

ANNOTATED BIBLIOGRAPHY
for
“DIFFICULT” CLINICIAN-PATIENT
RELATIONSHIPS



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I. THE “DIFFICULT” PATIENT

Katon W, Von Korff M, Lin E, Lipscomb P, et al. Distressed high utilization of medical care: DSM-III-R diagnoses and treatment needs. *Gen Hosp Psychiatry* 1990;12:355-362.

A sample of the top 10% of utilizers in a large HMO with the top 10% of scores on a measure of psychosocial distress. These were not the “worried well” - their doctors rated them as moderately to severely ill. Although panic, depression, and somatization were common findings, the doctors found patients with personality disorders to be the most difficult. An intervention study has demonstrated that mental health consultation and treatment had a positive financial impact.

Goodwin JM, Goodwin JS, Kellner R. Psychiatric symptoms in disliked medical patients. *JAMA*. 1979;241(11):1117-1120.

The purpose of this study was to determine the characteristics of patients disliked by their clinicians and to examine if the “dislike” could be used as a diagnostic tool. Twenty two patients seen in a clinic for systematic lupus erythematosus were tested for organicity, depression, anxiety, and hostility. Instruments include a mental status questionnaire to measure organicity and the Symptom Questionnaire to measure depression, anxiety and hostility. Four clinicians were asked to rank these patients from most liked to least liked. Ten patients were ranked among the most disliked by one or more clinician. Results indicated dislike was significantly correlated with the patients’ degree of organicity. In addition, there were individual differences between clinicians regarding which patients they tend to like and dislike.

Crutcher JE, Bass MJ. The difficult patient and the troubled physician. *J Fam Pract*. 1980;11:933-938.

The purpose of this study was to discover the: 1) rate of troubling encounters; 2) factors in the problem, patient, or clinician that influence this rate; and 3) factors in the problem, patient, or clinician that influence the intensity of the troubled feelings. Twelve community clinicians, practicing within 30 miles of London, Ontario, with similar training and practice locations evaluated a total of 722 patient encounters for presence of troubling emotions. Clinicians kept a record for each visit for 3 different periods of office activity on a special encounter form. Just under 30% of visits were troubling to the clinicians. Patients with psychosocial problems were more likely to be troubling, as were older and working class patients. There was no relationship between sex of clinician and rate of troubling. The more experienced the clinicians, the less likely they were to be troubled.

John C, Schwenk TL, Roi LD, Cohen M. Medical care and demographic characteristics of “difficult” patients. *J Fam Pract*. 1987;24(6):607-610.

The purpose of this study was to determine demographic and medical characteristics of the “difficult” patient. Data were collected from: 1) clinicians’ descriptions of “difficult” in their own terms; and 2) audits of patients’ charts. “Difficult” patients were older, more often divorced or widowed, and included a higher percentage of women. In addition, “difficult” patients have more acute problems, chronic problems, chronic medications, x-ray examinations, blood tests, clinician referrals, and visits to the family practice center. These patients were a source of frustration because of clinicians’ inability to reach closure in their acute medical problem solving due to mutual underlying interpersonal or communication problems.

Kahana RJ, Bibring GL. Personality types in medical management. In: Zinberg NE, ed. *Psychiatry and Medical Practice in a General Hospital*. New York: International Universities Press; 1964:108-123.

Seven basic categories of personality types found among “difficult” patients were identified and defined: 1) dependent, overdemanding; 2) orderly controlled; 3) dramatizing, emotionally involved, captivating; 4) long-suffering, self-sacrificing; 5) guarded, querulous; 6) feelings of superiority; and 7) uninvolved and aloof. Psychoanalytic principles were utilized to explain: 1) the meaning of illness; 2) the threat each personality type is trying to cope with; and 3) the kinds of defensive and adaptive behavior expected for each personality type. In addition, clinicians’ reactions to these personality types were addressed.

Lipsitt DR. Characteristics of “crocks” *Int J Psychiatry Med.* 1970;1:15-25.

A case illustration and treatment of a “difficult” patient or patient with “thick chart syndrome.” This patient had a 20 year history of multiple problems and operations. She was treated for 12 years before anyone suggested she may have psychological or social problems and be depressed. Focus was drawn to the patient’s depressive and masochistic tendencies and the tendency to inappropriately utilize multiple symptoms and complaints to evoke interest and concern in others which were often to their own detriment. Suggestions for treatment included: 1) recognizing early warning signs of masochistic and depressed behavior; 2) conveying greater interest in the relationship than in curing symptoms; 3) knowing clinical signs of depression; and 4) prescribing cautiously.

Lorber J. Good patients and problem patients: Conformity and deviance in a general hospital. *J Health Soc Behav.* 1975;16:213-225.

The purpose of this study was to investigate attitudes and behaviors of surgical patients and the reactions of doctors and nurses to these behaviors. The sample included 103 patients entering the hospital for elective surgery and their clinicians. Reated patients did differ in their attitudes regarding “good patient” norms. Good patients were described as those who were dependent/helpless, accepted and followed the routine, did not ask for too much information or have too many questions trusted you completely, and were obedient. The best predictors of deviant and conforming behavior toward hospital-patient role were age and education. For example, a college educated person under 60 years was more likely to be deviant that a poor person over 60. Patients were labeled “problem patients” if they interrupted the well-established hospital routines and did not play the submissive role. How these patients were treated depended on the severity of the illness - the more severe, the more tolerant the staff. Possible consequences for being labeled a problem patient were premature discharge, neglect, and referral to a psychiatrist.

Malcolm R, Foster HK, Smith C. The problem patient as perceived by family physicians. *J Fam Pract.* 1977;5(3):361-364.

The purpose of this study was to determine: 1) if family clinicians perceive problem patients according to a composite criteria; 2) if family clinicians view the clinician-patient relationship differently with the various types of problem patients; and 3) if family clinicians’ age and experience had an effect on their view of problem patients. Demographic data were collected from 27 family practice residents and 26 trained clinicians who were asked to: 1) rank the three most frequent presenting complaints they saw in problem patients and to rate whether these were perceived as functional or organic; 2) check whether they thought psychiatric symptoms were present; and 3) rate each of 24 descriptive terms regarding the clinician-patient relationship. Problem patients were identified as those with: 1) poor treatment outcome; 2) vague complaints which were functional and changing; and 3) psychiatric symptoms or syndromes which complicate treatment and create difficulties in the clinician-patient relationship. Neither clinicians’ age nor time in practice had any significant influence on responses. Frustrating, dependent, and manipulative were the most frequently rated clinician responses to the clinician-patient relationship. Suggestions for management were: 1) early detection by attending to increasing frustration levels; 2) confine initial treatment to one complaint; 3) remain open to examine psychosocial aspects; 4) respond to patients’ expectations and keep them informed; and 5) avoid early referrals.

Stimpson GV. General practitioners, “trouble” and types of patients. *Sociological Review Monograph.* 1976;22:43-60.

The purpose of this study was to determine how clinicians construct views of most “difficult” and least “difficult” patients. A sample of 453 general practitioners answered an open-ended survey questionnaire. Clinicians’ answers fit into four major categories of concern: 1) social groups (age, sex, ethnicity, occupation); 2) illness (44% psychological and/or psychiatric); 3) patient behavior (take up too much time, ungrateful); and 4) social competence (unhappy, lonely, inadequate). The least troubling patients were described as middle-aged, hard-working men with illnesses that were quickly resolved, or with which they came to terms with quickly.

II. THE CREATION OF THE “DIFFICULT” PATIENT

Anstett R. The difficult patient and the physician-patient relationship. *J Fam Pract.* 1980;11:281-286.

The purpose of this article was to reframe the concept of “difficult” patient to conceptualizing these patients as products of failed relationships with clinicians. Specific problem areas of clinician patient communication were described as: 1) failure to achieve mutual understanding; 2) failure to share basic information; 3) failure to recognize implicit needs and expectations; and 4) failure to recognize or share the symbolic aspects of the disease.

Kuch JH, Schuman SS, Curry HB. The problem patient and the problem doctor or do quacks make crocks? *J Fam Pract.* 1977;5(4):647-653.

Provided case vignettes to illustrate how doctors can produce “difficult” patients by organizing patients’ complaints. This clinician behavior serves to reinforce the feeling in the patient that his/her body is “sick” and thus perpetrates the sick role. Often this type of approach serves to boost the doctors’ confidence in the short term (by providing something to treat) and produces frustration in the long term (by promoting the sickness model and encouraging an endless list of symptoms, tests and medications). This behavior was perceived to place the patient at the risk by ignoring significant behavioral problems underlying the symptom. These authors encouraged teaching patients that behavior can and does affect health.

Leiderman DB, Grisso JA. The Gomer Phenomenon. *J Health Soc Behav.* 1985;26:222-232.

The purpose of this study was to reach an understanding of the phenomenon of gomerism. An analysis of hospital records of “gomer” patients and the attitudes and perceptions of the house staff who treat them was conducted. Gomers were no more ill than control patients, however, their problems were more frustrating, engendered disagreement, and aroused uncertainty in the house staff. “Gomerism” was described as a function of dilemmas in the health care system and society. Specifically, gomers represent: 1) those for whom technological medicine cannot eliminate illness; 2) the aged who cannot be healed; and 3) a failure in society’s ability to provide humane care for the socially isolated.

Longhurst MF. Angry patient, angry doctor. *CMAJ.* 1980;123:597-598.

An editorial describing clinicians as being addicted to “purpose”. Specifically, the patient must have a purpose for a visit and it must be solvable. The belief in purpose leads to clinicians’ feeling helpless (an intolerable state). Management included: 1) becoming aware of one’s own feelings; 2) acknowledging these feelings; and 3) confronting feelings before the clinician can appreciate the patient’s feelings.

Schuller AB. About the problem patient. *J Fam Pract.* 1977;4(4):653-654.

