Clinician Burnout and Dealing with Difficult Patients

The Challenging Patient: Problem Solving for the Professional Care Giver Conference

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Classic Difficult Patient Case

A 51-year-old attorney specializing in medical negligence was enraged when his many complaints were ultimately diagnosed as multiple sclerosis. Known for his flashy wardrobe and courtroom pyrotechnics, he roamed from doctor to doctor, refusing to understand the nature of his illness and threatening to sue the previous “bastard” who tried to help him. He was like Job (xiii:4), who raged, “ye are floggers of lies, ye are all physicians of no value.” He adomanantly refused treatment and demanded more and more tests and consultations. Eventually, his doctors did not return his calls for appointments and were frightened and depressed about him. How long this situation might have continued is not known, because at this point — to the relief of all concerned — he was stopped by an exacerbation of his demyelinating process that required hospitalization in a chronic-care facility.


What is Workplace Violence?

• Any physical assault, threatening behavior, or verbal abuse occurring in the workplace, includes but is not limited to such events as:
  – Beatings, shootings, rape, suicide or attempts psychological traumas, such as threats to harm, obscene phone calls, intimidation, bullying, incivility, harassment, including being followed or sworn at*.

  * Italics also referenced definitions of disruptive behavior.


Aggression as Iceberg Continuum

As Perceived by the Recipient

Mega-violence

Micro-violence

Below the line of society’s colloquial definition of violence. Many are part of formal definition of Workplace Violence (NIOSH) Cause micro‐traumas which are additive and cumulative.

Mega-violence examples: Homicide, assault, threats of harm, terrorism, etc.

Micro-violence examples: Bullying, Micro-aggression Micro-insults Micro-insults Micro‐assaults Micro‐mistakes Badgering, teasing others Persistent cumulative Aggressions Poorly designed work procedures, policies, mandates, Care implications Poorly managed turnover.
**Dose-Response Relationship**

More Workplace Violence -> More Burnout, ITL and ITC

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**Opposite of Burnout is Engagement**

<table>
<thead>
<tr>
<th>BURNOUT</th>
<th>ENGAGEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Exhaustion:</strong></td>
<td><strong>Vigor:</strong></td>
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<tr>
<td>Physical and Emotional.</td>
<td>High levels of energy, mental resilience</td>
</tr>
<tr>
<td>Nothing left to give.</td>
<td></td>
</tr>
<tr>
<td><strong>Depersonalization:</strong></td>
<td><strong>Dedication:</strong></td>
</tr>
<tr>
<td>Keeping your patients at a distance: Cynicism, sarcasm,</td>
<td>High job involvement, with sense of significance, enthusiasm</td>
</tr>
<tr>
<td><strong>Lack of efficacy:</strong></td>
<td><strong>Absorption:</strong></td>
</tr>
<tr>
<td>What is the use? Work ‘feels’ and may be subpar</td>
<td>Fully concentrating, deeply engrossed, extra mile</td>
</tr>
</tbody>
</table>

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**The Impact of Healthcare Burnout**

**Institutional & Patient Toll:**
- Increased medical errors and malpractice claims
- Disruptive behavior
- Reduced empathy for patients, patient satisfaction,
- Reduced patient adherence to treatment regimens.

**Financial Toll:**
- 27% drop in Patient Satisfaction Scores
- 50% of turnover costs attributed to work stress
- 114% increase of medical claims by employees.
- 30% of short-term and long-term disability costs.

**Personal Toll:**
- Higher suicide rate known in physicians, Nursing? Social Work?
- Locally in 2014 in MDs: One death at URMC, and one death at RGH.
- Substance abuse, divorce, heart disease, depression.

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**Six categories of Work Stress that can contribute to Burnout**

1. Excessive workload - physical, cognitive and emotional
2. Lack of control - being able to influence work environment
3. Poor balance between effort and reward - material and intangible rewards.
4. Lack of community - culture of mutual appreciation and teamwork
5. Lack of fairness - resources and justice
6. Value conflict - moral distress of having to participate in suboptimal, unethical circumstances.

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Barriers to Recognition and Resolution of Organizational Stress and Burnout

1. **Individual perception.** “Hidden curriculum”—conspiracy of silence, self-effacement in training. Trust authority... but multiple authorities, not harmonized.

2. **Organizational response.** Not enough systemic awareness of total load on individual clinicians as silo-ed sources of authority.

