Case 1 (Objectives 1, 5, 6, 7, 8)

You are a fresh, newly licensed, family doctor. You've just finished residency and have started locuming around your home province. You're working in a family practice clinic in a small town in Northern BC. You're reviewing the next patient up,
34 year old Biff Tannen, when you see a little flag next to his name with a comment from the GP you're filling in for. It simply says "History of verbal aggression towards HCP".

Scanning through his chart, you can see that he has a complicated social history consisting of multiple incarcerations - mainly on account of physical altercations and illegal gambling charges, as well as stimulant use disorder, currently in sustained remission.

Medically, Biff has some recurrent right shoulder pain for several years after having injured it in a car crash that resulted in a dump truck of manure emptying out into his new convertible.

You welcome Biff into your office and begin collecting a history.

Biff tells you how his shoulder pain has been flaring up recently - and how he thinks this is because he has been related to increased heavy lifting that he has been doing as part of his job restocking shelves at a local supermarket.

To manage the pain, he has been using a friend's supply of Tylenol 3 along with a few hydromorphone tabs from another friend of his.

He has not tried anything else for his shoulder pain, such as stretching exercises, physiotherapy, ice and compression, topical analgesic creams, or non-opioid painkillers, because

> "That stuff doesn't work for my body. I don't know what they teach you in med school but my research tells me that these pills are the only thing that will work. I'm gonna need a prescription for both of them. I also need you to order an MRI for my shoulder."

As you begin to explain that you'd like to get a full history and physical before you make any decisions, he cuts you off, saying:

> "And don't think just because you're a doctor you know better than me. I've done so much research that I could be teaching you a thing or two. I was gonna be a doctor but realized that my IQ is too high so they'd never let me in. It'd probably look bad for them when their student knows more than they do."

As Biff continues to speak, you are able to identify several key characteristics of narcissistic personality disorder - and anticipate that this encounter will be challenging to navigate. You

perform a focused history and physical exam and are fairly certain that Biff's shoulder symptoms represent subacromial impingement syndrome.

So, [host], lot to unpack here. The big challenge here will be effective communication. What sort of techniques can we use to navigate this encounter?

Well, you hit the nail on the head, effective communication is really the cornerstone of this interaction, and is going to make all the difference in this case.

According to the Canadian Medical Protective Association (CMPA), the first and most important step is safety:

> Physicians should not hesitate to contact the police if they feel their safety or the safety of others is at risk due to a patient's aggressive or threatening behaviour. If reporting to police, only give the information necessary for the police to address the threat, such as the threatening individual's name and the nature of the incident. Avoid divulging any further patient medical information that could be considered a privacy breach.

Thankfully, Biff doesn't seem to be aggressive or threatening as of yet, but we also haven't disclosed that opioids are not indicated in this particular case and that MRI really isn't indicated either. How are we gonna break this news to him?

It all comes back to communication. Making an effort to connect with the patient, listen actively, convey empathy, and communicate clearly can help physicians understand and address patients' motivations, emotions, and expectations.

When in the midst of challenging interactions with patients, physicians should avoid arguing, talking over patients, and making judgmental statements. It is advisable to speak in a conversational tone. Verbalizing the difficulty can help define it.

Consider saying something like, "We both have very different views about how your symptoms should be investigated and that's causing some difficulty between us. Do you agree?" This approach names the problem without assigning blame. Supporting patients, finding common ground, and focusing on solutions may increase the possibility of finding a way to work more effectively together.

The infamous FIFE model (feelings, ideas, function, and expectations) is another possible approach when dealing with conflict and aggression. This model explores patients' emotions, their ideas on what caused the problem, the effects of the illness or problem on functioning and relationships, and their expectations for care and for the future. Eliciting patients' expectations helps develop trust, and assists physicians and patients to understand why they have come together and what they are hoping to achieve.

When physicians cannot meet patients' expectations, it is best to communicate this directly, for example, "Based on my clinical assessment, opioid medications are not indicated for your condition".

Remain calm and professional when speaking to patients and families, even when facing an angry patient or undeserved criticism. Staying composed and not raising your voice may de-escalate a tense situation.

That said, sometimes a situation will continue to escalate despite your best efforts. Patients exhibiting aggressive behaviour can pose a threat to office staff and physicians. Although it is generally necessary to meet with patients in private, away from other patients and staff, you must be mindful of your own safety and may even want to ask a staff member or colleague to join you in some cases.

You should try not to interrupt or talk over the patient, something that we can do without even being aware of. It's also a good idea to maintain physical space between yourself and aggressive patients and stay near the door if you need to exit the room quickly. Doctors and staff should also know how to quickly contact security or the police. Also, physicians may be able to manage patient expectations by creating a policy on how they will respond to anyone's use of aggressive behaviour or offensive language, and then making the policy public by placing a sign in their practice.