The purpose of this paper was to discuss the phenomenon of the problem patient. Data on six patients were from a series of behavioral conferences on problem patients held at the University of California, Davis, Family Practice Residency Program. The “difficult” patient was described as female, a mean age of 43 years, who presents with multiple complaints that are difficult to define and treat, and when symptoms are relieved new and equally vague ones appear. They had chaotic and crisis-ridden relationships. In addition, they made frequent demands on their clinicians and rarely played an active role in their own treatment. Clinicians’ responses were anger, frustration, feeling drained, feeling overwhelmed and helpless. Suggestions for management included: 1) giving up the expectation that the patient would participate actively and get better; 2) offer empathy, expert diagnostic skill, and appropriate therapeutic suggestions; 3) set the following limits: a) tell patient that the final decision in treatment regarding what they do is up to them, b) define abuse of the system and that they will be informed when it occurs, c) schedule more frequent visits; 4) when psychological problems warrant attention, the clinician should state so giving specific evidence; and 5) negotiate a therapeutic contract. Follow up consultation indicated the clinicians felt less overwhelmed and were more allied with patients.

Wills TA, Hahn SR. Challenges to altruism in medical settings. In: Montado L, Bierhoff HW, eds. *Altruism in Social Systems*. Hogrefe & Huber Pub. 1991:204-223.

A review of the literature regarding help-seeking behavior, "difficult" patient characteristics and clinicians' reactions. Focus was on the characterization of "difficult" patients as a function of the clinician's inability to achieve success in diagnosis, treatment, or the interpersonal relationship with the patient. The clinician was perceived as unable to accomplish these tasks due to a conflict in the expectations of the clinician and the patient. Solutions for overcoming this conflict included: 1) understanding and addressing "difficult" patients behavior in a systems context by diagnosing and managing the compensatory alliance; and 2) developing an appreciation for the therapeutic power of "empathic witnessing" when the patients' problems defy the clinician's or the health care system's ability to intervene.

III. THE CLINICIAN IN THE "DIFFICULT" RELATIONSHIP

Calnan M. Images of general practice: The perceptions of the doctor. *Soc Sci Med*. 1988;27(6):579-586.

The purpose of this study was to examine general practitioners' perceptions of their work role and to examine how these are represented in their own ideas about their work. A sample of 1,419 general practitioners in England and Wales were sent the questionnaire. The response rate to the survey was 67.4%. Nonrespondents tended to be female, to have qualified outside of the U.K. and Ireland, and qualified prior to 1950. Perceptions of work role were measured by 18 items in four clusters: 1) a social versus medical dimension; 2) the doctor-patient relationship; 3) the doctor's relationship to other members; and 4) the doctor's attitude toward financial incentives. Results indicated two distinct orientations to work roles: 1) emphasis on social aspects of medicine (holistic); and 2) emphasis on biomedical aspects of medicine (traditional). Those with social orientations were more likely to doubt the value of financial incentives, whereas the biomedically oriented were more likely to indicate their behavior was influenced by financial incentives. In addition the two groups are different in terms of personal characteristics and the settings in which they worked.

Eubank DF, Zeckhausen W, Sobelson GA. Converting the stress of medical practice to personal and professional growth: 5 years of experience with a psychodynamic support and supervision group. *J Am Board Fam Pract*. 1991;4(3):151-157.

A description of seven clinicians' solutions to dealing with the stresses in their professional and personal lives. The 5 year evolution of a clinician support group that provided supervision and psychodynamic support was described. Key elements of effectiveness were: 1) leadership; 2) connecting work issues to personal dynamics; 3) defusing defenses; and 4) ensuring confidentiality. Issues that were addressed in the group included: 1) competitiveness; 2) mistakes; 3) anger; 4) "difficult" patients; 5) death; 6) fear of malpractice; and 7) family-work tensions. Success of the group was attributed in part to having a professional group leader.

Fidell LS. Sex role stereotypes and the American physician. *Psychology Women Quarterly*. 1980;4(3):313-330.

The influence of sex-role stereotypes on women patients was examined. Myths regarding women perpetuate the problem of differential treatment. It was suggested that clinicians tend to attribute symptoms presented by women as having psychogenic origins. However, women, as opposed to men, continue to receive more medical treatment, unnecessary surgery, and psychotropic medications. Women were also reported to be labeled "difficult" more often than men.

Gorlin R, Zucker HD. Physician's reactions to patients: A key to teaching humanistic medicine. *N E J Med*. 1983;308(18):1059-1063.

An overview of a program for training clinicians where focus was to reinforce that all doctors have negative and positive feelings and impulses which can interfere with professional action or judgement. Acknowledging and dealing with these feelings can produce positive outcomes for both clinician and patients. Typical emotional responses of clinicians were: 1) avoidance; 2) identification with patients; 3) hostility/ rejection; 4) inadequacy/ feelings of impotence; 5) frustration, confusion, uncertainty; and 6) anxiety, guilt, and frustration about meeting

patient's recognized emotional needs. Strategies for coping include: 1) recognize and acknowledge; 2) analyze why; 3) be realistic about what you can do; 4) seek peer supervision; and 5) refer if necessary.

Klein D, Najman J, Kohrman AF, & Munro C. Patient characteristics that elicit negative responses from family physicians. *J Fam Pract.* 1982;14:881-888.

The purpose of this study was to determine the medical and social characteristics of patients that evoke negative responses in clinicians who treat them. A survey questionnaire was mailed to a random sample of 1,000 family clinicians who were members of the Michigan Academy of Family Clinicians. The response rate was 45% thus the sample consisted of 450 clinicians. The largest category (60%) of medical conditions which elicited negative responses were those conditions which offered little or no likelihood of cure or alleviation. Other medical categories included were conditions that challenged the clinician's competence and conditions for which patients were perceived as culpable. The largest category (33%) among the social characteristics included behavior that violated the clinician's norms and values. Other social categories include characteristics that threaten or impede therapy, characteristics that threaten the clinician's authority or prestige, characteristics that impede communication, and characteristics that impede clinician's personal norms. These results indicate a need for clinicians to examine their values and orientations and how these may affect treatment delivery.

Langley GR, Till JE. Exemplary family physicians and consultants: Empirical definition of contemporary medical practice. *CMAJ.* 1989;141:301-307.

The purpose of this study was to determine the characteristics of exemplary family clinicians and consultants. The sample consisted of 25 clinicians and 25 consultants perceived by their peers to be exemplary. Results indicated participants have well formulated concepts of exemplary practitioners. Five main categories of performance emerged: 1) clinical competence; 2) relationship with patient; 3) availability; 4) family clinician-consultant relationships; and 5) organizational ability and personality attributes.

Lichtenstein R. Measuring job satisfaction of physicians in organized settings. *Med Care.* 1984;22:56-68.

The purpose of this study was to pilot test a self report questionnaire measuring clinician job satisfaction. The questionnaire was mailed to 588 clinicians (382 clinicians responded indicating a 65% return rate) who worked in prison settings. Analysis of the instrument indicated good reliability and validity. Seven factors regarding job satisfaction emerged from factor analysis, these included: 1) satisfaction with resources; 2) satisfaction with self-directed autonomy; 3) satisfaction with other-directed autonomy; 4) satisfaction with patient relationships; 5) satisfaction with professional relationships, 6) satisfaction with status; and 7) satisfaction with pay. In addition, the instrument indicated good predictive validity of intention to leave the job. The instrument may serve to identify elements in the work setting that need to be changed to improve job satisfaction.

LeBaron S, Reyher J, Stack JM. Paternalistic vs egalitarian physician styles: The treatment of patients in crisis. *J Fam Practice.* 1985;21(1):56-62.

Compared the effect of paternalistic vs. egalitarian clinician styles of communicating to female patients receiving outpatient abortions. Patients treated in a paternalistic manner had higher responsiveness to suggestibility, felt they could depend more on the clinician, perceived the clinician as warmer and more supportive, and had lower levels of psychological distress. These authors conclude that for patients in "crisis" a paternalistic approach may promote more positive outcomes.

McCue JD. The effects of stress on physicians and their medical practice. *NEJ Med.* 1982;306:485-463.

Identified areas of stress which are intrinsic to the job of the clinician such as: 1) suffering; 2) fear; 3) sexuality; 4) death; 5) inadequate training for fundamental professional tasks, i.e., handling "problem patient"; and 6) demands from society or patients that cannot be met, i.e., need for certainty when current medical knowledge provides approximation. Adaptations to these stresses included: 1) emotional withdrawal; 2) social isolation; and 3) denial of problems. Suggestions for management include: 1) changes in medical school admissions; and 2) changes in society.

Mawardi BH. Satisfactions, dissatisfactions, and causes of stress in medical practice. *JAMA*. 1979;241(14):1483-1486.

The purpose of this study was to examine: 1) what types of patients clinicians like and dislike; 2) what types of medical problems they prefer to work with; and 3) what aspects of practice they find satisfying. The sample included clinicians who graduated from Case Western Reserve School of Medicine who had been examined in several longitudinal career studies. Career satisfactions and dissatisfactions were reported for private practice practitioners and non-office based practitioners. Satisfactions for private practitioners that were named most frequently include: 1) accurate diagnosis; 2) successful therapy; and 3) service to humanity. For non-office based practitioners, satisfactions include: 1) research; 2) accurate diagnosis; and 3) successful treatment. Sources of dissatisfaction for both groups of practitioners were: 1) time pressures; 2) therapy failure; and 3) patient related problems. Clinician groups were ranked by satisfaction with their practice and suicide rates in their particular professional group. Full-time medical faculty were the most satisfied and pediatricians were the least satisfied. Psychiatrists had the greatest number of suicide and pediatricians had the lowest suicide rate.

Merrill JM, Laux L, Thornby JI. Troublesome aspects of the patient-physician relationship: A study of human factors. *S Med J*. 1987;80(10):1211-1215.

The purpose of this study was to examine three aspects of the clinician-patient relationship. A "hassle index" identified factors of vexation to clinicians: 1) the mechanics of running a practice; 2) medical conditions of patients; and 3) social characteristics of patients. The sample included 200 internists. Different practice settings were examined regarding this relationships to the 3 hassle factors. The only difference noted was variations in factor 1 which probably reflected how well the practice was organized and managed. There were no reported significant differences across practices and factors 2 and 3. Clinicians reported feeling hassled by patients with: 1) unclear prognosis; and 2) those whom the clinicians perceived they had little control over. Personality profiles for 81 clinicians in the sample were examined for their relationship to vexation. Clinicians who were most vexed were more likely to have been least guarded, most self-derogating, most in need of support, and least extroverted upon entering medical school. Clinicians who had low self esteem were more likely to be annoyed by patients with trivial, undiagnosable complaints and those who failed to respond to treatment.

