Dealing with Difficult People and Why It Matters

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Every physician has dealt with a "difficult" patient. These people may exhibit behaviors that include their being demanding, argumentative, aggressive, disrespectful, self-absorbed, or ungrateful. Often in high-stress situations, an inpatient stay, for example, one loses the ability to navigate societal courtesies, making the patient's behavior difficult and exhausting. Of course, the concept of a difficult person is nebulous and not limited to a specific type of individual—and may extend beyond patients to include colleagues. Learning to interact with these individuals while maintaining composure and a sense of calm is critical to prevent us from responding adversely.[1] When empathetic communication is improved, malpractice claims decline, physician well-being improves, and patient satisfaction increases, which can lead to better outcomes.[2–4]

We cannot change the behavior of others; however, a number of techniques can be used to mitigate negative consequences of difficult behavior. For instance, we can use deescalation strategies to counter a contentious interaction and manage how it affects our well-being. Furthermore, situational self-awareness is essential to controlling our emotions, both positive and negative, and limiting unfavorable interactions that are emotionally draining.[1] This article focuses on behaviors that define a difficult person, including patients and colleagues, and offers techniques to manage troublesome interactions—and the stress that often follows.

DEFINING DIFFICULT PATIENTS

Groves defines four types of difficult patients[5]:

1. The "dependent clinger" is a patient with multiple and increasingly frequent requests and needs.
2. The "entitled demander" is needy, controlling, and intimidating to obtain whatever services they believe they deserve.
3. The "manipulative help-rejector" is never helped by any therapy offered and has new symptoms or problems continuously.
4. The "self-destructive denier" engages in deleterious behaviors despite physician recommendations, such as continuing to smoke with a diagnosis of lung cancer.

Finally, with today's easy access to medical information and misinformation on the internet, the "I-read-it-on-the-internet" person will challenge diagnoses or treatment options (Fig. 1). Many difficult patients fall into one of these categories, and overlap is common. Although these patterns in behavior may be frustrating, there are many techniques to reduce friction within these interactions.

TECHNIQUES FOR DEALING WITH DIFFICULT PEOPLE

There is not one universal framework for dealing with difficult people. However, there are many general techniques that can be applied (Fig. 2), beginning with the time-tested technique of taking a deep breath. A deep breath floods the body with oxygen and helps to calm us.[1] Next, take a moment to pause. It may be helpful to count to 10 slowly and silently; doing so permits thoughts and emotions to slow down rather than escalate.

During this moment of respite, it is essential to work toward separating the patient from his or her behaviors.[1] When our judgments and perceptions are negative, we often label the person—rather than the behavior—as difficult. For instance, rather than "this patient is difficult," a physician may change his or her patterns of thinking to, "I dislike the behavior that this person is exhibiting."

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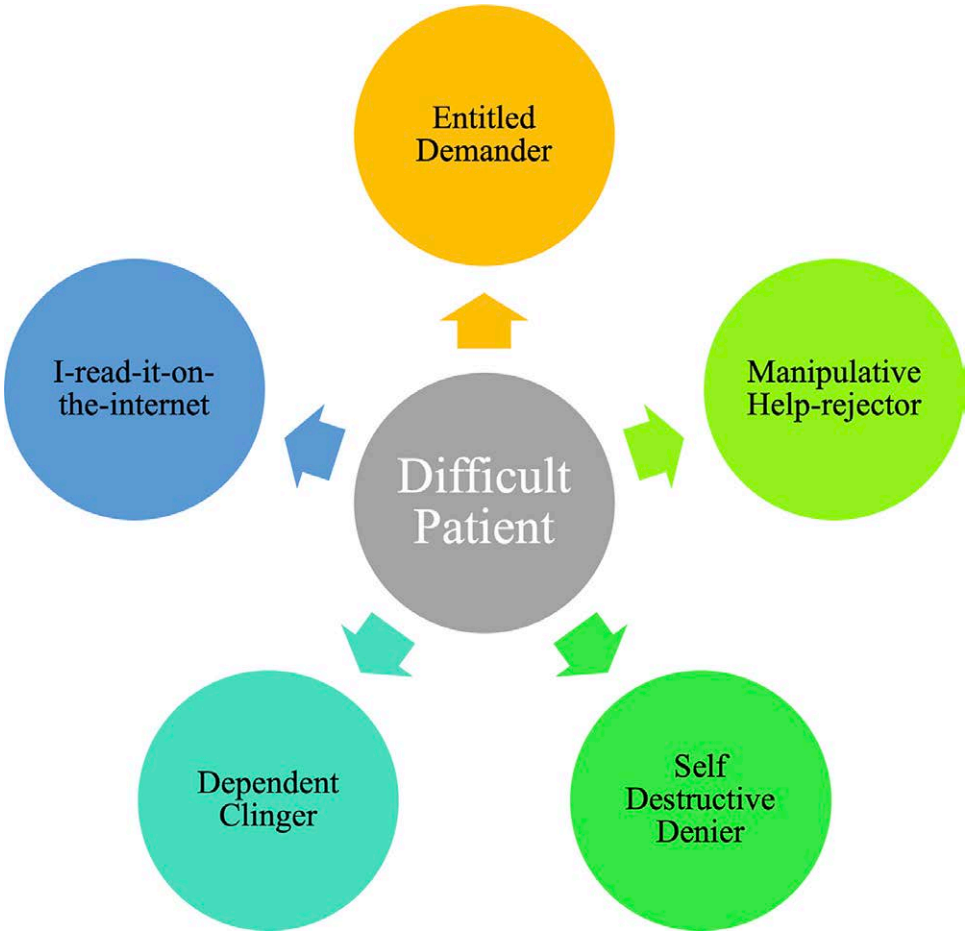