Jumping back into our case with Biff, you decide to employ the trusty FIFE technique to help frame Biff's shoulder pain in the context of his own life and his goals.

You use empathetic statements reflecting the challenge he must be facing in dealing with this shoulder pain but that, thankfully, there are a number of treatment options, both pharmacologic and nonpharmacologic, that can be employed to help relieve some of his pain.

You then go on to explain that opioid medications, although often effective in the short-term for relieving acute pain, are not among these treatment options at this point - and can actually lead to significantly more harm than good, both in terms of their overall safety profile, addiction potential, and lack of efficacy in dealing with this type of pain.

Biff becomes visibly upset at this, and begins to raise his voice. When patients raise their voice, it's important to reinforce that they are absolutely entitled to good medical care, but that their anger should not be misdirected at those trying to help.

You acknowledge and validate his emotions by stating "I can see that you're angry - it must be really challenging to try and get through a day of work with this shoulder pain. I totally agree that we need to do something about this, but I am afraid that opioid medications are far from the best

option. Thankfully, we have so many other options in our toolbox - and I'm confident that they will give you the best possible chance of recovering"

You redirect the conversation into many of the treatment options that *are* beneficial, taking the time to discuss these as opposed to lingering on the treatments (like opioids) that aren't indicated.

You also take time to educate him about subacromial impingement syndrome and even provide a patient handout that gives him some more information to take home. As a side note, because these difficult patients tend to take more time, you should try and proactively book longer appointments when possible. Because you'll also be providing counselling, you'll be able to bill for it - which will help offset the costs of running longer appointments.

Ultimately, Biff reluctantly agrees to the treatment plan and is somewhat more calm, albeit still a bit disgruntled, at the end of your visit. You wish him well, leave the office, and sigh a breath of relief.

To summarize, the four techniques that we used in the above case were:

1) Active listening (eg, "help me understand why this upsets you so much")
2) Validating emotions and offering empathy (eg, I can see that you're angry right now, I can only imagine how tough this must be for you)
3) Exploring alternative solutions (eg, "What else can I do to help meet your expectations for this visit?")
4) Provide closure (eg, "Let's try these treatment options for 2 weeks and then follow up with me to continue to work on this problem")

Those four techniques were yanked from Table 4 in the 2013 AAFP article about managing difficult patient encounters that we briefly mentioned at the beginning of this episode. As always, check out the article for a deeper dive.

One thing we also wanted to mention, just before we move onto case 2, relates to ending the physician-patient relationship. As mentioned earlier, the CMPA is a great place to go for advice if you are ever unsure, and has an article titled **How to manage conflict and aggressive behaviour in medical practice** that has some great tidbits (linked in the show notes). I really, really cannot stress how useful the CMPA is for situations or patients like this. Absolutely give them a call any time you have concerns or questions about how to handle a particular situation.

Barring any acute safety concerns (for which you should immediately remove yourself from the situation and call for help), if a patient's behaviour begins to escalate, verbalize the specific behaviour, clearly tell the individual that it is unacceptable, and outline the consequences of continuing or repeating such behaviour.

In hospital or large clinic settings, consider using other available resources such as security, social work, patient advocacy, and pastoral care. If the abusive behaviours are recurring, but minor, there may be insufficient trust in the relationship to provide continued quality care. This may lead to ending the doctor-patient relationship.

Sometimes excessive complaints, significant conflict, or a loss of trust may lead physicians to consider ending the doctor-patient relationship. While this may be necessary on occasion, doctors should think carefully before doing so (and ALWAYS run it past CMPA). Physicians are permitted to end a doctor-patient relationship for reasons other than retirement, relocation, or leave of absence provided the patient does not need urgent or emergent care. The patient generally requires adequate notice to find another doctor.

While important in all jurisdictions, doctors in Québec in particular must have reasonable and just cause to end the relationship. T**he definition of reasonable and just is fairly strict, so make sure you call CMPA and run the situation past them prior to discharging a patient from your practice.**

Doctors should also be aware of any human rights legislation, College policies, and codes of ethics that prohibit discrimination in the provision of medical services and that may require reasonable grounds to discharge a patient or that may otherwise affect one's ability to terminate the relationship

If the relationship is terminated, this should be documented in the patient's medical record.

As mentioned above, our Canadian listeners who are members of the CMPA (which all of you should be, unless you're a medical student), you can always reach out to the CMPA and speak to a physician advisor for more specific advice on a case-by-case basis.

With that doozy out of the way, let's move onto case 2.