Quill TE, Williamson PR. Healthy approaches to physician stress. *Arch Intern Med*. 1990;150:1857-1861.

The purpose of this study was to examine how clinicians cope with ten common dilemmas such as mistakes, death, self-care, uncertainty, patient demands, and time demands. Questionnaires were sent to 550 readers of the *Medical Encounter*. The response rate was 10%. There was no information on non-respondent characteristics. Those who reported they were effectively coping reported five general areas of personal growth: 1) self-awareness; 2) sharing feelings and responsibility; 3) self-care; 4) developing a personal philosophy; and 5) nontraditional coping skills of reframing and limit setting. These five coping areas may provide a framework for teaching better coping skills.

Schwenk TL, Marquez JT, Lefever RD, Cohen M. Physician and patient determinants of difficult physician-patient relationship. *J Fam Pract*. 1989;28(1):59-63.

The purpose of this study was to examine the effects of both clinician and patient characteristics in understanding the "difficult" clinician-patient relationship. The sample consisted of 25 family clinicians and their perceptions of 205 "difficult" patients. The assumption of this research was both the clinician and the patient share responsibility for the "difficult" relationship. Clinicians rated patients on 40 behavioral and physical characteristics. Results from factor analysis indicated two factors underlying clinicians' perception of "difficult" patients: 1) medical uncertainty or inability to diagnosis the problem; and 2) interpersonal difficulty. In addition, the top six ranked ratings for primary motivation of clinicians were satisfaction derived from solving medical problem and helping people.

Shahady EJ. Uncovering the real problems of "crocks" and "gomers". *Consultant*. 1984;24(4):33-43.

Described gomerism-an acronym for "Get Out Of My Emergency Room"- as a mutual illness of doctors and patients. Clinicians' reactions to the "difficult" patients were discussed. Clinicians were frustrated because they could not identify diseases in these patients and these patients did not act in the "expected" manner. One suggestion was labeling these patients' charts with I=FACH (I feel impotent because I am frustrated, angry, confused, and hostile). This would provide the cue to act versus react. Case examples were provided with

common responses and more adaptive responses. In addition, four steps for improving clinician-patient relationships were suggested: 1) establish mutual trust; 2) dispel mythical beliefs (both doctor and patient); 3) define the problem and clearly convey the diagnosis; and 4) make a contract that is mutually understood and accepted.

Simpson LA, Grant L. Sources and magnitude of job stress among physicians. *J Behav Med.* 1991;14(1):27-42.

The purpose of this study was to determine sources and magnitude of job stress among clinicians. A sample of 204 beginning clinicians (57 female, 147 male) indicate four factors of job stress: 1) patient issues; 2) competence; 3) time issues; and 4) business issues. Competence was indicated to be the most stressful, followed by time pressures, business concerns, and patient concerns. No gender differences were found to be significant. Practice structure and gender were not predictive of any particular stressors.

Smith RC. Teaching interviewing skills to medical students: The issue of 'countertransference'. *J Med Educ.* 1984;59:582-588.

The purpose of this study was to examine any possible adverse effects medical students have upon their patients as a result of countertransference due to their own unrecognized feelings. A sample of 17 medical students beginning their clinical work were observed individually in a single 30 minute interview. Countertransference was measured by the author in two specific ways: 1) if any of the following behaviors were present during the interview: avoidance of certain topics, controlling the patient, changing the subject and directing the interview, attempts to please, overly social, detachment, lack of respect and sensitivity, seductiveness, and miscellaneous; and 2) if the student expressed any of the following during a post interview conference: fear of causing harm, fear of unpleasant topics, fear of loss of control, fear of affect, disdain, feeling intimidated, feeling inadequate, performance anxiety, biomedical orientation, identification with the patient, and feelings unique to the student. Two students did not have adequate interview skills and were excluded. Results indicated 13 of the remaining 15 students expressed some countertransference behaviors during the interview, while 14 revealed evidence of countertransference in the post interview discussion. Typically, unrecognized feelings were: 1) fear of harming the patient; 2) fear of loss of control; 3) performance anxiety; and 4) fears unique to the student (such as fear of cancer in self). These data suggest the need to address the issue of countertransference in addition to interviewing skills.

Smith RJ, Steindler EM. The impact of difficult patients upon treaters: Consequences and remedies. *Bull Menninger Clin.* 1983;17(2):107-116.

Described "difficultness" as a joint function of impaired interactions between both doctor and patient. Suggestions for withstanding the impact were: 1) gain perspective; 2) detachment; and 3) self confidence. Factors that increased clinician vulnerability were: 1) therapeutic zeal; 2) overidentification; and 3) isolation. In addition, the authors suggested one learn to anticipate problems by being sensitive to the patient's signals, prepare a plan, and establish reasonable and firm boundaries. Five suggestions were given for preventing burnout: 1) develop interests outside of your profession; 2) communicate and collaborate with peers; 3) modify duties and responsibilities; 4) change institutional practices; and 5) personal counseling and psychotherapy.

IV. DEFINITION OF THE ILLNESS

Barnlund DC. The mystification of meanings: Doctor-patient encounters. *J Med Educ.* 1976;51:716-725.

An exploration of the symbolic and communicative aspects of illness and treatment. Factors that complicate interpersonal communication were identified: 1) ego involvement; 2) differences in knowledge; 3) communicative purposes; 4) emotional distance; 5) one-way communication; 6) verbal manipulation; 7) ambiguity of language and jargon; and 8) the pressure of time. Each of these factors can be found in the medical encounter and complicate the process of sharing meaning in interactions between doctor and patient.

Helman, CG. Communication in primary care: The role of patient and practitioners explanatory models. *Soc Sci Med.* 1985;20(9):923-931.

The purpose of this study was to examine the inter-related aspects of clinician-patient communication in primary care relationships. The sample included 42 adults diagnosed with a chronic condition with a psychosomatic component. Aspects explored were: 1) patient's view of the origin, significance, and effects of their condition; 2) clinician's view of patient's condition; 3) clinician's view of how the patient views their condition; and 4) the degree of agreement (disagreement) between these perspectives. Results indicated clinicians had limited knowledge of patient's explanatory models. This difference in perception was exacerbated when patients were less educated.

Kindelan K, Kent G. Concordance between patients' information preferences and general practitioners' perceptions. *Psychol Health.* 1987;1(4):399-409.

The purpose of this study was to examine the hypothesis that when doctors accurately gauge the types of information desired by patients, satisfaction would be higher for both patients and doctors. The sample included 4 male doctors in group practice and 103 patients (22 males and 81 females). Patients were asked for their preference for five types of information regarding their illness prior to examination. After examination the patients were given another questionnaire to measure satisfaction. The doctors were asked to complete a questionnaire after each consultation. Doctors' perceptions of patients' desire for information and patients' stated desires were not in concordance. Patients preferred information regarding prognosis and diagnosis and doctors perceived a greater demand for treatment information. Both parties were satisfied, however, satisfaction was not found to be significantly related to concordance between doctor and patient.

Kleinman A, Eisenberg L, Good B. Culture, illness, and care: Clinical lessons from Anthropologic and cross cultural research. *Ann Intern Med.* 1978;88:251-258.

Highlighted the distinction between illness and disease and the notion of a cultural construction of clinical reality. Included case studies. Emphasized the necessity of eliciting the patient's model of the illness and negotiation.

Lazare A, Eisenthal S, Wasserman L. The customer approach to patienthood. *Arch Gen Psychiatry.* 1975;32:553-558.

The medical interview was conceptualized as a process of negotiation between doctor and patient. The patient enters the interview with: 1) a complaint; 2) a goal; and 3) a request. Problems arise when the doctor fails to elicit the patient's request. It is the doctor's job to elicit all three and negotiate between the request and wants of the patient and clinical appropriateness. Provided very practical examples of specific behaviors and questions to elicit the patient's request. In addition, they addressed resistance to this approach from both patients' and doctors' perspectives.

Maoz B, Antonovsky H, Ziv P, Avraham-Shiloh L, Durst N. The family doctor and his "nudnik (bothersome) patients": An exploratory study. *Isr J Psychiatry Relat Sci.* 1985;22:1-2,95-104.

The purpose of this study was to address the following research questions. 1) To what extent do doctors and patients agree with regard to: a) severity of symptoms; b) the possibility of treatment? 2) How do patients and clinicians react to their frustrations? 3) To what extent do "nudnik" patients exhibit a similar personality structure? The sample included 10 primary care doctors and 42 of their "nudnik" (bothersome) patients. Data were obtained via patients' charts and self report questionnaires were completed by clinicians and patients. Personality characteristics were measured by a short form of the MMPI and psychiatric interviews. Results indicated clinicians felt inadequate to treat the emotional problems of these patients. In contrast, the patients felt their symptoms were somatic and their clinicians could treat them. Personality tests and interviews indicate the patients were suffering from emotional problems, specifically, behavior and personality disorders. Suggestions for resolving these "difficult" interactions include intensive liaison and consultation services from a psychiatrist. In addition, it was suggested these patients be given "regular" appointment so the clinician can prepare for these encounters and decrease unnecessary visits.

Wright AL, Morgan WJ. On the creation of “problem” patient. *Soc Sci Med*. 1990;30(9): 951-959.

The purpose of this study was to understand the interaction between medical personnel and problem patients. A sample of 7 cystic fibrosis patients in a pediatric pulmonary clinic at a university hospital were selected based on their identified status as “problems” and interviewed over a period of several years. Problem patients were found to be created on two levels: 1) the macro-level where cultural expectations of power were negotiated and expressed by differences between legitimate roles prescribing “desired” behavior (specifically those related to the structure of institutions which can be contrary to patient needs); and 2) interpersonal beliefs and illness meanings that were divergent.

