FROM THE EDITORS' DESK

Patient Encounters of a Difficult Kind

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J Gen Intern Med 29(8):1083–4
DOI: 10.1007/s11606-014-2914-x

Approximately one in six patient encounters are perceived as "difficult."[4] Given this high prevalence, we are likely to see "difficult" patients or at least have difficult conversations with patients every day in clinic. Jackson and Kroenke[2] examined several correlates of patients perceived as difficult. These patients were more likely to have a mental health disorder, have multiple physical symptoms, have severe symptoms, experience chronic pain, and have poor functional status. Furthermore, patients with more unmet expectations after a clinic visit, less satisfaction with care, and who were high "utilizers" were more likely to be involved in difficult encounters.

In the context of chronic pain care, Matthias and colleagues[5] described the emotional toll experienced by primary care providers (PCPs) as a result of difficult patient encounters. PCPs often felt frustrated, ungratified, and guilty when treating patients with chronic pain. Difficult encounters exact a profound toll on patients too. Hinchey and Jackson[3] conducted a prospective cohort study of 750 adults presenting to a primary care walk-in clinic with a physical symptom. The patients involved in difficult encounters had worse short-term outcomes (less trust in their provider, less satisfaction, and experienced worsening of physical symptoms).

What can we do to manage these potentially difficult encounters? Stein, Frankel and Krupat's[9] "Four Habits Approach to Effective Clinical Communication" is an excellent starting point and provides a framework to engage in difficult conversations. The "Four Habits" represents four patterns of communication behaviors and has strong empirical support in primary care. For example, the Four Habits training approach has been used since 1996 in the Kaiser Permanente Health System and has led to positive, long-term effects on patient–provider communication and patient satisfaction.[9] The Four Habits include: 1) invest in the beginning; 2) elicit the patient's perspective; 3) demonstrate empathy; and 4) invest in the end. Each habit involves several related skills and behaviors that are interdependent and sequentially related to one another to be applied in a clinical encounter, especially in a busy primary care setting.

This issue of JGIM features four interesting articles related to communication. These rigorous studies address patient groups that may pose certain communication challenges: patients with depression, those experiencing suicidal thoughts, those with limited health literacy, and those patients undergoing cancer care. The patients in each of these patient groups can be perceived by providers as "difficult patients." Encounters with these patients frequently involve discussions of sensitive issues, such as telling a patient that they have symptoms consistent with depression and need an antidepressant to feel better. In the same patient, the provider may be faced with the difficult task of asking and addressing their thoughts of hurting or harming themselves or others. Of course, difficult cancer care discussions are commonplace and complex, whether they involve breaking "bad news," delivering prognostic information, or discussing goals of care and survivorship, or end-of-life issues. These discussions are often emotionally charged; complicating the effective exchange of information, rapport and trust building, and displays of empathy.

In two related studies in this issue of JGIM, depression care is the focus. In their observational cohort study of more than 1,200 patients, Bauer et al.[1] examined associations between shared decision making, patient–provider trust, and communication with antidepressant adherence. The researchers found that a lack of shared-decision making was strongly associated with non-adherence to a newly prescribed antidepressant. The antidepressants were never dispensed, suggesting that patients decided not to follow providers' recommendation for depression treatment and did not pick up the prescribed medication. In a similar vein, less trust in their provider was significantly associated with non-adherence.

To date, most efforts to improve communication have focused largely on provider skills training. However, in an innovative study, Shah et al.[8] compared two patient-targeted interventions to address patient engagement and encouragement to discuss their suicidal thoughts. One intervention involved a public service announcement video targeted to depression. The second intervention was an individually tailored interactive multimedia computer program. To test these interventions, the research team conducted a randomized control trial among 867 patients across five healthcare

Published online June 17, 2014

systems in Northern California, to determine if these interventions lead to more PCP discussions of suicidal thoughts among patients with depressive symptoms. Compared to an attention control arm, the individually tailored intervention led to more PCP discussions of suicidal thoughts.

Prouty and colleagues[7] identified providers' perceptions regarding the nature and causes of communication breakdowns with patients in cancer care and potential solutions to managing and preventing breakdowns. In their qualitative, focus group study of PCPs, oncologists, and nurses, they described communication breakdowns at patient, provider, and system levels. Patients were perceived as having unrealistic expectations at times, had difficulty understanding cancer-related information, and experienced psychological distress leading to breakdowns. Provider-to-provider information exchange was identified as a communication problem, i.e., inadequate sharing of information or inaccurate information. At the system level, time constraints, payment systems, and changing treatment protocols were identified as contributing to breakdowns. Potential solutions included greater patient engagement, team coordination, and systems that promote patient feedback.

Price-Haywood et al.[6] tested a training program to teach PCPs to engage in cancer risk communication and shared decision making. The researchers conducted a cluster randomized controlled trial in 18 PCPs and 168 patients who were overdue for colorectal, breast, or cervical cancer screening and had limited health literacy. Interestingly, ratings of communication behaviors were performed by standardized patients who presented unannounced to PCPs on three separate visits (baseline, 6 and 12 mos). Compared to feedback of clinical performance alone, the PCPs who received the communication intervention coupled with audit and feedback were rated higher in their communication of cancer risks and shared decision making related to cancer screening. While screening rates increased among patients of PCPs in both study groups, the only between group difference was found for mammography screening.

So while difficult patient encounters will continue to be part of generalist practice, important communication research as highlighted in this issue of JGIM teaches us about specific patient groups and specific communication challenges that may arise. Hopefully, we can learn how to reframe and embrace these challenges as an opportunity to learn and improve our communication skills.

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