Fig. 1. Different types of difficult patients.

Reversing this mental script by placing the label of "difficult" on the behavior rather than the person may help approach the situation with empathy and recognize that the patient may be struggling to cope with stressful medical experiences.

Furthermore, it is critical to develop deescalation techniques beginning with recognition and validation of patients' concerns. This has been shown to convey the message that you are invested in their care.[1] Be open, honest, and confident (though not arrogant). This can be accomplished by using communal gestures. For example, engaging in eye contact shows that the physician is interested in a patient's concerns. Show genuine concern, empathy, and sincerity.[6] It is critical for physicians to regulate their own emotions by remaining calm, even if they are feeling anxious internally.

Promoting autonomy for the patient is essential when dealing with aggression that may stem from a patient's sense of losing control.[6] For instance, if a patient is struggling with chronic wrist pain in the setting of scapholunate advanced collapse, having a candid conversation and acknowledging the pain shows empathy for the patient's frustration. This provides a strong base for the physician to provide the patient with information about the spectrum of treatments and help determine the best plan—further alleviating some stress and improving behavior.

Consider a lower extremity trauma patient injured in a car accident with significant soft-tissue deficit and exposed ankle hardware. The patient may be dealing with severe pain, the fear of amputation, and loss of a loved one. He or she may appear hostile, but by speaking calmly, the surgeon can establish rapport and build trust. Help the patient understand the reconstructive options and, if feasible, let the patient help with decision making—which thigh to take the flap from or which flap to use for coverage.

Finally, it is essential to turn inward. Introspection helps us to learn from our difficult encounters. Although there are multiple ways to be introspective, perhaps the most relevant in the moment of a deescalation is mindfulness, which entails focusing on the present moment and

