Unburdening the Difficult Clinical Encounter

ONE MUST COMMEND AN AND COLLEAGUES1 FOR EXAMINING A PROBLEM THAT, ALTHOUGH PERVERSIVE IN CLINICAL PRACTICE, IS UNDERSTUDIED AND Seldom FUNDDED. THIS IS NOT “DISEASE-BASED” RESEARCH BUT RATHER AN INVESTIGATION OF THE CONTEXT AND PROCESS OF PRACTICE, IN PARTICULAR, THE FACTORS THAT MAY LEAD TO A DYSFUNCTIONAL CLINICAL ENCOUNTER. SUCH RESEARCH WOULD BROADLY BE CLASSIFIED UNDER THE RUBRIC OF “PHYSICIAN-PATIENT RELATIONSHIPS” OR “HEALTH COMMUNICATION.” THE AUTHORS WERE CREATIVE IN ATTACHING THIS SECONDARY QUESTION TO A STUDY PRIMARILY FUNDED AS PART OF THE NATIONAL PATIENT SAFETY INITIATIVE. ALTHOUGH LIMITED FUNDING IMPEDES RESEARCH ON DIFFICULT ENCOUNTERS, EACH SMALL ADDITION TO THIS 1000-PIECE JIGSAW PUZZLE MAKES THE SECTION COMPLETED MORE COHERENT AND THE PARTS TO BE FILLED IN INCREASINGLY CIRCUMSCRIBED. EVERY PHYSICIAN EXPERIENCES DIFFICULT ENCOUNTERS ON A DAILY BASIS. ALTHOUGH CLINICAL RESEARCH, MEDICAL SCHOOL CURRICULA, AND CONTINUING EDUCATION FOCUS PROMINENTLY ON DISEASES, PRACTITIONERS ARE CONFRONTED WITH A DISEASE OR ILLNESS MANIFESTED IN A PARTICULAR PATIENT. IN CONTRAST TO THE POPULAR BOOK “ALL I REALLY NEED TO KNOW I LEARNED IN KINDERGARTEN,” THE TOPIC ADDRESSED BY AN AND COLLEAGUES CAN BE CHARACTERIZED AS “MUCH OF WHAT I REALLY NEED TO PRACTICE I LEARNED AFTER MEDICAL SCHOOL.”

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THE EPIDEMIOLOGICAL CHARACTERISTICS OF DIFFICULT ENCOUNTERS HAVE IN FACT BEEN REPLICATED ACROSS SEVERAL STUDIES: PHYSICIANS EXPERIENCE 1 OF EVERY 6 PRIMARY CARE VISITS AS DIFFICULT.2–4 THIS MEANS THAT IN A BUSY OUTPATIENT PRACTICE, PHYSICIANS EXPERIENCE 1 OF EVERY 6 PRIMARY CARE VISITS AS DIFFICULT. This means that in a busy outpatient practice, a physician must work through 3 to 4 difficult encounters each day. In retrospect, these are likely to be the visits recalled with some chagrín. Indeed, it may require multiple satisfying encounters to compensate for the residual angst of a frustrating visit.

The first generation of studies in this area had a rather pejorative focus on the patient, using labels such as “heart-sink” or “black holes” in the United Kingdom and “difficult,” “problem,” “disliked,” “frustrating,” “troublesome,” or even “hateful” in the United States.4 A more progressive view was that difficulty is dyadic, a consequence of both patient and physician factors. Each party brought something to the table. A still more fiduciary perspective recognizes the asymmetry of the relationship, wherein the healer carries a greater responsibility for empathy and for “turning the other cheek.”

All of this has made us more circumspect about referring to the “difficult patient,” and the event is instead referred to as a “difficult encounter” or “difficult physician-patient relationship.” Presumably neutral, encounter is itself a nuanced term, defined in the American Heritage College Dictionary5 as an “unexpected meeting,” a “hostile confrontation,” an “often violent meeting,” a “clash.” These connotations suggest that, although blaming the patient for a difficult encounter is now considered philistine, the mutual distress and dissatisfaction suffered during these “clashes” is real. The authors aptly title this the burden of difficult encounters.

So what makes encounters difficult? Although the corpus of research is modest, several patient factors have consistently been identified. Psychological symptoms or disorders have regularly emerged as predictors, including the strongest evidence for somatization (multiple unexplained symptoms) and varying degrees of evidence for depression, anxiety, personality disorders, and substance abuse. Patients who are high utilizers of health care (called “frequent attenders” in some countries) also are disproportionately represented among difficult encounters.

