Mortality from COPD on admission to hospital is closely linked to the degree of acidosis[3] and presence of concomitant medical disorders.[4,5] As a consequence, patients with a pH < 7.35 were not considered suitable for our assisted hospital discharge, although we elected not to exclude patients with other medical disorders such as clinically stable ischaemic heart disease, diabetes mellitus or cardiac failure.

Assisted hospital discharge schemes can be extended to involve patients with chronic respiratory disorders other than COPD, and successfully operate outwith the realms of randomized controlled trials. Greater emphasis should be made of such schemes in national guidelines, in addition to provision of a suggested working template. Practising respiratory physicians and health authorities should be aware of the existence of assisted hospital discharge schemes, and of potential financial savings plus reductions in bed occupancy.

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Difficult patients or difficult encounters?

Sir,

Dr Schattner[1] stresses that research interest in the psychosocial and behavioural aspects of medical illness is rapidly growing, and extensive data have accumulated to support a bi-directional relationship of high clinical significance. In this field, communication studies on the doctor-patient relationship have been of interest to a growing number of researchers. Many studies investigate different aspects of communication. There are studies[2] aimed at observing communication models (e.g. biomedical model, psychosocial or biopsychosocial model) or centeredness (e.g. patient-centered, doctor-centered or relation-centered models) and communications channels.

A topic receiving growing attention is a patient category associated with the distress they provoke in the professional, variously labelled[3] 'hateful patients', 'heartsink patients', 'frustrating patients', 'problem patients' and 'difficult patients'. 'Difficult patients' are those who provoke distress in their physician that exceeds the expected and accepted level of difficulty. Hahn[3] estimated that 10% to 20% of consultations deal with such patients. Compared with 'non-difficult' patients, 'difficult' patients have twice the prevalence of significant psychopathological disorders (67% vs. 35%), an abrasive personality style or a pathological personality disorder (90%), and greater incidence of multiple physical symptoms.[3]

The 'difficult patient' category has been increasingly accepted in studies, but as this label has both practical and emotional implications, some researchers have preferred to focus on encounters and relationships, speaking of 'difficult encounters' or 'difficult relations'.[4] Even among studies that have used the 'difficult patients' category, many have emphasized how professionals may contribute themselves to the problems.[4]

Hall[5] emphasizes the need of studies on concordance between the provider and patient on values and expectations associated with their respective roles. She underscores that providers' characteristics are studied much *less* than patient characteristics are, perhaps because of the relative difficulty of persuading the providers to be studied. She presents a paradox: it is often said that provider communication is studied more than patient communication. However, provider *characteristics* are studied much *less* than patient characteristics. There are several reasons for this. Providers probably are not eager to be personally studied and to

spend time filling in questionnaires about themselves. Furthermore, an assumption sometimes seems to be made that only patients have emotions, attitudes, and characteristics (such as social class) that might influence the nature of communication. The 'difficult patient' category exacerbates this distortion, reinforcing only one side of a complex issue.

These considerations emphasize the importance of treating these studies as relational in nature, rather than looking at only one of the components. To apply this categorization to only patients or only doctors may provoke distortions, and the tendency to moral, rather than scientific, debate. To illustrate how this perspective arouses intense emotional reaction, it is only necessary to imagine the reaction to a symmetrically created 'difficult doctor' category.

Therefore, we consider it more appropriate to place the emphasis on difficult relationships and encounters, to investigate further the factors that contribute to these problems.

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