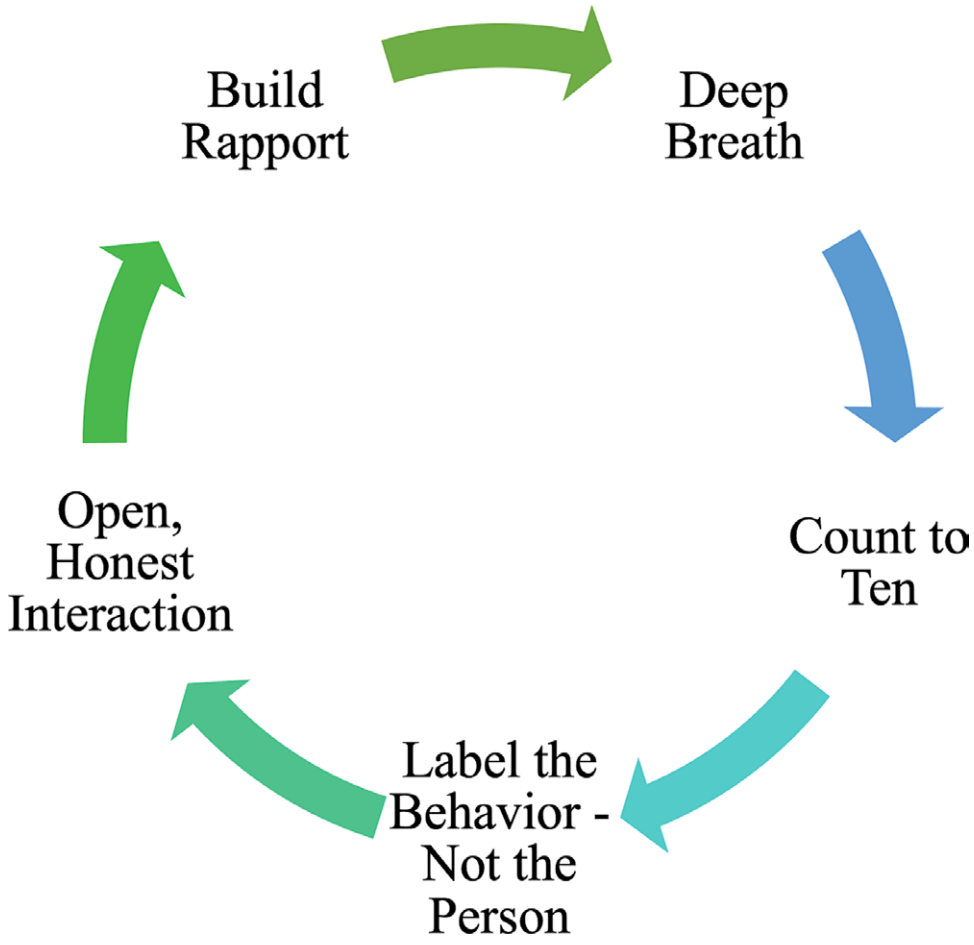

Fig. 2. Techniques for deescalation.

remaining nonjudgmental. Mindfulness may be performed individually or as a group activity where team members encourage each other to remain in the present moment.[7] A form of meditation, mindfulness focuses on inner peace, self-awareness, and gratitude through relaxation methods such as deep breathing and body-scan meditation.[8] Online modules and phone applications are available to help guide those interested in mindfulness.[8,9] These techniques have been shown to improve with practice. Furthermore, this mental training helps lower stress in health care professionals and is linked to improving physician empathy, serenity, burnout, and improving the sense of self.[7] Burnout may be a consequence of dealing with difficult patients. At least 60% of physicians report burnout during their careers,[7] but mindfulness training has been shown to help reduce it.[7]

DIFFICULT PHYSICIANS

Dealing with difficult people applies not just to challenging patients. Relationships with colleagues may also be strenuous. De Leon et al. identified three relevant types of troublesome colleagues[10]:

1. The "impaired physician" is intoxicated or addicted.
2. The "disruptive physician" displays intimidating or inappropriate personal conduct that disturbs a healthy working environment and has an adverse impact on patient care. This physician is verbally abusive and consistently berates and belittles residents, technicians, and nursing staff, leading to an environment of fear and animosity.
3. The "problem physician," most often encountered, is a poor clinician who may also exhibit inappropriate personal conduct. Although this physician may be hardworking and conscientious, he or she unfortunately lacks self-confidence, resulting in poor decision-making that can affect patient care. This physician may also be overconfident without appropriate experience, offering complex operations without the ability to perform them.

TECHNIQUES FOR DEALING WITH DIFFICULT PHYSICIANS

The techniques described above can be applied to help calm yourself in a stressful interaction with a difficult colleague. For instance, a difficult surgeon may project their anger with the case on the resident or technician. This is often in relation to the situation, and it is important to remember that surgery is stressful, and some people handle it better than others. Another technique that may take time to learn is known as "reading the room." This technique is essential to cultivate a working environment conducive to learning and growth. For instance, if a certain time in a procedure is particularly critical or requires a difficult maneuver to perform, that is not time to start a conversation or ask questions. Medical students and ancillary staff sometimes fail to recognize these points that may lead to outbursts from the surgeons. Disruptive behavior through serious and continual verbal and emotional abuse outside of infrequent, stressful times in the operating room, however, should not be tolerated. These outbursts are challenging to deal with and may result in an environment steeped in fear. Inappropriate conduct from superiors should be dealt with through an official channel, such as being reported to the nursing or operating room managers, department chair, or anyone in a position to help defuse such behavior. If such behavior is not dealt with, it has the potential to deleteriously impact patient care by causing damage to the staff member's mental health that may lead to lapses in patient care.