Physician characteristics associated with difficult encounters have been even less studied. One element appears to be the psychosocial factors the physician is experiencing, either job-related (burnout, job dissatisfaction, or stress) or personal (depression or anxiety). This was a key finding in the present as well as in a previous study.6 In fact, it is impossible to completely disentangle job and personal distress because since each is likely to have an adverse reciprocal effect on the other. Likewise, the directionality of the relationship between physician distress and difficult encounters is unclear because unhappy physicians may have a lower tolerance for complex or challenging encounters, just as higher rates of the latter may contribute to physician dissatisfaction. A bundled approach that tackles organizational, contextual, and physician factors may be more successful in unburdening difficult encounters than in addressing only a single factor. Younger physicians reported a greater number of difficult visits in the studies of both An et al1 and Krebs et al,3 as did female physicians, and the authors offer potential explanations.1,6 Whatever the reasons physicians differ, be they demographic, psychosocial, practice milieu, or patient mix characteristics, tailoring initiatives for reducing difficult encounters based on individual rates of such encounters may be desirable.

In addition to focusing on a neglected aspect of difficult encounters (ie, physician factors), the study by An et al1 has several other strengths. One is the sample size and clinic mix: 449 physicians from 118 clinics in several different regions of the United States, including urban and rural areas. Another strength is the representativeness of the study sample: family physicians and general
internists each represented about half the sample, which also had a balanced sex distribution (44.4% women) and a wide age distribution.

The study has several limitations besides those acknowledged by the authors. Their 8-item Burden of Difficult Encounters measure might have included a more explicit question about somatization or multiple unexplained symptoms because this has been the strongest and most consistent correlate of difficult encounters. However, some of the questionnaire items probably do capture troublesome features of somatization, such as unrealistic expectations, high demand for tests and medications, and complaints that persist despite exhaustive evaluations. Of greater concern is the response set on the questionnaire: “seldom” or “rarely” might have been a less extreme option than “never” at the lower end of the scale, whereas “frequently” and “often” do not appear to be that different from each other. This may have led to the infrequent endorsement of the extremes of the scale on many items. It is possible that more clearly differentiated or less extreme response options might have produced a scale with a frequency distribution less crowded around the middle and better able to identify and distinguish correlates of difficult encounters. Future research should link perceived difficulty to specific encounters, measure the patient’s and physician’s perspectives in tandem, and include longitudinal assessment to examine the impact of difficult encounters on patient and physician satisfaction, adherence, symptomatic improvement, quality of life, and health care costs. Also, difficult encounters in specialty care as well as the impact of clinic, payer, and other systems factors require further research.

What can we do in the meantime with our nascent understanding of difficult encounters that might alleviate some of the burden? In the absence of randomized trials, any advice must be considered as tentative rather than definitive. However, I offer several preliminary thoughts:

1. Intensify physician training in the psychosocial aspects of care, including somatization, depression, anxiety, and substance disorders. Evidence-based treatments exist, but physicians need not only the knowledge and skills but also more conductive attitudes.8,9 Physicians with a distaste for the psychosocial side of patient care identify 3 times as many of their outpatient encounters as difficult than do their more psychosocially oriented colleagues (23% vs 8%, respectively).4 Moreover, biopsychosocial care should not be solely the domain of the generalist. Psychosocial issues are as ubiquitous in specialty as in primary care,10,11 and a model of collaboration rather than “turfing” is optimal.

2. Identify up front the patient’s expectations for the visit. An internist’s day is populated with patient encounters laden with multiple medical and psychosocial concerns. The balancing of acute problems, chronic disorders, preventive medicine, and documentation can sometimes squeeze out the patient’s agenda, which is more commonly unsolicited than hidden. Addressing patient expectations improves patient and physician satisfaction and possibly other outcomes.12

3. Accept the rough edges of real-world practice, and do not take every difficult visit personally. Despite our best intentions, the inevitability of discordant encounters must be conceded. Albert Schweitzer said: “Medicine is not only a science, but also the art of letting our own individuality interact with the individuality of the patient.” Knowing that 3 to 4 difficult encounters are part of everyday practice makes these normative rather than exceptional events.

4. Reform the context and reimbursement of primary care. The disproportionate undervaluing of cognitive services and “talk time” puts even greater pressure on the 15% to 20% of visits considered difficult. Innovative means of identifying somatizing and high-utilizing patients through clinical predictors or electronic medical records may provide a systems approach to targeting patients for longer encounters on the front end that potentially could save time and resources downstream.13,14

5. Celebrate the well-navigated difficult encounter. Dealing with difficulty signifies mastery rather than weakness. Olympic dives are rated in terms of difficulty, as are mountain climbs, hiking trails, musical works, crossword puzzles, and highly technical procedures. Partnering with patients in the challenging aspects of their health, lives, or medical care is a stepping stone to surmounting together the difficult encounter.

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REFERENCES