Case 2 (Objectives 2, 3, 4)

After you bid farewell to Biff, feeling a bit drained from that encounter, you get ready to see your next patient of the day: Lorraine McFly. She's a 54 year old woman with a history of hypothyroidism, major depressive disorder, and somatic symptom disorder. Her regular medications include Levothyroxine and duloxetine.

So, being a bit drained from our encounter with Biff raises a good point: we need to be highly self-aware and responsive to our OWN factors that might be contributing to a difficult patient interaction.

With our previous case, we were able to touch on a few *patient* factors that contribute to challenging interactions. Broadly speaking, these can be grouped into three categories:

- Behaviour issues (eg angry, argumentative, manipulative, or highly anxious)
- Certain conditions (eg, addictions, chronic pain syndromes, functional somatic disorders, or multiple medical issues per visit)
- Psychiatric diagnoses (eg, borderline or dependent personality disorders, mood disorders)

However, to err is human, and there are definitely some physician factors that feed into challenging patient interactions as well. These can be broadly characterized into four main groupings:

- Attitudes (eg, emotional burnout, intolerance to diagnostic uncertainty, negative bias toward certain health conditions, or perceived time pressure)
- Conditions (eg, exhausted/overworked, anxiety, situational stressors, sleep deprivation)
- Knowledge (eg, inadequate training in psychosocial medicine or limited knowledge of the patients specific health condition)
- Skills (eg, difficulty expressing empathy)

Those were pulled from the aforementioned 2013 AAFP article, by the way.

All that is to say that it's important to be mindful of our own limitations or biases, and work to address those. Easier said than done, however.

Moving back into our case, we should also address that “feeling of dread” that we have as we are about to enter the patient room. Internal signals such as a sense of dread or negative feelings toward the patient, including anger or frustration, will influence the patient-physician relationship. Strategies to help physicians identify personal factors that may contribute to a difficult encounter include self reflection, recognizing biases, discussions with an experienced or trusted colleague, participating in Balint groups, or possibly seeking help from a psychotherapist.

The primary responsibility to address and resolve problems with the physician-patient relationship rests with you - not with the patient.

And for those who aren’t aware, Balint groups are meetings among family physicians that allow you to discuss any topic that occupies your mind, typically centered on clinical cases. Essentially a support group for family docs.

Jumping back to the case, you walk into your office to find Lorraine sitting in front of you. She’s a well appearing 54 year old woman in no apparent distress, although she does appear to be quite anxious. She’s holding a list in front of her with a number of concerns to be addressed.

As a brief background on Lorraine, she has a several year history of excessive fatigue, abdominal pain, and heartburn, all of which have been thoroughly worked up with extensive bloodwork, imaging, and other investigations including sleep studies, barium swallows and upper endoscopy, among others. She's been seen by sleep specialists, gastroenterology, endocrinology, and rheumatology without any definitive diagnosis.

Despite this, she unfortunately continues to have a fairly high symptom burden - along with the occasional new symptoms that will come and go on an almost routine basis. These symptoms have put her in a state of near-constant anxiety, for which she has had psychotherapy in the past with moderate benefit, along with duloxetine - which she finds takes the edge off her anxiety as well as helping control some of her pain.

She presents today with a list of new concerns that have arisen since her last appointment with you since your last visit together 1 month ago.

So, lots to unpack here. Can we break down the main issues here?

So the main issue driving Lorraine's presentation is her somatic symptom disorder. As a refresher, Individuals with somatic symptom disorder often have multiple physical symptoms that cause significant distress and also have a history of extensive (and fruitless) diagnostic testing and medical procedures.

Affected individuals maintain a preoccupation with their symptoms and health concerns over an extended period. Symptoms and motivation are unconscious and symptoms are not intentionally produced (as opposed to factitious disorder).

Importantly, symptoms may be related to another medical disorder, but over-investigation can often be unnecessary, costly, and harmful. It will be critical to use your clinical judgement to decide when and how to investigate new concerns.

Because we're locuming for another physician, we unfortunately don't have the luxury of a longitudinal relationship - as patients with somatic symptom disorder benefit from regular visits with a **single** care provider. Other treatments should involve addressing underlying psychological issues with psychotherapy - but this needs to be done tactfully, since these patients will often not agree with referrals to psychiatrists, instead believing that their symptoms are due to an underlying organic pathology.

Unsurprisingly, these tend to be really challenging cases to navigate - having to balance addressing the patient's concerns and making them feel heard and believed with your responsibility to not order inappropriate, costly, and/or risky tests or treatments, all while being mindful of the time constraints of regular office visits. This is a delicate balancing act that challenges even the most seasoned family docs.

Patients with symptoms of functional somatic disorders should also be screened for previous or current exposure to violence or to physical, mental, or psychological abuse, given that functional somatic syndromes may be a result of intense bodily responses of varying organ systems to overwhelming stress.