Additional measures may be required for dealing with impaired physicians. If concerns about an impaired physician arise, this needs to be countered quickly to protect patient safety. Up to 10% of physicians struggle with alcohol or drug addiction, similar to national rates.[11,12] Although confronting a colleague suspected of being impaired may be difficult, it can lead to getting the physician the help he or she needs and protect patients. In these instances, either the hospital or state licensing board should be contacted, and the impaired individual typically enters an addiction program. Encouragingly, a large cohort study found that of the 802 physicians in addiction programs, 75% were licensed and working at 5-year follow-up.[11]

STRESS

Interactions with difficult people adds stress to our lives. Stress levels vary over time, depending on our circumstances and ability to cope. How we perceive a situation is critical in determining whether it will evoke a stress response.[13]

Stress leads to physiologic sequelae at the molecular level that can contribute to macrovascular disease, leading to a heart attack, stroke, depression, anxiety, or burnout.[13] Burnout is of particular significance to the physician, as it is more common than depression, substance abuse, and suicide.[14] Chronic stress leads to emotional exhaustion and depletion, depersonalization, and decreased sense of self.[14]

MEDICAL TRAINING

The Accreditation Council for Graduate Medical Education requires evaluation of six core competencies in each residency program.[10] Two of the competencies—professionalism and interpersonal/communication skills—directly relate to interacting with difficult people. If these are emphasized more during residency training, young physicians may be better equipped to handle difficult people. Although medical training is beginning to include discussions on humility, respect, and empathy, studies show empathy generally decreases during the course of medical school and residency.[2,15] Ironically, a physician's perception of his or her own empathy does not correlate with how patients perceive this empathy during interactions.[16]

Although nonverbal communication is an important component of human interaction, recognizing, understanding, and analyzing these cues are not often taught in medical training.[17] An effective tool to teach and remember these components is EMPATHY[17]: eye contact, muscles of facial expression, posture, affect, tone of voice, hearing the whole patient, and your response (Fig. 3).[17] The EMPATHY approach was developed following a randomized controlled trial that showed greater empathy by means of a patient-rated scoring system in residents who had received empathy training compared with a control cohort of residents.[2]

Subtle facial changes indicate different emotions in humans. A recent study investigated 177 health care workers who were trained to recognize subtle facial expressions.[18] These "microexpressions" (thought to represent early manifestations of true emotions) typically last approximately one twenty-fifth of a second and are easily missed if one is not aware of their existence.[18] This is important, as some patients may never disagree with their physician, and missing subtleties can damage the patient-physician

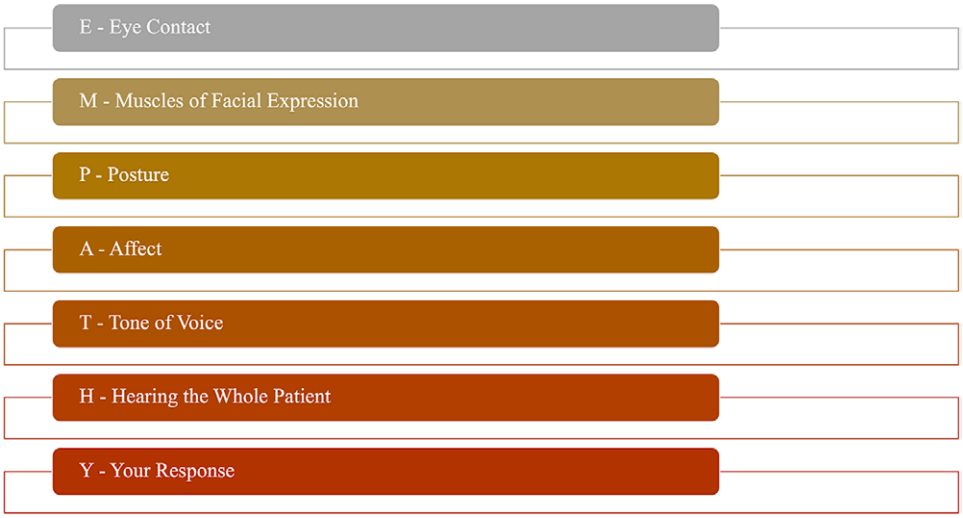

Fig. 3. EMPATHY acronym.

relationship.[17] Using a commercially available subtle expression training tool, the authors showed multiple pictures with subtle facial expressions of the same person to the participants during training. Individuals with training in this area improved significantly in recognizing seven universal human emotions.[18] This study demonstrates a benefit to training health care workers on reading facial expressions.

By remaining calm and nonjudgmental, physicians can deescalate difficult interactions. We do not know what others have experienced; being "difficult" is often a manifestation of circumstances rather than inherent negative behavioral traits. How we interact with others affects our emotions and stressors, which affects our mental health.

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