3. **Socio-political perception.** Patient Safety Movement initiatives and Triple Aim.

   “Halo” effect—because it is called “quality” it must be good. (If too numerous, chaotic, unproven “quality” metrics— not good and in fact harmful).

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Four Major Factors that Affect Cognitive Overload

1. Too much information supply
2. Too much information demand
3. Constant multitasking and interruptions
4. An inadequate workplace infrastructure to reduce the need for:
   a. Planning
   b. Monitoring
   c. Reminding
   d. Reclassifying information.

Cognitive Load Theory

- Extraneous Load: Burden in cognitive processing information that can be improved by better design.
- Germane Load: Manage the care, emotional work of patient care, work with families, operate EHR.
- Intrinsic Load: Inherent level of difficulty. E.g., Diagnosis and treatment of CHF, HTN, CVA, Depression etc etc thought to be immutable load.


Executive Functions of the Brain

1. Focus, Attention
2. Self Control of Behavior and Speech
3. Plan and Organize
4. Perspective Taking
5. Cognitive Flexibility
6. Medical and other Decision Making
7. Ability to Defer Gratification
8. Estimating Time
9. Working Memory

Executive Function (EF) of Brain

- Controlled by Prefrontal Cortex (PFC)
  - with connections throughout the brain.
- Sensitive to stress exposure.
  - Even mild acute uncontrollable stress can cause a rapid and dramatic loss of prefrontal cognitive abilities.
- Prolonged stress exposure ➔ Anatomical change (architectural changes in prefrontal nerve cells (cortex thins) and amygdala enlarges).
- Executive Function affected by:
  - Personality
  - Culture*
  - Genetics
  - Sleep deprivation*
  - Substances*
  - Executive task switching*
  - Interruptions*
  - Cognitive load*
  - Poor design of workflow*
  - Burnout*
  - Symptomatic Major Mood Disorders (Unipolar and Bipolar disorder).

* We can do something to help these factors.

Cognitive Flexible Memory:

1. Examine and weigh multiple factors
   - Synthesize a more accurate diagnosis from many things learned in medical training (good differential diagnosis).
   - More comprehensive and effective care plan.
2. Make the mental connection for planning next steps.
   - The anticipated need to have emotional availability to the patient and family.

Habit Memory:

- Spares cognitive resources
- Automates response to a preceding stimuli, without link to outcome that follows.

Mental Reserve Remaining
Have access to Cognitive Flexible memory

Extraneous Load- Excessive

Germane Load

Intrinsic Load

MDM Impaired !!!!

Mental overload/ poor decision outcome
Goal shielding—looses larger context issues
Revert to Habit Memory

Structures affected by Chronic Occupational Stress

- Cognitive Flexible Memory:
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<table>
<thead>
<tr>
<th>Factors Affecting Difficult Relationships</th>
<th>Patient Factors</th>
<th>Clinician Factors</th>
<th>Healthcare System Factors</th>
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</thead>
<tbody>
<tr>
<td>Psychiatric Disorder.</td>
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<tr>
<td>Personality Disorder.</td>
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<tr>
<td>Subclinical Behavioral Traits.</td>
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<td>Low resources for self care.</td>
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<tr>
<td>Coming in with past struggles to get care, sensitized to perceiving inadequate help provided.</td>
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<tr>
<td>Entitlement amplification by current &quot;patient satisfaction&quot;/customer service environment of HC Reform.</td>
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<tr>
<td>Overwork, Burnout, depersonalization, emotional exhaustion.</td>
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<td>Poor communication skills.</td>
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<td>Low level of experience.</td>
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<td>Discomfort with uncertainty.</td>
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<td>Overly paternalistic.</td>
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<td>Not do well with challenge to opinion.</td>
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<td>Productivity pressures, business emphasis.</td>
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<td>Value schism between administrators and clinicians.</td>
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<td>Changes in HC system financing.</td>
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<td>Fragmentation of visits.</td>
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<tr>
<td>Poor design of electronic and systemic workflows.</td>
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<tr>
<td>Outside challenges to clinician authority Hidden criteria for pre-authorization, etc. inadequately addressing clinician satisfaction and engagement.</td>
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<tr>
<td>Poor Organizational Health.</td>
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</table>

