Conflict in the Physician-Patient Relationship

Effective communication is essential during difficult interactions. Studies suggest that between 10-15 percent of patient visits are described by the physician as "difficult." These concerns are important for a variety of reasons. Patient satisfaction is now a frequently measured parameter and poor interactions may lead to bad ratings. Personal satisfaction on the part of the provider is also an issue; frustrating interactions can leave the physician unhappy as well. If the patient interaction is sidetracked into an angry discussion, important parts of the clinical history might be missed. Finally, increased legal issues are seen in physicians who have frequent difficult interactions; there are board complaints, and even lawsuits that may result. Even physicians with the best bedside manner encounter difficult interactions.

Case Study

A primary care physician saw a 45-year-old female for diffuse aches and pains. She felt the symptoms were most compatible with fibromyalgia. A thorough workup was negative. The patient demanded that she be referred to the rheumatologist who saw her for one visit and outlined a treatment plan. Multiple medications were tried, but the patient was intolerant or had side effects to all medications. The patient returned with widespread pain and stated she felt she had multiple sclerosis (MS). The neurologic exam was normal and the symptoms seemed mainly musculoskeletal. The physician suggested not doing a referral to a neurologist as the symptoms were not suggestive of MS. The patient became angry and stormed out. The physician drafted a dismissal letter, but it was not sent immediately. When the patient called to make a new appointment, the receptionist stated she would have to check with the physician first. The patient swore at the receptionist and hung up. She then wrote a complaint letter to the Colorado Medical Board.
Understanding Conflict

Clear communication is essential when there is conflict or misunderstanding. Physicians should start all visits with setting the agenda by asking “what are we talking about today?” If the physician has issues that need to be discussed, he or she should let the patient know their intentions as well. If the interview turns bad, one needs to have a clear understanding of why the patient is angry, upset or concerned. It can be you or the patient with the issue.

Sometimes we get upset as the patient triggers our own “pet issues” (narcotics, boundaries, multiple somatic complaints, reminds us of our last difficult patient, etc.). Care should be taken to not interpret conflict as personal. Finally, conflict may be inevitable, but deescalating it early is vital. Don’t wait for the interview to blow-up before saying “time out, what is going on here?”

Physicians may have emotional responses to a difficult encounter. Often the patient starts a difficult encounter with a high emotion, such as anger or sadness. We need to be aware of our own maladaptive responses which we might succumb to. This could include getting angry, telling the patient there is nothing wrong with him or her, or ignoring calls or emails from the patient. The physician must remain calm and focus on how best to respond to these situations.

In the previous case study, the issue is that the patient was making unnecessary or unreasonable requests. Other behaviors that can be an issue include not following instructions, reacting with anger toward the physician or undermining a therapeutic alliance with the physician. Managing conflict is especially challenging when the patient is angry, intimidating or even threatening. If one can understand where the anger is coming from (i.e. fear), one may find the path to deescalating the situation. We need to understand the behavior of the patient in the context of his or her conditions. Conflict may arise when the patient has unmet expectations. In the case study, there was a deep fear of MS which had struck a friend of the patient. Conflict resolution required the physician to understand the patient’s concerns, address them and verbalize his or her understanding about how scary MS can be. This reflection technique would have developed empathy and possibly defused the situation. When the physician can identify the fear or concern, then he or she and the patient can work toward a mutual understanding, healing and common ground.

Managing Conflict

Your communication skills and demeanor are paramount in a conflicted situation:

- Remember to use non-confrontational language such as “I” statements (see Pearls of Wisdom below) to verbalize your own feelings and thoughts.
- Expressing feelings in a non-blaming way can help build empathy.
- Stay calm and speak politely in a soft voice.
- Use active or reflective listening to verbalize what you heard and what the patient said.
- Recognize your own negative feelings.

If the patient has turned you off, you will have a difficult time in terms of caring for him or her. Body language speaks volumes and is quickly picked up on in tense situations. Make sure you are sitting down, leaning in and using a calm compassionate voice. Try to come up with a win-win response after hearing the issue or conflict.

There are indeed behaviors that should not be tolerated. Office policy should be clear around language, threats and name calling. Boundaries should be established about what you will tolerate. Difficult encounters, if they are anticipated, should be scheduled at a less busy time. You should never put yourself or your staff in danger, and if you feel threatened, established protocol should be followed. You should document conflict and inappropriate behavior in the medical record in a clear and non-judgmental fashion.

Despite your best efforts, a physician-patient relationship may not be salvageable. Terminating a patient should be a last resort. If behavior is intolerable or continues, this may be the only option. In support of effective communication with patients, the MagMutual Patient Safety Institute, in partnership with COPIC, offers the following on-demand courses through its website:
• Communication Techniques Module 1 and Module 2
• Difficult Interaction in the Office Setting

Visit www.magmutual.com [1] to register and take these courses online.

Pearls of Wisdom

Active listening—Physicians should listen in an open and attentive manner. Be careful of your own body language when tensions are high. Any probing should be done in a mild or respectful way. Patients should be able to express themselves and the physician should listen. Reflective listening—Repeating back to the patient in a summarizing fashion is a wonderful way of really hearing what the patient has said and it builds empathy as the patient realizes you have heard them. “You are right, I did not refer you to that specialist when you requested it.”

Acknowledge the emotions—“I can see you’re upset.” This reflects back the emotion you are seeing and builds empathy and rapport even in a difficult situation.

Apologize if appropriate—It really can be our fault sometimes. If that is the case, admit it and promise to make it right. “I am sorry you felt that way. That was not what I intended to suggest. I felt a referral was not indicated as the symptoms were not neurologic.”

Build a win-win—“Let’s act as a team and monitor your symptoms closely. I will help you through this situation and we will work through this together.” Remember to identify the “chief concern”—This is often different than the medical “chief complaint” that is distilled through the perspective of the health care team. The most important questions try to elicit the chief concern by “what do you think this is?” or “what is it that most worries you about this?” or “why today? how is this affecting your life now?”

Clinical communication can be taught—Poor communication is associated with poor clinical outcomes, reduced patient and provider satisfaction, and ultimately medical errors and medical liability claims. We hope this article will bring awareness to one’s communication skills and their importance. And, we hope this will encourage deeper investment in medical student, resident and attending physician’s training in effective communication.

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