V. INTERVENTION

Blackwell B, Guttman M. The management of chronic illness behavior. In: McHugh S and Vallis M (eds): *Illness Behavior*, Plenum, 1987.

Most clinicians (especially physicians) have little experience shaping illness behavior (what patients do in response to their disease). This article describes how to help patients replace illness behaviors with more healthy ones. Most of these techniques are conversational (et, what behaviors you inquire about and reward with praise and attention) during the visit.

Sullivan MD, Turner JA, Romano J. Chronic pain in primary care: Identification and management of psychosocial factors. *J Fam Pract* 1991;32:193-199.

Portenoy RK. Chronic opioid therapy in nonmalignant pain. *J Pain Symptom Manage* 1990;5:S46-S62.

Miotto K, Compton P, Ling W, Conolly M. Diagnosing addictive disease in chronic pain patients. *Psychosomatics* 1996;37:223-235.

The first article reviews epidemiology, diagnosis, and management of chronic pain and includes behavioral techniques appropriate for an ambulatory medical setting. The second reviews what little literature there is on narcotic treatment of chronic nonmalignant pain with narcotics. The rate of addictive behavior seems to be about 15%, although many clinicians find narcotics useful when NSAIDs or TCAs are contraindicated. The third demonstrates that traditional diagnostic criteria for addiction remain useful in patients with and chronic pain and outlines a diagnostic approach.

Johnson B, Clark W. Alcoholism: A challenging physician-patient encounter. *J Gen Intern Med* 1989;4:445-452. Review of diagnosis, treatment, and prognosis with emphasis on communication skills and discussion of denial.

Alper PR. Surefire ways to soothe the savage patient. *Med Econom*. 1985;March:131-136.

Techniques for winning over the hostile or angry patient were presented. Techniques presented included: 1) Resist the urge to snap back - try to avoid taking offense; 2) Break the underlying tension - let them know you understand how they feel; 3) Admit that you’re only human; and 4) Stand up to intimidation. In addition, it was suggested that one listen to possible inconsistency between tone and words and respond to the less hostile of the two.

Barsky AJ. Hidden reasons some patients visit doctors. *Ann Intern Med*. 1981;94(1):492-498.

Four clinical situations that should lead the clinician to suspect the patient is visiting for nonbiomedical reasons were described: 1) the patient who is unduly troubled by symptoms; 2) the medical diagnosis seems unimportant; 3) the patient expresses dissatisfaction with the medical profession and care they have received; and 4) the visit is initiated without a change in the patients’ clinical status. Suggestions for treatment were: 1) ask the patient what he/she imagines is causing the problem; 2) ask the patient how he/she hoped the doctor could help; 3) ask the patient why he/she is dissatisfied, because the real motive for seeking treatment may not have been discovered; and 4) ask the patient about current life stresses.

Baum N, Henkel G. *Marketing Your Clinical Practice: Ethically, Effectively, Economically*. Gaithersburg, MD:Aspen Pub. 1992:55-58.

Suggested resisting the urge of avoiding the “difficult” and complaining patient. These patients provide good publicity. Twelve strategies that can be used for managing this population were provided: 1) select a time for interaction; 2) do not downplay symptoms; 3) apologize for hurt patient feelings; 4) be empathetic; 5) establish rapport; 6) do not be defensive; 7) take control after you’ve heard the story; 8) develop a plan of action; 9) provide prior notice of your billing practices; 10) sell the plan; 11) check to be sure plan is being carried out by having timely follow-up; and 12) document your interaction that is not part of patient record.

Bishop ER. Somatization in the office patient—Approaches and management. *J Med Assoc GA*. 1981;70:35-39.

Described somatization disorders as analogous to a fever - “there are many things that can cause it”. The author recommended looking for specific etiology as management depends on the specific etiology. He further suggested somatization may be managed with: 1) biological intervention - if it is an expression of an anxiety, affective, or psychotic disorder; or 2) psychological or social intervention - this entails becoming familiar with the patient’s sociological concept of the sick role.

Block MR, Coulehan JL. Teaching the difficult interview in a required course on medical interviewing. *J Med Educ*. 1987;62:35-40.

A module used to teach specific skills required during “difficult” patient interactions was presented. The “difficult” interview was perceived as a problem of the patient, the interviewer, or both. Difficulties in an interview were categorized as occurring in one or more of the following areas: 1) technical and process—foreign language; 2) topical problems—drugs and alcohol; 3) patient’s personality style—seductive; and 4) interviewer’s feelings.

Branch WT, Lown B. Fatigue and other frequent manifestations of somatization. In: Branch WT, ed. *The Office Practice of Medicine*. Philadelphia: WB Sanders Co;1987:1338-1347.

Causes of fatigue and other somatization were described. Suggestions for management include: 1) a very structured interview including a) a biopsychosocial perspective, b) attention to nonverbal cues, c) attention to affect, d) focus on recent stresses or life changes; 2) providing reassurance; and 3) early recognition and diagnosis of these types of problems.

Cohen-Cole SA, Friedman AP. The language problem: Integration of psychosocial variables into medical care. *Psychosomatics*. 1983; 24(1):54-60.

The purpose of this study was to determine sources and effects of “problem” patients. Data were collected through observation, semi-structured interviews, and follow-up questionnaires. Language problems such as lack of expectations for psychosocial issues to be included in standard bio-medical workups and communications and lack of confidence in describing psychological problems were indicated to lead to unpleasant colloquial labels. Recommend specific psychosocial information be investigated and managed. This type of approach versus derogatory terms can lead to problems solving.

Connelly JE, Campbell C. Patients who refuse treatment in medical offices. *Arch Intern Med*. 1987;147:1829-1833.

The purpose of this study was to determine the nature and frequency of patient refusals to follow prescribed treatment in the office practice. A sample of 562 consecutive patient visits to a medical office were evaluated. During this study 23 (4%) of patients refused recommended treatment. Refusals occurred most often when preventative health measures and diagnostic studies were recommended. Management of these patients included providing them the opportunity to disclose the personal meaning of their illness and reasons for refusal. Until the above two issues have been fully explored, the clinician cannot make an informed decision about whether to accept the patients refusal.

Drossman DA. The problem patient: Evaluation and care of medical patients with psychosocial disturbances. *Ann Intern Med.* 1978;88:366-372.

Described a number of psychosocial and somatic behaviors which were problematic to clinicians. Provided a therapeutic approach directed toward modification. Emphasis was on flexibility and an adaptive value system for the clinician. Ten treatment steps were suggested: 1) establish the significance of the psychosocial factors in the patient's illness; 2) maintain an unbiased interest; 3) take a complete history and perform physical exam; 4) "don't just do something, stand there!"; 5) do not attempt to reassure by stating that the problem is emotional; 6) accept the symptoms; 7) set up regular visits - development of the therapeutic relationship; 8) be alert for new developments; 9) treatment may be prolonged; and 10) be aware of personal attitudes.

Fisch RZ. Masochistic patients: How to help the person who finds joy in pain. *Postgrad Med.* 1969;85(6):157-160.

Working with masochistic patients requires that the clinician recognize these behaviors early on in treatment so they can be handled correctly. These patients were described as: 1) needing their symptoms- their life accomplishment has been to endure misery and survive crippling misfortune, 2) having a pervasive sense of guilt for which pain and suffering function as punishment and atonement. Diagnosis can be made based on the patient's clinical presentation and history. Psychiatric consultation helps to establish or confirm the diagnosis. Treatment includes: 1) preventing further harm by avoiding unnecessary tests or procedures; 2) avoiding negative reactions; 3) showing appreciation of patient's suffering; 4) presenting progress as a benefit for others; 5) setting up regular and brief visits; and 6) realizing goal of treatment is not cure.

Fisher R, Ury W. Getting To Yes: Negotiating Agreement Without Giving In. Boston: Houghton Mifflin Co. 1981.

Defined steps in the negotiation process. 1) Don't bargain over positions. 2) Separate the people from the problem. 3) Focus on interests, not positions. 4) Invent options for mutual gain. 5) Insist on objective criteria. If these do not work: 6) What if they are more powerful?— develop your BATNA (Best alternative to a negotiated agreement). 7) What if they won't play?—use negotiation jujitsu—do not get into a battle of criticism and defending your position. 8) What if they use dirty tricks?-taming the hard bargainer-negotiate rules of the game.

Fraser A. My difficult patient. *Aust Fam Physician.* 1991;20(4):404-405.

An interesting commentary that addressed how difficult it is to say "there is nothing wrong with you."

Groves JE. Taking care of the hateful patient. *N E J Med.* 1978;298(16):883-887.

Four types of "difficult" patients and the reactions they elicit in their clinicians and other care takers were presented. Dependent clingers—evoke aversion—require limits to be set on patient expectations. Demanders—evoke a wish to counterattack—require feelings of entitlement be rechanneled into a partnership and away from unrealistic expectations of medical care. Help-rejecters—evoke depression—requires sharing their pessimism and encourage them that loss of symptoms does not indicate loss of clinician. Self-destructive deniers - evoke feelings of malice -require psychiatric consultations at times to ascertain depression and clinician to fight abandonment of patient and gain realistic expectations of patient.

Kaplan C, Lipkin M, Gordon GH. Somatization in primary care: Patients with unexplained and vexing medical complaints. *J Gen Int Med.* 1988;3:177-190.

Described the high frequency of somatizing patients and it's resulting demand on clinicians' time. Presented theories of somatization and etiology. Seven specific management suggestions for patients with somatization were presented: 1) encourage personal growth through the establishment of a trusting, caring relationship; 2) don't dispute the reality of the complaint; 3) respectfully evaluate symptoms as they occur, conservatively in stepwise fashion, and avoid the temptation to prematurely link physical symptoms with psychological stresses; 4) establish appropriate therapeutic goals—don't always aim for cure; 5) follow-up should be scheduled regularly at 1-4 week intervals, independent of symptom status; 6) treat depression, anxiety, or other psychiatric disorders as appropriate- otherwise try to avoid medications; and 7) refer only as appropriate and emphasize referral is not dismissal.