As a result, targeted therapies may be beneficial. Family physicians should be familiar with behavioral and psychiatric health care professionals and community services in their area so that they can make appropriate referrals.

The 2013 AAFP article that we've been referring to has a number of suggestions for managing cases like this. We'll list off a few of the more relevant ones for this case, which are as follows:

1) For challenging patients, set boundaries or modify your schedule if needed. This can improve your ability to handle difficult encounters.
    a) With Lorraine, this might involve an agreement with her that you can only focus on 2-3 issues per visit max, and/or booking longer or more frequent office visits with her - ideally with the same provider each time.
2) Try to be aware of your own inner feelings. This results in fewer patients being labeled as "challenging" and leads to better management of difficult encounters.
    a) With Lorraine, remember that feeling of dread before you walked in. Be mindful of that, and try to remember that, as challenging as this is for you, it's far more challenging for her.
3) Employ empathetic listening skills and a nonjudgmental, caring attitude during patient interactions. This will improve trust and adherence to treatment.
4) Assess challenging patients with symptoms of functional somatic disorders for past or current sexual abuse or significant trauma.
    a) This screening was already performed by Lorraine's GP (whom you're filling in for) and did not reveal any notable past or current trauma. Depending on how long ago screening was performed, re-screening can be appropriate - although, again, this is probably best left for her regular provider.

Lorraine reveals to you that she has been having recurrent headaches for the past 2-3 weeks - similar to headaches she's had in the past but more frequent and ranked at about 6/10 severity at their worst. She tells you she would like an MRI, bloodwork to check for cancer, and referral to a brain specialist so that we can get to the bottom of this.

This isn't a headache episode, stay tuned for that one, so we won't dive into any real detail - but after performing a thorough history and focused physical exam, you can identify **no** red flags or concerning features whatsoever.

When communicating this to Lorraine, you are sure to speak slowly and clearly and continue to emphasize how reassured you are by your findings. You are also able to correlate the start of her headaches to some increasing work-related stressors and consequently reduced sleep quality that she's recently been experiencing.

You provide education regarding sleep hygiene and provide her with some mindfulness techniques that she can try when she's feeling stressed out. With her permission, you also provide her with some resources that she can access herself, such as anxietycanada.com and the MindShift CBT phone app.

Finally, you provide a bit of education on the mind-body connection, and the perpetual cycle of stress begetting headache begetting stress and so on, and encourage her to reach out to the counsellor she has seen in the past.

You book a follow up appointment for 2 weeks from now, at which point you will be able to see how she's coping with her symptoms after trying out some of that advice you've provided.

Regarding her other problems on the list she's holding, you are able to very briefly discuss them with her - making sure you aren't missing anything dangerous or something that requires immediate attention - and tell her that you can cover them in more detail at the next appointment in 2 weeks.

Lorraine is satisfied with this plan, particularly given that the headache was by far her most pressing concern, and agrees to book a follow-up in two weeks.

Overall, the appointment ran just under half an hour - as booked - and you're really glad that you had the extra time. As mentioned before, there are counselling fees you can bill in order to make these longer appointments more financially feasible in a busy practice.

And with that, we bring our Difficult Patient episode to a close. Like we said before, difficult patients are part and parcel with primary care - and just like anything else, having an approach to managing these patients is critical for the wellbeing of your patients and for you as a provider.

Hopefully you were able to pick up a few pearls today, and as always, check out our show notes and references for a deeper dive on the topic.

Objectives

1. When physician-patient interaction is deemed difficult, diagnose personality disorder when it is present in patients.
2. When confronted with difficult patient interactions, seek out and update, when necessary, information about the patient's life circumstances, current context, and functional status.
3. In a patient with chronic illness, expect difficult interactions from time to time. Be especially compassionate and sensitive at those times.
4. With difficult patients remain vigilant for new symptoms and physical findings to be sure they receive adequate attention (e.g., psychiatric patients, patients with chronic pain).
5. When confronted with difficult patient interactions, identify your own attitudes and your contribution to the situation.
6. When dealing with difficult patients, set clear boundaries.
7. Take steps to end the physician-patient relationship when it is in the patient's best interests.
8. With a difficult patient, safely establish common ground to determine the patient's needs (eg. threatening or demanding patients).

References

- CMPA - How to manage conflict and aggressive behaviour in medical practice (cmpa-acpm.ca)
- CMPA - When physicians feel bullied or threatened (cmpa-acpm.ca)
- CMPA - Physician-patient communication: Making it better (cmpa-acpm.ca)
- Managing Difficult Encounters: Understanding Physician, Patient, and Situational Factors <FEFF>[Query: Should Difficult Patient Encounters be changed to Difficult Clinical Encounters for consistency with the text?] (aafp.org)