Three-way interaction: Patient, Clinician and Healthcare Environment

Work Environment Healthy  Work Environment Toxic

Overlapping Organizational Factors Contributing to Burnout and WPV

Vicious Cycle of Burnout and WPV

Heartsink Patients

• There are patients in every practice who give the doctor and staff a feeling of 'heartsink' every time they consult. O'Dowd (1988)
Signs and Symptoms of Potentially Difficult Interactions

- Thick chart
- Labeled non-compliant “Psych patient”
- Suicidal
- Unexplained somatic symptoms
- Alcoholic
- “Drug-seeking”
- Personality disorder
- Demanding
- Threatening
- Agitated
- Tearful
- Untreatable illness
- Social problems

Counterproductive Strategies

- Ignore the problem
- Export the problem patient to another MD
- Accuse and blame the patient as the PROBLEM
- Solve the problem with drugs/RX.

More counterproductive strategies

- Tell the patient there is nothing wrong
- Tell the patient it is all in their head and see a shrink.
- Tell the patient there is nothing you can do for them.

(Haas LJ. Am Fam Physician. 2005;72:206308.)

Reactions to Difficult Patients Interactions

- Anger that you have to see the patient when there are really sick people to treat.
- Guilt that you as a healthcare professional hate the patient.
- Fear that you will not be able to handle his/her problems and how they will react.
- A sense of failure that you will not be able to help this patient no matter how hard you try
“Drug-Seeking” Patients

Problem in certainty:
1. Can never be sure how much pain they are in.
2. Being in pain and missing opioids are not mutually exclusive
   Can be 50%/50%, 10%/90%, 90%/10%, etc.
3. Prescription drug monitoring system may help
   Exceptions: drugs through VA, Military system, mail order prescriptions,
   or can go across state lines to fill other prescriptions

Approaches:
- Humanitarian perspective may still need to treat with opioid in some patients if it is obvious that it is the most effective treatment—but try to mitigate risks.
- Try not to call them “drug-seeking”—stigmatizes and creates immediate prejudice of other staff.
- Don’t fixate on whether you believe them
- Help solve the problem, not stand in judgment
- Come in, sit down (not stand over them), face to face conversation.
- Focus on the treatment plan
- Can be honest about your concern about them, risks, and your duty to give them the best care.
- Important to frame as giving good care, not trying to withhold something from them.

<table>
<thead>
<tr>
<th>Personality Characteristic</th>
<th>Meaning of Illness</th>
<th>Evoke Countertransference</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>History</td>
<td>Melodramatic</td>
<td>Little attention, derision</td>
<td>Strike a balance between warmth and formality</td>
</tr>
<tr>
<td>(Perpetual victim)</td>
<td>Conspicuous or unassuming punishment</td>
<td>Anger, hate, frustration, helplessness</td>
<td>Clear boundaries, do not confront head on. Encourage patient to discuss fears.</td>
</tr>
<tr>
<td>Masochistic</td>
<td>Self-sacrificing martyr</td>
<td>Anger, hate, frustration, helplessness</td>
<td>Avoid excessive encouragement. Share patient’s pain. Suggest patient consider treatment as another burden to endure, and it’s a positive effect on loved ones.</td>
</tr>
<tr>
<td>Paranoid</td>
<td>Guarded, mistrustful</td>
<td>Fear that world is against patient, Care is invasive and exploitative</td>
<td>Avoid defensive stance, acknowledge patient’s feelings without disputing them. Avoid excessive warms, do not confront irrational fears.</td>
</tr>
<tr>
<td>Schizoid</td>
<td>Abducted, socially awkward</td>
<td>Fear of intrusion</td>
<td>Respect patient’s privacy, gentle quiet interest in the patient. Encourage routine and regularity.</td>
</tr>
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Difficult Patient Personality

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<tr>
<td>Dependent</td>
<td>Newly demanding</td>
<td>Clinginess to reassure self, make reassurance from others</td>
<td>Threat of abandonment. May affect loss of becoming well and loosing trust.</td>
<td>Initially position, feel powerful and involved. Tense, overwork, overemotional, may try to avoid the patient.</td>
</tr>
<tr>
<td>Obsessional</td>
<td>Meticulous, close to tailing</td>
<td>Loss of control over body, impulses</td>
<td>May administer, when necessary, anger—“battle of wills.”</td>
<td>Try to use control. Give patient choices to increase sense of control. Use collaborative, “hands off” attitude.</td>
</tr>
<tr>
<td>Narcissistic</td>
<td>Arrogant, demanding</td>
<td>Threat to self-concept of preeminence and invulnerability, desire control</td>
<td>Acts to create control, anger, feelings of superiority, or feeling of status of dealing with an important patient.</td>
<td>Handle the desire to challenge patient’s entitlement. Close all partnerships that acknowledge entitlement to good clinical care but not to unrealistic demands. Humble-stone, provide opportunities for the patient to show off, offer consultations if appropriate.</td>
</tr>
</tbody>
</table>