Lipp MR. Respectful Treatment: A practical handbook of patient care, 2nd ed. Elsevier. 1986.

A handbook that applied practical psychiatry to everyday behavioral problems found in a variety of medical settings. The book began with a discussion of problem patients as “normal” and the author suggested these relationship problems be seen as interactive between the clinician and patient. A major focus is on thinking about one’s own behavior and how to improve it. Other topics covered include difficult places to work, emotional aspects of disease, pain and addiction, psychosocial conditions disguised as physical illness, consultation and referral, and many others.

Lipsitt DR. The difficult doctor-patient encounter. In: Branch WT, ed. *The Office Practice of Medicine*. Philadelphia: WB Saunders Co; 1987:1348-1356.

Described how dysfunctional doctor-patient relationships evolve with the “difficult” patient. Provided a classification system for “difficult” patients and offered some suggestions for understanding and management. Principles of management included: 1) Understanding the meaning of symptoms; 2) the clinician’s awareness of personal feelings; 3) the need for therapeutic restraint; 4) limit setting; 5) appropriate referral with follow up or collaboration; and 6) “supporting” and “getting to know” the patient.

Murtagh J. The angry patient. *Aust Fam Physician*. 1991;20(4):388-389.

Described anger as a normal and powerful reaction for patients and family members facing medical problems. Anger was viewed as a response to provocation or as a threat to equilibrium. When anger is inappropriate, it is almost always a manifestation of fear and hidden insecurity. A table of do’s and don’ts for handling the angry patient was provided. In addition, there were examples of what to say to angry patients.

Nesheim R. Caring for patients who are not easy to like. *Postgrad Med*. 1982;72(5):255-266.

Described 5 types of “difficult” patients: dependent, contentious, suffering, dramatic, and psychiatric. Provided some characteristics and the feelings evoked in the clinician. Nine guidelines for management of the “difficult” patient were suggested: 1) take note of your feelings; 2) perform second differential diagnosis; 3) accept the symptom; 4) differentiate depression from dysphoria; 5) examine and obtain complete history; 6) refer patient with planned follow up, peer discussions or supervision; 7) tailor therapy to patient; 8) set limits; and 9) know who you cannot treat.

Nyman K. The weeping patient. *Aust Fam Physician*. 1991;20(4):444-445.

Weeping patients were described as engendering feelings of inadequacy in the clinician. Helping the weeping patient requires a warm atmosphere, empathy, and allowing them the opportunity to unburden themselves. Weeping was explained as sometimes being the result of uncertainty that is intolerable.

Patterson JE, Spees DN. Considering the options: A multilevel systemic approach to helping somatizing patients. *Fam Systems Med*. 1988;6(4):411-420.

Recommended a multi-level approach to dealing with the somatizing patients which includes a biological-psychological-social level. The clinician is included as part of the system. A case study was provided to explain this concept and its effectiveness.

Powers JS. Patient-Physician communication and interaction: A unifying approach to the difficult patient. *S Med J*. 1985;78(4):445-447.

Provided several case studies of “difficult” patients. Recommended a mutual participation approach.

Reis RK, Bokan JA, Katon WJ, Kleinman A. The medical care abuser: Differential diagnosis and management. *J Fam Pract*. 1987;13:257-265.

Reframed somatization disorders, psychogenic pain disorder, hypochondriasis, factitious disorder, and malingering as “addictions” to medical care. These addictions were described as a function of adapting to the “sick role”. Management suggestions include adapting an addictions model following two guidelines: 1) an agent to which there is an addiction needs to be withdrawn gradually, and 2) during maintenance or withdrawal the

agent should be given on a time contingent rather than need dependent schedule. Specific case examples were provided.

Robins LS, Wolf FM. Confrontation and politeness strategies in physician-patient interactions. *Soc Sci Med.* 1981;27(3):217-221.

The purpose of this study was to explore theories of politeness and strategic language usage as a framework for interpreting clinician-patient communication. The sample consisted of 172 first-year medical students. Students responded to vignettes. Responses were classified into one of seven categories. Two types of positive politeness; 1) assert reciprocity, and 2) give reasons; and two types of negative politeness; 3) apologize, 4) impersonalization, 5) question or hedge. Category six included empathetic responses and category seven included potentially face threatening responses. Results indicated 90% of responses were positive or negative, 5% were empathetic, and 5% were face threatening. Illustrated how concepts of “face preservation” and “politeness” could be used to eliminate some problems of these interactions and how to avoid communication difficulties. Specifically, when the doctor recommends that a patient make a lifestyle change, this threatens the patients’ face via disapproval or setting limits on future lifestyle. This in turn, elicits emotional response and defensive behavior. Doctors need to assess, acknowledge, and redress any damage to patient face. Suggested transforming treatment regimes from prescribed tasks to mutual endeavors and thus creating a favorable context for mutual cooperation. For example, “All right then, tell me the things that you want to eat. Let me help you to organize a diet you want.” This saves face and is therapeutic because it empowers the patient in the treatment process.

Sapira JD. Reassurance therapy: What to say to symptomatic patients with benign diseases. *Ann Intern Med.* 1972;77:603-604.

The author recommended and discussed six steps of reassurance therapy for dealing with the “difficult” or symptomatic patient: 1) eliciting a detailed description of the symptom(s); 2) eliciting the affective meaning of the symptoms; 3) examining the patient; 4) making a diagnosis; 5) explaining the symptom to the patient; and 6) reassuring the patient. These steps must be administered sequentially to be effective.

Smith RC. A clinical approach to the somatizing patient. *J Fam Pract.* 1985;21(4):294-301.

Provided an overview of common and rare somatizing disorders with clear definitions and symptoms. In addition, suggestions for treatment were provided. Treatment requires realistic goals. Countertransference was also discussed.

Stanley JC. Physicians and the difficult patient. *Social Work.* 1991;36:71-79.

Presented ideas on “reasons” for failed relationships between clinicians and patients. Four reasons why relationships fail: 1) breakdown in communication, i.e., patient does not understand; 2) clinician fails to gauge correctly patients needs, wants, expectations; 3) clinician fails to recognize the meaning of the illness for the patient; and 4) clinician is frustrated, overwhelmed, drained, powerless. Four suggestions for management of the “difficult” relationship were: 1) acknowledge own feelings; 2) write I=FACH (I feel impotent because I am frustrated, angry, confused, hostile) on these patients’ charts and avoid making value judgements; 3) pay attention to communication- verbal and nonverbal; and 4) accept the patient’s view and symptoms.

Sugrue NM. Emotions as property and context for negotiation. *Urban Life.* 1982;11(3): 280-292.

A case example of a hospitalized patient whose emotional reaction was not openly acknowledged and subsequent interactions with staff became very difficult. Provided a framework for incorporating the patient’s emotions into the negotiation process.

Ury W. Getting Past No: Negotiating with difficult people. New York: Bantam. 1991.

Described steps for negotiation. 1) Don’t React. 2) Disarm Them—step to their side. 3) Change The Game—don’t reject...reframe. 4) Make it easy to say yes—build a golden bridge. 5) Make it hard to say no—bring them to their senses, not their knees.

VI. CLINICIAN-PATIENT COMMUNICATION

Gordon GH, Baker L, Levinson W. Physician-patient communication in managed care. *West J Med* 1995;163:527-531.

Five problematic statements by patients to their physicians are presented, and responses are suggested based on current communication literature. Issues discussed include too many problems/too little time, requesting a test that is not indicated, changing doctors and health plans, and requests to bend the rules.

Acknowledge

Zinn WM. Doctors have feelings too. *JAMA*. 1988;259(22):3296-3298.

A commentary on the importance of paying attention to how patients make doctors feel. These feelings can provide insight into possible clinical syndromes in the patient, such as depression or character disorders. In addition, clinicians' affective responses may provide insight about themselves. Consciously recognizing and evaluating these responses can provide clinical information.

Lazare A. Shame and humiliation in the medical encounter. *Arch Intern Med* 1987;147:1653-1658.

Illness makes patients vulnerable to shame and humiliation which can be precipitated by their having to find their way through the maze of medical care. Clinicians can also be shamed by not knowing, causing pain, not being able to help, etc. Feelings of shame, and experiences of being humiliated by others, can lead to anger, nonadherence, withdrawal, and other relationship difficulties. Awareness and acknowledgment of shame or humiliation helps the relationship.

Novack DH, Suchman AL, Clark W et al. Calibrating the physician: Personal awareness and effective patient care. *JAMA* 1997;278:502-509.

Comprehensive review of the role of physician self-awareness in patient care. This is an expansion of a four-part core curriculum in psychosocial medicine for primary care physicians that was published in the Feb. 1984 *Ann Intern Med*. Items in the curriculum include: physician beliefs and attitudes (personal philosophy, family of origin issues, gender and sociocultural influences); physician emotional responses (conflict and anger, caring and attraction); "difficult" relationships including caring for dying patients and acknowledging mistakes; and physician self-care (balancing personal and professional life, prevention of burnout).

Wu AW, McPhee SJ, Christensen JF. Mistakes in medical practice. In: Feldman MD and Christensen JF: *Behavioral Medicine in Primary Care: A Practical Guide*, Appleton and Lange, Stamford, CT, 1997, 299-306.

Concise chapter summarizing authors' research on physician mistakes including causes, circumstances, outcomes for patient and physician, and common physician responses. Disclosure to patients, families, colleagues, and risk managers is discussed and a process is outlined for decision-making about disclosure.

Boundaries

Quill TE, Brody H. Physician recommendations and patient autonomy: Finding a balance between physician power and patient choice. *Ann Intern Med* 1996;125:763-769.

This article describes a middle ground between the clinician as general (Do as I say) and private (I'll do what you want). Patients are entitled not only to facts and information, but also to your experience and expertise. Make clear to the patient which are which. Also recall that patient requests for information does not necessarily mean a desire to participate in decision-making.

Quill TE. Partnerships in patient care: A contractual approach. *Ann Intern Med* 1983;98:228-234.

