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Guidelines for Providing Ethical Care in Difficult Provider-Patient Relationships

by Midwest Bioethics Center Ethics Committee Consortium

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The purpose of this document is to recommend guidelines for providing ethical care in the context of difficult patient/provider relationships. Healthcare professionals have the responsibility to respect the beliefs and preferences of their patients and the duty to balance the values and medical needs of the individual patient with the need to maintain a functioning healthcare system that can respond to the needs of many. These guidelines seek to balance the rights and corresponding responsibilities of patients and providers.

Statement of the Problem

The ideal clinical encounter may be challenged or damaged by a difficult relationship in which the values/behavior of the provider are in such conflict with the values/behavior of the patient that the therapeutic process is blocked and the medical needs of the patient cannot be met in a respectful manner. These guidelines advise providers how to proceed ethically in that conflicted situation. They consider the objectives to respect the patient, meet the patient's healthcare needs, and respect the justifiable needs of healthcare providers.

> Medicine works only where there is a cooperative and consensual relationship between patients and professionals (O'Rourke 1986).

Background

The Ethics Committee Consortium has historically focused on the rights of patients and the corresponding duties of healthcare providers to respect those rights. This focus is consistent with two assumptions:

1. Respect for the dignity of persons requires that the clinical relationship focus on the patient's beliefs and preferences, and

2. In healthcare institutions, individual patients and families have much less power than providers, which results in significant limitations on their ability to effectively negotiate their beliefs and preferences with healthcare professionals.

Patient-centered relationships are a primary emphasis of bioethics. A patient-centered relationship is a covenantal relationship. Professional standards require that providers identify, understand, and accommodate to the unique beliefs and preferences of individual patients to the degree necessary to meet their healthcare needs. Put in terms of the American Board of Internal Medicine (1995):

> Altruism is the essence of professionalism. The best interest of patients, not self-interest, is the rule.

To reach this ideal, the healthcare provider is required to subjugate personal interest to the patient's welfare. This requirement does not mean

that healthcare professionals must subordinate their personal interests to any and all of the patient's personal interests, but only to those interests that are necessary to meet the patient's healthcare needs in a respectful manner. The patient-centered relationship includes several expectations, namely, that

- mutual trust and respect will exist;

- confidences will be respected and maintained;

- the patient has been informed of, has consented to, and will cooperate with the healthcare treatment plan;

- the right care will be provided in a timely fashion; and

- services will be reimbursed.

Differentiating the patient's real needs from imagined needs, or medical needs from nonmedical needs, and judging what constitutes a respectful manner are important matters in ethical reflection. Ethical reflection helps guide the clinical encounter toward the right action for the good of the patient.

Nevertheless, the mandate to provide patient-centered care is tempered by a recognition that the clinical encounter does not occur in isolation from the complex matrix of relationships in which all persons exist. The patient's interests may not always justly dominate the relationship. The preamble to the AMA Code of Ethics expresses this complex context: "As a member of this profession, a physician must recognize responsibility not only to patients, but also to society, to other health professionals, and to self." A more complete description of the relational matrix includes family, friends, the legal system, and regulatory agencies.

Each patient/provider relationship falls somewhere on a continuum from nurturing to difficult. Providers must accept and expect that patients may behave idiosyncratically, and less than ideally, as a result of suffering and illness. Providers also need to recognize that some difficult relationships are created at least in part by systemic rules or procedures, or by the personal style of providers. Others are inherently difficult because of the nature of the disorder or treatment.

Providers need to explore their own internal expectations, values, and biases and examine their "professional" perspective and sense of themselves as experts. They also need to develop an awareness and understanding of their own communication and relationship style and skills. Many healthcare providers have an exaggerated view of the value and importance of healthcare and health maintaining behaviors — a view that their patients may not share. Questions that a provider may use for critical self-evaluation include the following:

- Is there a language or communications barrier between the patient and me?

- What is the patient's usual communication and relationship style? How does the patient's family communicate?

