negative feelings about some patients
- Everyone has trouble managing some patients

Step 2 in Managing “Difficult” Patients

Understand your patient

- Every “difficult” behavior is a form of communication
- Every “difficult” patient is trying to express real fears and needs

### Step 3 in Managing “Difficult” Patients

**Think before you act**

- Your duty is to help and not harm
- Focus on medical and psychiatric issues you can treat
- Strive to be empathic, consistent, and stable


### Step 4 in Managing “Difficult” Patients

**Form an alliance**

- Find something you can agree upon
- Educate the patient about your limits and responsibilities
- Reinforce positive behavior
- Don’t reward negative behavior

Step 5 in Managing “Difficult” Patients

Treat what is treatable

- Screen for medical conditions
- Screen for psychiatric disorders
- Use therapy and medication to treat problems

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Step 6 in Managing “Difficult” Patients

Avoid the traps of

- Wanting to save the patient and be idealized
- Wanting to reject the patient and not be hurt
- Wanting to punish the patient
- Doing anything to help the patient so he/she won’t hurt himself/herself

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Step 7 in Managing “Difficult” Patients
Get help

- Seek consultation
- Foster team consensus
- Refer for mental health and other psychosocial support
  - Encourage participation in support groups

Step 8 in Managing “Difficult” Patients
Handle your emotions

- Find constructive ways of venting frustration
- Prepare yourself for seeing “difficult” patients
- See managing “difficult” patients as a clinical and administrative skill to master
Learn From “Difficult” Patients

- Analyze cases
  - What worked?
  - What didn’t? Why?
- Seek input from colleagues
  - M & M Conferences
  - Balint groups
  - QAI/Performance improvement
- Video recordings

http://americanbalintsociety.org

Questions for Providers

- What feelings do you have as you think about the difficult patient?
- How might your feelings influence your relationship with, and treatment of, the difficult patient?
- What might be underlying the difficult patient’s behavior?

You Are a **Catalyst** For Change

- Focus on how you can help the patient move to the next stage of change
- The only thing health professionals can control is *their own reaction* to people, situations, events
- Health professionals can only be a *catalyst*
  - You are **not** responsible for changing patients’ behavior or outcomes

**Summary**

- “**Difficult**” patients are seen by all clinicians
- Some of the *difficulty* is due to mental illness
- Some of the *difficulty* is due to provider and systems factors
- Clinical management is critical
- Patients and providers deserve respect
- Providers can enhance their communication to improve interactions with patients

Thank You!

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Lunchtime Learning
Professional Skill Development
webinar Interpersonal Considerations for Elderly Persons on September 21st!
Thank You for Joining Us!

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