When difficult relationships occur it often helps to make roles and boundaries explicit so they can be discussed. Examples include antibiotics for a cold, narcotics for chronic pain, refusal to acknowledge psychosocial aspects of illness. Both parties need to gain something from the relationship. Neither clinician nor patient should go beyond what he/she thinks are in the patient's best interests. Sometimes an agreement cannot be reached and it

becomes clear that you and a patient are unable to work together. These concepts help dispell the notion that great communication skills can make any relationship more successful.

Lazare A. The Interview as a clinical negotiation. In: Lipkin M, Putnam SM, Lazare A (eds): *The Medical Interview: Clinical Care, Education, and Research*, New York, Springer-Verlag, 1995, 50-64.

Most common ways for clinicians and patients to disagree is in the nature of the illness and the methods of treatment. Describes practical negotiating techniques including direct education, second opinion, re-define the problem, brainstorm options, provide sample treatment, share some control, make some concessions, empathically confront, and make standards of care clear.

Quill TE, Suchman AL. Uncertainty and control: Learning to live with medicine's limitations. *Humane Medicine* 1993;9:109120.

Doctors "train for certainty" and there is always a right or best answer. Doctors and patients both expect that the doctor will know everything. Traditionally, uncertainty is taboo to discuss with patients. However, we see a lot of patients for whom we are uncertain as to the cause of their symptoms or the best treatment. This article suggests using the relationship to identify hopes and opportunities when the diagnosis or treatment is uncertain, and to partner with the patient in identifying and working toward goals other than "find it and fix it" when that approach hasn't worked.

Carey TS, Hadler NM. The role of the primary physician in disability determination for Social Security insurance and Workers' Compensation. *Ann Intern Med* 1986;104:706-710.

Clear and concise recommendations on role definition of clinicians re: two disability processes. Physicians must be aware that disability work involves multiple roles: treating physician, adjudicating physician, certifying physician, expert opinion, etc. Most primary care physicians will simply provide information, not opinions or judgments, in disability cases. Some of the roles are conflicting (you can't advocate for improved function and total disability at the same time). An opportunity to clarify boundaries with yourself and with patients.

Drummond DJ, Sparr LF, Gordon GH. Hospital violence reduction among high-risk patients. *JAMA* 1989;261:2531-2534

Sparr LF, Rogerrs JL, Beahrs JO, Mazur DJ. Disruptive medical patients: Forensically informed decision making. *West J Med* 1992;156:501-506. An entire institution sets limits on disruptive patient behavior.

Discover Meaning

Smith RC, Hoppe RB. The patient's story: Integrating the patient- and physician-centered approaches to interviewing. *Ann Intern Med* 1991;115:470-477.

DelBanco TL. Enriching the doctor-patient relationship by inviting the patients' perspective. *Ann Intern Med* 1992;116:414-418.

Two articles that review the rationale and techniques for eliciting the patient's "explanatory model" of illness. Smith's article suggests pausing after the agenda for the visit is set and asking, "Before we talk about these problems, how are you doing?" DelBanco describes a more systematic approach, like a psychosocial review of systems, regarding the illness experience. These two articles describe the importance of discovering the meaning of the illness for the patient and suggest practical ways for going about it.

Fordyce WE. Pain and suffering: A reappraisal. *Amer Psychologist* 1988;43:276-283.

Doctors and patients need to differentiate between pain (a perceptual and neurologic event) and suffering (what the pain does to your life). Doctors who just focus on the pain will find it can be hard to eradicate safely and effectively. Focusing on suffering helps doctor and patient feel less helpless and opens doors to new treatment goals.

Barsky AJ. Nonpharmacologic aspects of medication. *Arch Intern Med* 1983;143:1544-1548.

Some patients are intolerant of every medicine available for their condition. Other patients refuse to come off medications, even when they don't seem to be working. This paper reviews how to approach these problems. Also consider linking symptomatic medication to improvement in function rather than relief of symptoms, prescribe a fixed dose for a fixed amount of time, and discontinue it if function does not improve.

Buchner DM, Carter WB, Inui TS. The relationship of attitude changes to compliance with influenza immunization. *Med Care* 1985;23:771-779.

Patients decided whether or not to get flu shots based not on their medical risk but instead on their perception of the severity of the disease, the likelihood they would contract it, the effectiveness of treatment, and other factors. Example of the public health implications of the patient's explanatory model of illness and treatment.

Johnson TM, Hardt EJ, Kleinman A. Cultural factors in the medical interview. In: Lipkin M, Putnam SM, Lazare A (eds): *The Medical Interview: Clinical Care, Education, and Research*, New York, Springer-Verlag, 1995, 153-162.

Discussion of importance of cross-cultural medicine and cultural/ethnic diversity in communication with patients, and in discovering the meaning of illness. Examples of questions to ask. What do you call your illness? What do you think caused it? How long do you think it will last? Is there anything you (or anyone else) can do about it?

Compassion

Suchman AL, Markakis K, Beckman HB, Frankel R. A model of empathic communication in the medical interview. *JAMA* 1997;277:678-682.

The basic skills are: recognizing when emotions are present but not directly expressed; inviting exploration of unexpressed feelings; and effectively acknowledging the feelings so that the patient feels understood. Physicians are empathic but rarely express it overtly. This is probably the least utilized of the communication skills but one that is most closely associated with patient satisfaction and other outcomes.

Extend the System

Bursztajn H, Barsky AJ. Facilitating patient acceptance of a psychiatric referral. *Arch Intern Med* 1985;145:73-75.

Tell the patient you both need more information to figure out how to help. Let the patient know that mental health providers are skilled in helping patients cope with difficult medical problems and that you will continue to see them in tandem with the consultant. Tell them what to expect during the encounter, and when / how they can know the recommendations resulting from the consultation.

English A. Legal aspects of care. In: McAnarney E (ed): *Textbook of Adolescent Medicine*, New York, Saunders, 1992, Legal guidelines for the Amy case in the DCPR workshop.

Campbell TL, McDaniel S. Conducting a family interview. In: Lipkin M, Putnam SM, Lazare A (eds): *The Medical Interview: Clinical Care, Education, and Research*, New York, Springer-Verlag, 1995,178-186.

Discusses rationale and techniques for convening family members, developing hypotheses and goals, positioning yourself with respect to all family members, setting goals for the meeting, discussing problems, identifying resources, finishing with a plan, and debriefing the meeting. Concise ideas and tables, with attention to pitfalls. This is a good technique for better understanding what makes relationships difficult, and often leads to breakthroughs in understanding of treatment issues for individual patients.

VII. PATIENT SATISFACTION

Brody DS, Miller SM, Lerman CE, Smith DG, Lazaro CG, Blum MJ. The relationship between patients' satisfaction with their physicians and perceptions about interventions they desired and received. *Med Care.* 1989;27(11):1027-1035.

The purpose of this study was to determine the relationship between patients' satisfaction with their clinician, the types of intervention they received, and congruence between interventions received and desired. The sample included 180 primary care somatic adults who completed questionnaires before and after their medical visit. In general, patients were satisfied with treatment. One third to one half of patients who reported they received nontechnical intervention such as education, stress counseling, and discussing their ideas were significantly more satisfied than those who did not receive these interventions. In addition, perceptions about non-technical interventions were better predictors of patient satisfaction than perceptions about technical interventions.

Comstock LM, Hooper, EM, Goodwin JM, Goodwin JS. Physician behaviors that correlate with patient satisfaction. *J Med Educ.* 1982;57:105-112.

The purpose of this study was to determine which clinician caring skills affect the patient's satisfaction. The sample included 15 internal medical residents, each with 10 patients. The behavior was observed through a one-way mirror. Ratings of patient satisfaction were also obtained. Patient satisfaction correlated highly with clinician courtesy (formally greeting and discharging patients) and with information giving. Listening behavior also correlated with patient satisfaction. Nonverbal behaviors such as eye contact, body position, and physical contact did not correlate with satisfaction. The correlation between clinician behavior and patient satisfaction did not hold for the four female clinicians. In addition, female patients were significantly more satisfied with female clinicians than were male patients with female clinicians or male and female patients with male clinicians.

DiMatteo MR, Taranta A, Friedman HS, Prince LM. Predicting patient satisfaction from physician's nonverbal communication skills. *Med Care.* 1980;18(4):376-387.

The purpose of this research was to determine the relationship between clinicians' nonverbal communication skills and their patients' satisfaction with medical care in two studies. The sample included 71 residents in internal medicine and 462 of their ambulatory and hospitalized patients. Nonverbal communication was defined as ability to communicate and to understand facial expression, body movement and voice tone cues to emotion. Higher rates of satisfaction were given to clinicians who were skilled at decoding body movement and posture cues to emotion. The skill of accurate voice encoding also correlated with patient satisfaction.

Korsch BM, Gozzi EK, Francis V. Gaps in doctor-patient communication: I. Doctor-patient interaction and patient satisfaction. *Pediatrics.* 1968;42:855-871

The purpose of this study was to test the hypothesis that there is a relationship between the nature of the verbal communication between doctor and patient, and the outcome in terms of satisfaction and response to medical advice. The sample included 800 patient visits to an emergency clinic at a children's hospital. Data were collected via tape recorded interviews, post-visit interviews, review of charts, and follow-up interviews two weeks later. Seventy-six percent of visits were satisfactory. Dissatisfaction was related to: 1) lack of warmth and friendliness on the part of the doctor; 2) failure to take into account the patient's concerns and expectations; 3) lack of clear-cut explanation concerning diagnosis and causation of illness; and 4) use of medical jargon.

Mirowsky J, Ross CE. Patient satisfaction and visiting the doctor: A self-regulating system. *Soc Sci Med.* 1983;17(18):1353-1361.

The purpose of this study was to examine the pattern of satisfaction/ dissatisfaction as a self regulating system. Specifically, high satisfaction was coupled with high expectations which are likely to be disappointed as the frequency of visits increases. The system is explained as a self regulating because as the number of visits increase so does the likelihood of problematic encounters. This system thus avoids excessive demands on the clinician and decreases medical overuse.

Smith CK, Polis E, Hadac RR. Characteristics of the initial medical interview associated with patient satisfaction and understanding. *J Fam Pract.* 1981;12(2):283-288.