- What is my usual communication and relationship style?

- Do the patient and I have similar difficulties in other relationships?

- How often, or for how long, has this relationship been a problem?

- What do other members of the multidisciplinary team think about the relationship?

- Are there issues of justice? Are the appropriate resources being expended?

- Is there another way to define or frame the relational difficulty?

- What is an appropriate or proportional response to this difficult situation?

Preventing the Problem

It may be possible to avoid or prevent the escalation of a difficult relationship using the following processes:

- Engagement: Elicit and understand the patient's story; avoid closed-ended questions; establish the patient's expectations; set the agenda and establish mutual goals of treatment.

- Empathy: Respect the perspective of the other person; make the patient comfortable; create an emotionally safe environment; respond to the patient's behavioral and nonverbal expressions.

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- **Enlistment:** Ask the patient to define the problem; enlist the patient in providing information and collaborating in decision making.

- **Education:** Assume that the patient wants to know what is happening, and why; evaluate the level of the patient's understanding and curiosity; don't underestimate or overestimate the patient's ability to need and understand information.

Another alternative that may help prevent difficulties is to ask the patient questions developed by Arthur Kleinman et al. (1978):

1. What do you think causes your problem?

2. Why do you think it started when it did?

3. What do you think your sickness does to you? How does it work?

4. How severe is your sickness? Will it have a short or long course?

5. What kind of treatment do you think you should receive?

6. What are the most important results you hope to receive from this treatment?

7. What are the chief problems your sickness has caused for you?

8. What do you fear most about your sickness?

Triggering the Problem

On the other hand, elements that can trigger a difficult clinical relationship include the following:

- insensitive, arrogant, or rushed providers;

- patient or family demands for futile, excessive, or inappropriate care;

- lack of mutual understanding of, or agreement to the treatment plan;

- systemic rules, procedures, schedules;

- angry, rude, demanding behavior from the provider or patient;

- an assertive, well-informed patient;

- a passive, uninformed patient;

- evidence or suspicion of substance/medication abuse;

- basic mistrust, generally, or specifically, within certain relationships;

- patients or providers who feel "trapped" and who perceive no positive alternatives or reason for hope;

- patients or providers who have limited, marginal, or dysfunctional social skills;

- evidence of mental illness or personality disorder;

- untreated pain or other symptoms;

- psychological and social stresses, such as financial or family problems;

- discomfort with dependency or the role of "patient;"

- side-effects or iatrogenic impacts of treatment;

- patients or providers who appear unable or unwilling to control their own behavior; and

- prejudices or cultural biases.

Integrity, Empathy, and Compromise

This document encourages providers to make a respectful and accommodating response to all patients until it is clearly established that the clinical encounter is no longer manageable. Providers dealing with these situations must make a professional commitment to empathy, integrity, and compromise.

Integrity is a virtue in which a person intentionally adopts a position after careful consideration of the relevant factors. Integrity can become a vice if the person becomes inflexible and unwilling to consider the situation from the perspective of the other person.

Empathy is the ability and willingness to respect the perspective of the other person. Empathetic behavior often requires that one give up, or suspend, an adopted position in order to explore the situation fully from the other person's point of view. Empathy, fully exercised, can lead to compromise.

Compromise occurs when one or both parties are willing to move from an adopted position to accommodate the other. Compromise can mean

that one party capitulates to the other or that both change their positions to a mutually agreeable resolution.

Finding a balance among integrity, empathy, and compromise in a conflicted relationship is a mark of moral maturity.

Assumptions

1. A basic level of healthcare should be available to everyone in need.

2. Creating and maintaining a mutually satisfactory patient-provider relationship is essential to providing quality healthcare.

3. The definition of "mutual satisfaction" varies with each relationship, but at a minimum, "satisfaction" is that which allows the therapeutic process to go forward.