Perpetrator Characteristics

<table>
<thead>
<tr>
<th>Clinically Confused</th>
<th>Anti-Social / Angry</th>
<th>Socially Intoxicated</th>
<th>Frustrated</th>
<th>Distressed / Frightened</th>
</tr>
</thead>
</table>
CYCLE OF AGGRESSION

- Patient Stress / Loss
- Unmet Needs / Expectations
- Anxiety Decreased
- Frustration
- Anxiety Aroused
- Feelings of Powerlessness and Hopelessness
- Anxiety Increases
- Assaultive Behavior
- Anxiety Converts to Anger

Warning Signs-Phase I

- Red face
- Pacing
- Scowling or sneering
- Crossing arms and legs
- Tenseness of muscles/clenched jaw
- Sweating
- Trembling or shaking
- Rigid posture
- Exaggerated gestures
- Glaring eye contact
- Exaggerated gestures
- Clenching of fists and teeth
- Statements of fear of losing control

Defuse Phase I

**DO**
- Show respect
- Personalize interaction
- Validate feelings
- Offer apologies
- Project positive outcome
- Ask questions
- Hear them out
- Provide choices
- Problem solve/solutions
- Establish behavior plan for identified risks
- Follow through on what you say you will do for them

**DON’T**
- Pass judgment
- Avoid involvement
- Dismiss or minimize
- Cite rules
- Out talk them
- Back them into a corner
- Leave them hanging

Warning Signs-Phase II

- Verbally abusive
- Speaks and/or complains loudly
- Uses profanity/sexual comments
- Boasting of prior violence
- States he/she will lose control
- Challenges authority
- Appears to be under the influence of drugs and/or alcohol
- Makes a mess, scatters clothes or objects
- Blames others for his/her problems, error or mistakes
- Communicates unrealistic and unnecessary demands for service

From Lt. Cynthia Coates, URMC Security Services
Defuse Phase II

**DO**
- Speak calmly and clearly
- Respect personal space
- Project confidence
- Be aware and alert
- Set limits/redirect
- Contain the person
- Remove potential weapons
- Remove others
- Get assistance
- Remove yourself if you’re the target
- Mobilize resources

**DON’T**
- Enter into argument
- Touch or get too close
- Turn your back
- Tell them to “Calm down”
- Think you can handle it yourself
- Allow your ego to rule
- Talk to large groups of people

From Lt. Cynthia Coates, URMC Security Services

Warning Signs-Phase III

**Significant change in baseline activity**

**Hyperactivity:**
- Threatening gestures
- Throws objects down, banging, kicking walls or furniture
- Vicious cursing
- States there is “nothing to lose”
- Develops plan or makes clear, concise threat

From Lt. Cynthia Coates, URMC Security Services

De-Escalation Concepts

- “Calming the patient” has dominant-submissive connotation
- Contemporary goal: “helping the patient calm himself”—a form of treatment, help patient find internal locus of control

4 main objectives:
1. Ensure safety of patient, staff and others in the area
2. Help patient manage his emotions, distress, and maintain or regain control of his behavior
3. Avoid use of restraint when at all possible
4. Avoid coercive interventions that escalate agitation

- If unable to engage in conversation - may be on edge of new or repeated violence (e.g. Phase III)
  - Different management, safety issues of imminent risk, but remember compassion and respect.

10 Domains of De-Escalation

1. **Respect Personal Space of patient and yourself.** (2 arm’s lengths)
2. **Do Not be Provocative (avoid iatrogenic Escalation)**
   - Humiliation of patient needs to be strongly avoided.
   - **Body Language:**
     - Stand at angle to patient (to not appear confrontational),
     - No clenched fists
     - Hands visible.
     - Avoid excessive eye contact
     - Avoid arm folding or turning away.
     - Body language should be congruent with words (otherwise seems insincere)
3. **Establish Verbal Contact and 1 person verbally interacts**
4. **Be Concise, and keep it simple, repetition may be needed.**
5. **Identify Wants and feelings** –
   - Use “Free information” (trivial things patient says, his body language or even past encounters with patient) to identify wants and feelings.