The purpose of this study was to examine the relationship between selected interview characteristics, particularly clinicians' nonverbal behaviors, and level of patient satisfaction and understanding. The sample included 29 initial patient interviews with 11 clinicians at the University of Washington Hospital Family Medical Center. Data were gathered via videotape and rated using a modified Bales' technique. Patients responded to questionnaires regarding satisfaction and understanding. Results indicated higher patient satisfaction was correlated with greater interview length, increases in the proportional time spent by the clinician in presenting information and prevention techniques, and shorter chart reviews. Patient understanding was correlated with increases in the proportional time spent presenting both information and opinions, close physical proximity, and reduced chart review time.

VIII. ADHERENCE

Brody DS. Feedback from patients as a means of teaching nontechnological aspects of medical care. *J Med Educ.* 1980;55:34-41.

The purpose of this study was to improve house officers' recognition of potentially important behavioral, psychological, and social aspects involved in medical care of chronically ill ambulatory patients. Fifty nine house officers were interviewed along with a random sample of 235 of their patients over a ten week period. Patients were interviewed for a period of 15 minutes to assess adherence to therapeutic regimens, satisfaction with clinicians, psychiatric problems, recent stressful life events, and attitudes toward illness. Each clinician was asked to complete a questionnaire designed to evaluate the clinicians' recognition of patient noncompliance, psychiatric problems, and recent stressful life events. In addition, the charts were reviewed. Results indicate 36% of patients did not comply with prescribed medication regimens, many did not understand changes in their medications, 37% were successful in following advice, 54% were not as successful as they ought to be, 8% did not even try to comply. Sixty-three of the patients' general health questionnaire scores indicate psychiatric disorders. Clinicians overestimated by 10% patients' consumption of prescription medication, 34% of patients were recognized as having psychiatric problems, and only 24 % of stressful life events were recognized. Clinicians were given feedback from the study. Questionnaires were administered at the end of the project and revealed no significant differences in clinician behaviors despite the feedback they received.

Coleman VR. Physician behavior and compliance. *J Hypertens.* 1985;3:69-71.

Four components of clinician's behavior that influence patient compliance with therapeutic regimens were described: 1) compassion; 2) communication; 3) activating self-motivation; and 4) shared responsibility with the patient. Factors that are beyond the clinicians' control include: 1) factors within the patient; 2) factors within the environment; and 3) factors with the nature of the disease.

Eisenthal S, Emery R, Lazare A. "Adherence" and the negotiated approach to patienthood. *Arch Gen Psychiatry.* 1979;36:393-398.

The purpose of this study was to test the following hypotheses: 1) the index of the negotiated approach and the items that compose it will correlate positively with the adherence measure; 2) the index of negotiated approach and the items that compose it will correlate with the patient ratings of satisfaction, feeling helped, and feeling better, replicating the results of a previous study; and 3) the index of the negotiated approach will correlate with adherence more strongly than will the index of diagnostic understanding. A sample of 130 patients were administered the patient request form, a general information questionnaire, and a post-interview evaluation questionnaire. Information on adherence was obtained from patient records. Results indicate 41% of patients adhered to the treatment referral. Adherence was significantly related to negotiation. Adherence was predicted by the patient getting the plan he wanted. Adherence was not related to demographic variables or scores on the patient request form. The index of negotiation was significantly correlated with the patient's evaluation of the interview.

Garity TF. Medical compliance and the clinician-patient relationship: A Review. *Soc Sci Med.* 1981;15:215-222.

A review of the literature of provider-patient interaction related to compliance. Provides four categories for classification of techniques found in the research: 1) pedagogical techniques—greater clinician explicitness regarding patient behavior results in greater patient adherence; 2) mutuality of expectations—sharing expectations regarding appropriate behavior; 3) raising patient responsibility; and 4) attending to the affective tone of the clinician-patient encounter.

Stimpson GV. Obtaining doctor's orders: A view from the other side. *Soc Sci Med.* 1974;8:97-104.

The purpose of this study was to obtain patients' views of normative doctor-patient relationships, patient's expectations of the interaction, and the origin of these ideas. The sample consisted of patients from two general practices in southern Wales who were interviewed and observed at different states in the consultation process. Results indicated: 1) people have distinct ideas about the use of medicines; 2) people have ideas about what sorts of medicines they like; 3) people get advice from many sources including family and friends and compare notes; 4) people evaluate the doctor's actions. Suggestions include relabeling this phenomenon from a "default" perspective on the patient's part to having clinicians considering personal, cultural, and contextual factors influencing the taking of medications.

Stone GS. Patient compliance and the role of the expert. *J Soc Issues.* 1979;35(1):34-59.

Patients' failure to comply with recommended treatment regimens was viewed as a mutual problem between the patient and the expert. Three areas of responsibility were described as being assigned to the expert: 1) exploring the individual patient's situation fully; 2) anticipating difficulties in following the recommendations fully; and 3) communicating information in a way that will maximize its effectiveness.

Stoudemire A, Thompson TL. Medication noncompliance: Systematic Approaches to evaluation and intervention. *Gen Hosp Psychiatry.* 1983;5:233-239.

Determinants of patient compliance include: 1) the illness; 2) sociological factors; 3) patient's knowledge of their disease; 4) patient's knowledge of their medications; 5) the medical regimen; 6) medication side effects; 7) patient attitudes toward health and illness; 8) involvement of the spouse and family support; 9) the doctor-patient relationship; and 10) psychiatric factors. Specific reactions to medications are described for different types of psychiatric diagnoses. Intervention strategies to improve compliance include: 1) medication charting; 2) pill packs; 3) medication monitoring—pill counts; 4) serum drug levels; 5) increase the frequency and length of appointments; 6) social service intervention, i.e., visiting nurse; 7) brief hospitalization—stabilization, evaluation, and education; and 8) psychiatric referral.

IX. COLLABORATION AND REFERRAL

Beitman BD, Featherstone H, Kastner L, Kayton W, Kleinman A. Steps toward patient acknowledgement of psychosocial factors. *J Fam Pract.* 1982;15(6):1119-1126.

Provided seven steps for clinicians to help patients recognize and accept psychosocial influences on health. 1) Overcome your own reluctance to act upon psychosocial factors. 2) Be alert to signs that suggest significant psychosocial difficulty. 3) Judge the value of patient's acknowledgment of these influences. 4) Determine patient's willingness to acknowledge these influences. 5) Strengthen the relationship to provide an atmosphere of trust so these issues can be explored. 6) Gather data. 7) Offer a diagnosis and treatment plan that is negotiated and includes the patient's personal theory.

Goldberg ID, Krantz G, Locke B. Effects of short-term outpatient psychiatric therapy benefit on the utilization of medical services in a prepaid group practice medical program. *Med Care.* 1970;6:419-428.

The purpose of this study was to measure the effect of short-term outpatient psychiatric therapy benefit on the utilization of general medical services at Group Health Association of Washington, D. C., a prepaid medical group practice. The sample included 256 patients who had been members for 12 months before and after psychiatric

referral. Results indicated considerable reduction, during the year after referral, in utilization of nonpsychiatric clinician services and laboratory or x-ray procedures. Reduced utilization was still obtained when age, race, sex, psychiatric diagnosis, and number of therapy sessions were controlled for.

Hyland JM, Novotny E, Coyne L, Travis J, Area H. The psychosocial team and the difficult-to-treat patient. *J Psychosoc Oncol.* 1987;5(1):11-50.

Issues involved in forming a psychosocial team were discussed. Before a psychosocial team can be organized, the following issues need to be addressed: 1) the team setting and the relationship of the psychosocial element to the medical team as a whole; 2) the functions and responsibilities of the team; 3) who will underwrite the costs of such a team and how the cost effectiveness of the team will be demonstrated; and 4) who will be in charge of the team and who will bear primary responsibility for the patient's care and for what length of time. Strengths and weaknesses of the team were discussed. Education of the team for dealing with "difficult" patients should include: 1) psychosocial education; 2) development of a profile for the at-risk patient; 3) development of a profile for the at-risk family; 4) differentiation of categories of "difficult"-to-treat patients; 5) development of treatment strategies for each category; and 6) anticipation by the leader of how "difficult" patient's problems will be manifested. Models of the team approach were presented for three settings: the radiotherapy center, the oncology unit, and the oncologist's office.

Kris K. Psychiatric consultation in management of patient ambivalence interfering with the doctor-patient relationship. *Amer J Psychiatry.* 1981;138(2):194-197.

Described patient ambivalence as involving a conflict over issues of: 1) dependence versus autonomy; 2) self-indulgence versus self-deprivation; and 3) self-blame for illness versus wish for omniscient healer. Provided three case examples of patients and how these conflicts were handled in consultation by helping the patients recognize and tolerate their own conflicts.

Linn LS, Daniels M. Social and structural factors affecting psychiatric consultation in the ambulatory medical setting. *Int J Psychiatry Med.* 1984;14:77-86.

The purpose of this study was to explore the kinds of help primary care clinicians request from psychiatric consultants and to explore the relationship between selected social and structural features of the interaction and what was actually requested. Data were collected in the Medical Ambulatory Care Clinic at UCLA from 173 encounters involving 54 clinicians. Types of help requested included: 1) desire to learn about psychiatric treatments that did not involve drugs (19%); 2) desire to be observed and receive feedback on clinicians' interpersonal skills (18%); 3) desire to have psychiatric assistance in evaluating a patient (16%); and 4) desire to explore unresolved feelings about a "difficult" patient or patient care issues (16%). Female clinicians were more likely to initiate encounters that dealt with personal feelings about themselves or their patients. Male clinicians were more likely to request assistance in evaluating patients.

Phillips S, Sarles RM, Friedman SB. Consultation and referral when, why, and how. *Pediatr Ann.* 1980;9:269-275.