4. Providers must understand and accommodate the behavior of patients in order to achieve a therapeutic process.

5. Providers must maintain their ethical commitment to providing care even in difficult situations and relationships.

6. Providers may negotiate an episodic or time-limited commitment to provide care to a specific patient.

7. Providers have the right to refuse any request or demand for healthcare intervention that they believe violates professional standards of practice.

8. Depending on the location of the service and the duration of the illness episode, providers have varying levels of obligation to address and respond to the healthcare needs of specific patients.

9. Providers have a right to expect that a patient will willingly cooperate with a mutually negotiated treatment plan.

10. Decisionally capable adults have the right to refuse any healthcare intervention.

11. Patient-provider relationships are embedded in a matrix of other relationships that may prevent and ameliorate, or create and exacerbate, conflict. All relevant relationships need to be considered to develop a consensus about the patient's care plan.

12. Because professionals have the greater power to enter and control the therapeutic relationship, they have the greater obligation to establish and maintain the cooperation required for the therapeutic process.

13. Professionals have an unconditional obligation to undergo, or submit to self-critical evaluation and peer review.

Guideline Principles

1. Necessary healthcare ought to be provided to patients regardless of their values or behavior.

2. The provider has a greater obligation to establish and maintain the cooperation required for the therapeutic process.

3. When the patient blocks the therapeutic process, the provider is obligated to renegotiate the cooperation necessary to restore the therapeutic process.

4. When the provider blocks the therapeutic process, other professionals involved in the matrix of relationships are obligated to help that provider restore the therapeutic process.

5. If the therapeutic process cannot be reestablished, the conflicted providers at the core of the relationship ought to withdraw and be replaced by others who can negotiate the necessary cooperation.

6. If the provider refuses to withdraw from the conflict, it may be necessary to use a formal process to assess and/or replace the provider.

7. If a provider cannot withdraw without causing abandonment, the provider must subjugate self-interest to the interests of the patient and continue to negotiate the cooperation necessary to provide treatment.

8. The decisionally capable patient who has given informed consent to treatment has an obligation to cooperate sufficiently to allow for the therapeutic process; or that patient should withdraw from the clinical encounter.

9. The provider is obligated to provide information to the patient about the potential consequences of his or her lack of cooperation with treatment.

10. Determining decisional incapacity must be a critical, open process which is centered on the patient's interests. Declaring a patient to be decisionally incapable without justification

may not be used as a means to resolve a difficult relationship with an uncooperative patient.

11. Providers must do all they can to enhance decisional capacity and enhance the patient's ability to meet mutually agreed-to expectations for the provision of healthcare.

12. If the patient is not decisionally capable of negotiating the required cooperation, the substitute decision maker should be treated with the same full respect as that accorded the patient.

13. Providers have no obligation to meet a patient's healthcare expectations if those expectations are

   • beyond the provider's competence,

   • medically contraindicated and/or futile,

   • illegal, or

   • unethical.

14. If providing care is acutely or immediately dangerous to the provider, the level of danger must be decreased so that needs can be met.

15. The following strategies may not be used without compelling justification:

   • physical restraints,

   • chemical restraints,

   • chemical alteration of behavior,

   • legal threats,

   • threatening harm,

   • deceit or misrepresentation,

   • incomplete disclosure that results in misinformed consent,

   • excessive persuasion, manipulation, or coercion,

   • co-opting others to coerce a patient, or

   • limiting access to equipment or assistance that is necessary for self-care.

Ethics Consultation

An ethics consultation may be indicated if conflict becomes so disruptive that it blocks the therapeutic process. The trigger of the conflict may be the patient's or family's behavior, the provider's behavior, systemic policies or procedures, or an inability to achieve mutual understanding and goals.

The consultation team should consider the following:

1. Look beyond the current complaint or conflict to the whole of the relationship.

2. Assure that the provider has accepted and carried out the obligation to place the patient's best interest foremost.

3. Evaluate the patient's behavior for the purpose of understanding the patient's beliefs and preferences rather than for making a psychological diagnosis.