10 Domains of De-Escalation (cont'd)

6. Listen Closely to what patient is saying:
   - Active Listening.
   - Use "Miller’s Law": assume patient’s point is truth and try to imagine what it could be true of.
7. Agree or Agree to Disagree:
   - "Fogging" is empathic behavior in which one finds something of patient’s position upon which to agree.
8. Lay down Law and Set Clear Limits:
   - Establish basic working conditions.
   - Must be reasonable and done in respectful manner.
   - Coach patient how to stay in control
9. Offer Choices and Optimism.
   - Breach subject of medications.
   - Be optimistic and provide hope.
10. Debrief the patient and staff.

Conclusions: Step One in Managing Difficult Patients Interactions: Understand Yourself

- Be aware of your negative feelings toward certain types of patients.
- Understand what it is that upsets you about these patients.
- Realize you are not a “bad” clinician because you feel antipathy toward the patient.
- Recognize your not alone if having trouble dealing with difficult pts.

Step Two: Understand the patient

- Difficult behavior is a form of communication.
- There are legitimate fears, and needs behind the demands and complaints.
- Behind the labels: There is terrible pain.

Take Home Messages

- Negative reactions constitute important clinical data.
- Awareness and responsible use of these negative reactions can facilitate better understanding, care and improve management.

Need both: Personal And Organizational interventions to be effective

Change in Paradigm

• We currently are acting under the belief (illusion?) that it is actually possible to do all we're expected to do.

Paradigm shift:
1. Accept that everything expected from all sources is individually impossible to do
2. How can we achieve all "boxes checked" to satisfy evaluators?
3. "Satisficing" (Herbert Simon, Nobel Prize winner) [combination of satisfy + suffice]
   - For lesser priority decisions: Not getting the very best option but one that is good enough. Cost/benefit analysis between effort and benefit
4. High priority decisions are different—>can continue to invest pursuit of excellence there.

Personal Reduction of Stress

(Quadrant I)

1. Mindfulness Based Stress Relief (MBSR), Mindful Practice
2. Squeegee Breath
3. Gratefulness Journaling
4. Narrative Medicine to vent past traumas in training and practice
5. Celebrate all wins ("treat yourself like a dog")
6. Acquire leadership, delegation and patient flow skills
8. Letting Go: Of thoughts, ideas, things, pleasant and unpleasant.
9. Ways of dealing with Upset Patients
10. Ways to master EMR
11. Three Good Things that happen each day (Duke, USF & Georgia Tech)
12. Personal Time management
13. E-mail grouping in batches during the day (e.g. 11:30 and 4:30 PM)
15. Stress reduction classes
16. Yoga
17. Employee Assistance Program (EAP) 475-0432
18. Behavioral Health Partners (BHP) 276-6900

Seven Essentials of Mindfulness

1. Non-Judging: Impartial witness to your experience. Observe w/o judging, editing or intellectualizing it.
2. Non-Striving: No goal other than to be yourself.
3. Acceptance: Willingness to see things the way they are.
4. Letting Go: Of thoughts, ideas, things, pleasant and unpleasant.
6. Patience: Things must unfold in their own time.
7. Trust: In yourself and your feelings. Confidence that things can unfold in framework that embodies order and integrity.

Kabat-Zinn, 2004
Squeegee Breath

To clean the window of your awareness
Transform native behavior into intentional

• 4 part super-breath (highly concentrated mini-meditation)

1. Set intention- that going to release anything that doesn’t need to be here. Become calm, relaxed, completely present.
2. Breathe in. Hold in….two….three
3. Breathe out and release. Hold out...two...three
4. Smile

Personal Recharge

(Quadrant II)

1. Honoring Self
2. Boundary ritual between work and home
   - Car ride home relaxing music, mindful breathing
   - Mr. Rogers routine (yeah, the sweater, the slippers!)
3. Schedule the things you are going to do outside of work.
   - Get them on your calendar that you can see at work.
4. Recreation and Exercise
   - Start small and sustainable - simple, frequent and fun
5. Care for your body and its physical needs
6. Bucket List activities
   - Write them down and start doing the list.
7. Regular Vacation:
   - Don’t run yourself ragged before you decide to take off.
8. Spirituality:
   - Put work within the larger context.

Drummond D. 2014.