Specific behaviors that indicate the need for consultation or referral included: 1) psychosis; 2) autism; 3) suicidal gestures; 4) fire setting; 5) cruelty to animals; 6) vandalism; 7) child abuse; 8) secondary enuresis; 9) rape; 10) sudden change in behavior. Four factors to distinguish between "normal" and "problematic" behaviors were presented: 1) quantity ; 2) distribution; 3) severity; and 4) duration. Problems that are most likely to be missed are described as "quiet problems" (low self-esteem, withdrawal, dysphoria) because these do not make life difficult for others. Hesitancy to request consultation or referral was discussed. Rationale for pursuing consultation were: 1) early intervention is the best prescription; and 2) referral is not necessarily labeling because many times behavior problems are an indication of lack of skills rather than deep-seated pathology. One suggestion for utilizing consultation or referral was to include behavioral specialists in your practice. The necessity to prepare both the parent and the child and to have an appropriate professional or agency to utilize were discussed.

Smith GR, Monson RA, Ray DC. Psychiatric consultation in somatization disorder: A randomized controlled study. *NEJM*. 1986;314(22):1407-1413.

The purpose of this study was to investigate the effect of psychiatric consultation and suggestions on management given to primary care clinicians. The hypothesis was that more appropriate care (defined as less inpatient care, more outpatient care, and less costly care without a worsening outcome) of patients with somatization disorders could be given after psychiatric consultation. The sample included 41 patients (38 completed the study) assigned to either a control or a treatment group and they were studied for 18 months. After the treatment group received consultation their quarterly health care charges decreased significantly by 53%. The control group indicated wide variations but no significant overall changes. The between group changes were significantly higher for the treatment group. After the control group received treatment their quarterly charges decreased significantly by 49%.

Wurzberger B, Levy NB. A hateful epileptic patient in the burn unit. *Gen Hosp Psychiatry*. 1990; 12:198-204.

A case presentation of a group consultation with an epileptic burn patient who has elicited very negative reactions in the medical staff. The consultation raised the possibility of her burns being a suicide attempt. This consultation emphasized the need for a comprehensive approach that considers the biological, psychological, and social aspects of the patient.

Wragg RE, Dimsdale JE. Psychiatric consultation as conflict resolution. *Gen Hosp Psychiatry*. 1987;9(6):420-425.

Patterns of conflict between doctor and patient can arise from three areas: 1) problem definition; 2) the treatment contract; and 3) the relationship itself. The consultant's job is to determine where the conflict lies, each participant's view of the problem, attempted solution, and implications related to the problem. Four intervention strategies were suggested: 1) modify communication style and skills, 2) recognize the context and its constraints, 3) define and reframe the problem, and 4) generate alternative options. Case examples were provided to explain areas of conflict and interventions.

X. FAMILY

Frey J. A family systems approach to illness maintaining behaviors in chronically ill adolescents. *Fam Process*. 1984;23:251-260.

The purpose of this paper was to examine patterns of illness maintaining behavior in chronic, seriously ill adolescents from a family systems perspective and to present intervention strategies. Chronic illness requires a central role in the family initially so the family can reorganize. However, the illness needs to be placed in perspective so the family can progress and not be the family's central defining characteristic. If the illness becomes the family's identity, they may function to maintain the illness. When this process occurs and the family gets stuck, family therapy is indicated. The psychotherapeutic process was discussed and includes six stages: 1) referral; 2) joining; 3) restructuring; 4) consolidation; 5) termination; and 6) follow-up.

Glen ML. The doctor-patient-family relationship. In Henao S, Grose NP. (eds.) *Principles of family systems in family medicine*. New York: Brunner/Mazel, Pub.: 1985:111-130.

Several theories of the role of the clinician and the patient were discussed followed by a discussion of the family as the frame of reference for understanding the patient. The patient needs to be viewed in the context of the family. Increased understanding of the patient can be gained by considering the patient's life cycle stage, the family's life cycle stage, and how these may conflict or mesh. Other considerations include: 1) how does the illness affect the family? 2) how does the family affect the illness? and 3) what does the illness mean in the context of the family? In addition, the clinician's response to patients and their families may also provide clues to underlying problems.

Haggerty JJ. The psychosomatic family: An overview. *Psychosomatics*. 1983;24:615-623.

Four characteristic family patterns specific for psychosomatic illness were described: 1) enmeshment; 2) overprotectiveness; 3) rigidity; and 4) lack of conflict resolution. It was suggested that family evaluation or therapy should be considered in psychosomatic illnesses of childhood such as asthma, diabetes, and anorexia nervosa.

Hahn SR, Feiner JS, Bellin EH. The doctor-patient-family relationship: A compensatory alliance. *Ann Intern Med*. 1988;109:884-889.

Focus was on understanding the role the clinician plays in the patient's illness. The "difficult" patient's illness is reframed as a need to have an alliance with the clinician to compensate for some conflict or deficit in the family system. When the clinician experiences a sense of helplessness, anger, and frustration this can often be a sign of a dysfunctional alliance. Diagnosis of a compensatory alliance can be accomplished via simple family assessment through a genogram. Suggestions for management include involving other family members. Case examples were provided to help recognize when compensatory alliances are present.

Jaffe DT. The role of family therapy in treating physical illness. *Hospital & Comm Psychiatr*. 1978;29(3):169-174.

Focus was on explaining family relationships, behavior patterns, responses to stress as important causal factors in creating and maintaining physical illness and health. A family therapy program was presented as a possible addition to bio-medical treatment.

Richtsmeier AJ, Waters DB. Somatic symptoms as family myths. *AJDC*. 1984;138:855-857.

Case examples were utilized to demonstrate an approach to dealing with persistent somatic complaints for which no organic explanation can be found. Psychosocial factors were suspected. However, the families intensely rejected a non-organic explanation. Three rules for management were provided: 1) do not proceed with explaining what is "really" wrong; 2) obtain information from other sources about the child and meet with as many family members as possible (sometimes individually)—the hope is to gain an understanding of the meaning of the illness; and 3) when things begin to improve resist the impulse to make the family see what was "really" going on.

Stubbe DE, Yates A. Stress and the role of the family in psychosomatic illness. *Ariz Med*. 1984;41:324-327.

Focus was on the role of stress, dysfunctional marriage, overinvolved or rejecting parenting, family dynamics and the family tradition of being sick in perpetuating psychosomatic illness within the family system. Four steps for intervention were presented: 1) involve all family members in the evaluation; 2) define and describe emotional as well as physical factors and indicate stress can play a role; 3) emphasize positive aspects of the family; and 4) foster healthy individuation.

Taylor RB. The extended family encounter. *AFP*. 1980;22(3):119-121.

Focus was on presenting a technique for involving the extended family to provide more extensive data, diagnostic insight, and help with treatment planning with a patient when conventional methods have failed. The extended family encounter is necessary to understand family dynamics which may support the continued symptoms. These encounters were suggested when: 1) undifferentiated problems present diagnostic puzzles; 2) family problems seem to defy the solutions; 3) emotional problems are present that are nonresponsive to support; 4) organic problems exist that fail to improve as anticipated; and 5) clinical problems develop that are associated with excessive anxiety.

XI. ETHICS

Connelly JE, Campbell C. Patients who refuse treatment in medical offices. *Arch Intern Med* 1987;147:1829-1833.

Twenty-three of 562 general medical outpatients refused physicians' recommendations, usually for preventive health measures or diagnostic testing. Reasons for refusal included fear and anxiety, previous "bad" experiences

with the recommended intervention, distrust of physicians, and problems of communication. Five patients had delayed diagnosis and one died of an MI after refusing treatment. Ethical aspects of these encounters are discussed.

Drew J, Stoeckle JD, Billings JA. Tips, status and sacrifice: Gift giving in the doctor-patient relationship. *Soc Sci Med.* 1983;27:397-404.

The purpose of this study was to examine gifts clinicians receive from their patients. The sample included 14 staff clinicians in a hospital based practice of internal medicine. The study was conducted over a 4 month period. Clinicians kept diaries of gifts and participated in interviews regarding the gifts they received from their patients. Seventy two gifts were received including over \$2000 in cash, 36 bottles of liquor, 24 gifts of food, and 19 misc. gifts. Three categories of gifts emerged: the gift as a tip; the gift to address the status imbalance of the doctor-patient relationship; and the gift as a sacrifice to the clinician. The authors stated their belief that if the gift was a lavish one, it invalidates the patient's view of the clinician as being in a superior position in negotiation.

Kass FC. Identification of persons with Munchausen's syndrome: Ethical problems. *Gen Hosp Psychiatry.* 1985;7:195-200.

A discussion of the ethical issues involved in violating confidentiality of patients identified with Munchausen's syndrome. Recommendations included evaluating patients individually and considering the nature of the diseases they tend to mimic. Specifically, disclosure was more justifiable when the patient presents for emergency surgery. In addition, if disclosure was deemed necessary to protect the patient, it should be made discretely and only to clinicians who are also obligated to keep the patient's secrets.

XII. MEDICAL INTERVIEWS

Lipkin M . Sisyphus or Pegasus? The physician interviewer in the era of corporatization of care. *Ann Intern Med* 1996;124:511-513.

Duffy FD. Dialogue: The core clinical skill. *Ann Intern Med* 1998;128:139-141. Communication skills remain paramount despite changes in the organization and delivery of medical care.

Barsky AJ, Kazis LE, Freiden RB, Goroll AH, Hatem CJ, Lawrence RS. Evaluating the interview in primary care medicine. *Soc Sci Med.* 1980;14:653-658. Provides an assessment instrument for the interview.

Lipkin M. The medical interview and related skills. In: Branch WT, ed. *The Office Practice of Medicine*. Philadelphia:

WB Saunders, Co. 1987. An overview of the medical interview. Function of the interview. Outline of the interview. Barriers to communication. Negotiation and contracting techniques. Return visits and termination. Adapting the interview to the patient and situation especially to "difficult" personalities such as hysterical, obsessive-compulsive, paranoid, dependent, narcissistic, impulsive, and borderline. Very specific techniques and suggestions.

Platt FW, McMath JC. Clinical hypocompetence: The Interview. *Ann Intern Med.* 1979;91:898-902. Provided examples of "defective interview syndromes" with case examples and then discussed what was wrong and suggested proper ways to address these issues. Guidelines for an interview data base were outlined. In addition, the authors discussed why interviews go wrong.