4. Examine the influence that group or system dynamics have on both the physician and the patient.

5. Focus on the patient's definition of the problem and the patient's need.

6. Avoid blame. Look for middle ground.

7. Look for ways to begin the negotiation or mediation process.

8. Look for "win-win" outcomes.

9. Keep the patient's "medical good" in mind, but be careful not to focus on "medical good" to the exclusion of the patient's "personal good."

Possible Outcomes of Difficult Relationships

1. One party accommodates or capitulates to the other by sacrificing his or her beliefs or preferences.

2. The trigger point or immediate cause of the difficulty is removed.

3. A breakthrough to mutual understanding resolves the relational difficulty.

4. The conflict is minimized by compromise for the sake of the shared goal of meeting the patient's medical need.

5. The member of the healthcare team who relates most effectively may take on the primary communication or case management responsibility.

6. Either the provider or the patient withdraws from the relationship.

7. An authoritative third party assumes responsibility.

8. A contract for treatment is developed that may or may not be based on mutual understanding and agreement.

9. Judicial remedies are pursued, including psychiatric commitment or confinement to jail.

Bibliography

American Board of Internal Medicine. 1995. *Project Professionalism*. Philadelphia, PA: American Board of Internal Medicine.

Angell, Marcia. 1982. "The Quality of Mercy." *NEJM* 306:99-100.

Beckman, Howard. 1997. "Difficult Patients." In M.D. Feldman, and J.F. Christensen, eds. *Behavioral Medicine in Primary Care*. Stanford, Conn: Appleton and Lange, pp. 20-29.

Benjamin, Martin. 1990. *Splitting the Difference: Compromise and Integrity in Ethics and Politics*. Lawrence, KS: University of Kansas Press.

Brody, D. S. 1980. "The Patient's Role in Clinical Decision Making," *Annals of Internal Medicine* 93:718-722.

Brown, J.B. 1995. "Exploring Both the Disease and the Illness Experience." In *Patient-Centered Medicine*, ed. Moira Stewart, et al. London: Sage.

Callahan, Daniel. 1998. "Public Health and Personal Responsibility." *False Hopes*. New York: Simon & Schuster.

Council on Ethical and Judicial Affairs. 1997. *Code of Medical Ethics*. Chicago, IL: American Medical Association, p. viii.

D'Oronzio, Joseph. 1997. "Ethical Obligations in the Body Politic: The Case of Normalization Policy for Marginal Populations." *Cambridge Quarterly of Healthcare Ethics* 6:480-493.

Egan, Gerard. 1994. *The Skilled Helper: A Problem-Management Approach to Helping*, 5th ed. Pacific Grove, CA: Brooks/Cole Publishing Company.

Feudtner, Chris, Dimitri Christakis, and Peter Schwartz. 1996. "Ethics and the Art of Confrontation: Lessons from the John Conley Essays." *JAMA* 276(9): 755-756.

Fins, Joseph. 1998. "Approximation and Negotiation: Clinical Pragmatism and Difference." *Cambridge Quarterly of Healthcare Ethics* 7:68-76.

Groves, James. 1978. "Taking Care of the Hateful Patient." *NEJM* 298(16): 883-887.

Hahn, Steven, Kurt Kroenke, Robert Spitzer, David Brody, Janet Williams, Mark Linzer, and Frank deGruy III. 1996. "The Difficult Patient: Prevalence, Psychopathology, and Functional Impairment." *Journal of General Internal Medicine* 11:1-8.

Heymann, Jody. 1995. *Equal Partners*. Boston: Little Brown and Company.

Kleinman, Arthur, Leon Eisenberg, and Byron Good. 1978. "Culture, Illness and Care: Clinical Lessons from Anthropologic and Cross-Cultural Research." *Annals of Internal Medicine* 88:251-258.

Lebacqz, Karen. 1985. *Professional Ethics: Power and Paradox*. Nashville: Abingdon Press.

Lerner, Barron H. 1997. "From Careless Consumptives to Recalcitrant Patients: The Historical Construction of Noncompliance." *Social Science and Medicine*. 45(9): 1423-1431.

Lerner, Barron H., Roy Gulick, and Nancy Neveloff Dubler. 1998. "Rethinking Nonadherence: Historical Perspectives on Triple-Drug Therapy for HIV Disease." *Annals of Internal Medicine* 129(7): 573-578.

Macklin, Ruth. 1998. "Ethical Relativism in a Multicultural Society." *Kennedy Institute of Ethics Journal* 8(1): 1-22.

May, William F. 1983. *The Physician's Covenant*. Philadelphia, PA: Westminister Press.

Morgan, Mark. 1998. "Overcoming a Failure to Communicate." *American Medical News* (May 11): 3, 60.

National Kidney Foundation. 1996. *Initiation or Withdrawal of Dialysis in End Stage Renal Disease: Guidelines for the Health Care Team*, pp. 17-18.

Novack Dennis, et al. 1997. "Calibrating the Physician: Personal Awareness and Effective Patient Care." *JAMA* 278:502-509.

O'Connor, Patrick, and Richard Schottenfeld. 1998. "Patients with Alcohol Problems." *NEJM* 338(9): 592-602.

O'Rourke, Kevin. 1986. *Medical Ethics: Common Ground for Understanding*. St. Louis: St Louis Catholic Health Association, p. 16.

Pellegrino Edmund D., and David C. Thomasma. 1981. *A Philosophical Basis of Medical Practice*. New York: Oxford.

———. 1988. *For the Patient's Good: The Restoration of Beneficence in Health Care*. New York: Oxford.

———. 1993. *The Virtues in Medical Practice*. New York: Oxford.

Quill, T.E. 1983. "Partnerships in Patient Care: A Contractual Approach." *Annals of Internal Medicine* 98:228-234.

Peterson, Marilyn R. 1992. *At Personal Risk: Boundary Violations in Professional-Client Relationships*. New York: W. W. Norton and Company.

Remis, David, and Maysel Kemp White. 1998. "A New Model for Physician-Patient Communication." *Family Practice Recertification* 20:67-81.

Rusk, Tom. 1993. *The Power of Ethical Persuasion*. New York: Penguin Books.

Sharp, David. 1998. "Difficult Patients." *Hippocrates* 12 (March): 51-56.

William Sledge, and Alvan Feinstein. 1997. "A Clinimetric Approach to the Components of the Patient-Physician Relationship." *JAMA* 278:2043-2048.

Slomka, Jacquelyn. 1998. "Understanding Culture Clashes in the Clinical Setting." *Cleveland Clinic Journal of Medicine* 65(2): 66-69.

Smith, Sam. 1995. "Dealing with the Difficult Patient." *Postgraduate Medical Journal* 71:653-657.

Staples, P., et al. 1994. "Empowering the Angry Patient." *The Canadian Nurse* (April): 28-30.

Stoddard, Jim. 1997. "The Difficult Patient Relationship." Kansas City: Unpublished Lecture Outline.

Veatch, Robert M. 1981. *A Theory of Medical Ethics* New York: Basic Books, Inc.

Ward-Collins, Diana. 1998. "Noncompliant: Isn't there a better way to say it?" *American Journal of Nursing* 98(5): 27-31.

Waitzkin, Howard. 1991. *The Politics of Medical Encounters: How Patients and Doctors Deal With Social Problems*. New Haven: Yale University Press.

Weeks, Dudley. 1992. *The Eight Essential Steps to Conflict Resolution*. New York: G.P. Putman's Sons.

Weiss, Donald H. 1987. *How to Deal with Difficult People*. New York: American Management Association.

Welds, Kathryn. 1995. "Managing the Difficult Patient." *Hospital Practice*, 24e.

Weston, W.W., and J.B. Brown. 1995. "Overview of the Patient-Centered Clinical Method." *Patient Centered Medicine*. London: Sage.