The Doctor-Patient Relationship Difficult Patient

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Definition and Importance

- A professional bond between doctors and patients.
- Essential for accurate diagnosis, effective treatment, and patient satisfaction.
- The doctor-patient relationship is at the heart of good care. It's not just about delivering technical skills; it's about building trust, fostering communication, and understanding the patient's individual needs and values

The Significance of the Doctor-Patient Relationship

- Serves as the foundation of effective medical care
- Enhances trust, respect, and collaboration
- Leads to improved patient outcomes and satisfaction
- Encourages active patient participation in healthcare decisions

Essential Elements of the Doctor-Patient Relationship

- Mutual respect and honesty between doctor and patient
- Patient-centered approach that considers individual needs
- Ethical and professional responsibility in medical care
- Confidentiality and trust as guiding principles
- Cultural competence in addressing diverse patient backgrounds
- Encouraging shared decision-making

Understanding the Duty of Care

Definition: A legal and ethical responsibility to ensure patient safety and well-being

Key obligations include:

Delivering safe, competent medical care	Practicing within professional expertise	Reporting systemic failures that impact care	Ensuring continuity and follow-up	Acting with empathy and professionalism

Core Duties of Doctors

- Make patient care your first concern
- Respect dignity, privacy, and autonomy
- Listen and communicate effectively
- Be honest and trustworthy
- Maintain confidentiality
- Do not let personal beliefs affect care

Transference and Countertransference

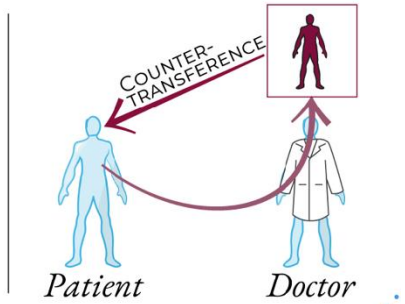
Transference: When a patient unconsciously redirects emotions from past relationships onto their doctor

- Can impact trust and communication
- Awareness helps doctors manage patient expectations

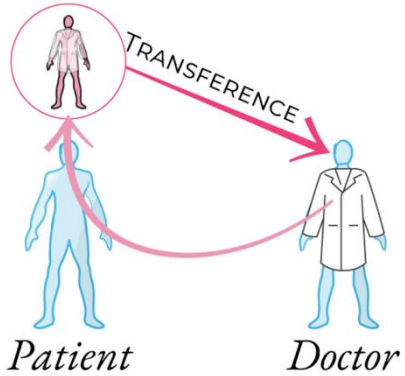
Countertransference: A doctor's unconscious emotional reaction to a patient

- May affect clinical judgment and lead to bias
- Self-awareness and reflection are crucial to managing responses effectively

Countertransference



Transference



Transference

Can influence the patient-provider relationship positively (trust, rapport) or negatively (mistrust, resistance).

Common in chronic care settings or with patients who have complex psychosocial histories.

Recognizing transference helps providers understand patient behavior and improve communication.

Countertransference

Can impact clinical judgment, leading to over-identification, frustration, or burnout.

Self-awareness and reflection are critical to managing countertransference effectively.

Duty of Doctors to Contact Patients Who Miss Important Appointments

Patient Rights: Patients can refuse treatment or follow-up

Doctor's Responsibility:

Inform patients about the consequences of missed appointments

Respect patient autonomy while ensuring they are aware of risks

Contact patients regarding essential follow-ups while maintaining confidentiality

Document all attempts

Exceptions: Further efforts may not be required unless concerns about vulnerable individuals arise

Supporting Patients with Communication Barriers

- Use interpreters (NOT family members)
- Adapt for:
  - Language barriers
  - Disabilities (hearing/visual)
- Ensure valid informed consent
- Document communication needs

Handling Medical Errors

- Must:
  - Inform patient
  - Apologize
  - Explain what happened
  - Discuss consequences
- Take steps to correct harm
- Report and learn from errors

Delegation and Referral

Delegation: Assigning tasks to other healthcare professionals while retaining responsibility

Referral: Transferring a patient's care to a specialist for more advanced management

Key Responsibilities:

- Informing the patient about the referral and the reason behind it
- Ensuring that the receiving provider gets relevant medical history
- Clarifying to the patient who will be responsible for their care
- Confirming patient understanding of the referral process

Patient Autonomy and Decision-Making

Definition: Patients have the right to make informed healthcare choices

This includes the right to:

Select their healthcare provider and treatment options

Accept or decline medical interventions

Seek a second opinion

Receive clear and comprehensible information

Engage in advanced care planning

Patient Choice in Healthcare

Choosing a Provider:

- Patients can select their GP surgery and preferred specialists
- Some limitations apply for urgent and emergency services

Limitations on Choice:

- Mental health patients, military personnel, and prisoners may have restrictions
- Not all services offer full patient choice due to resource availability

Communication and Honesty

Effective communication builds trust and improves care

Doctors must:

- Listen actively and acknowledge patient concerns
- Provide clear and accurate information
- Ensure patients understand their conditions and treatment options
- Maintain honesty and transparency in all interactions

Communicating with Patients

Key Components of Effective Communication

- Use simple, clear language to explain medical terms
- Encourage patient participation in decision-making
- Address emotional and psychological concerns
- Adapt communication style for diverse patient needs (e.g., disabilities, language barriers)

Active Listening Techniques

- Maintain eye contact and open body language
- Summarize patient concerns to ensure understanding
- Validate patient feelings and encourage questions

Communicating with Colleagues

Clear and professional communication improves patient care

Best Practices:

- Share relevant patient information responsibly
- Ensure continuity of care through proper documentation
- Clarify roles and responsibilities in patient management
- Address communication gaps to prevent medical errors
- Balance confidentiality with necessary information sharing

Honesty, Openness, and Truth-Telling

Patients have the right to full, honest information

Key Considerations:

Balance truth with sensitivity and empathy

Offer support and guidance when delivering difficult news

Respect patients who choose not to receive information

Explain diagnoses, prognoses, and treatment options in an understandable way

Ethical and Professional Considerations

MAINTAINING CONFIDENTIALITY WHILE ENSURING EFFECTIVE CARE

INFORMED CONSENT : PATIENTS MUST UNDERSTAND RISKS AND OPTIONS

AVOIDING CONFLICTS OF INTEREST IN MEDICAL DECISIONS

RESPECTING CULTURAL AND RELIGIOUS BELIEFS IN HEALTHCARE

SUPPORTING END-OF-LIFE DECISIONS IN ACCORDANCE WITH PATIENT WISHES

Marinating professional boundaries

01

1. ‘You must not pursue a sexual or improper emotional relationship with a current patient.’

02

2. ‘You must not use your professional relationship with a patient to pursue a relationship with someone close to them.’

03

3. ‘You must not end a professional relationship with a patient solely to pursue a personal relationship with them.’

04

4. ‘Personal relationships with former patients may also be inappropriate.’

Can I accept ‘friend’ or ‘follow’ requests from patients on social media?

Material posted onto social media sites, intended for friends, can be accessible to others, including patients.

This means that patients may gain personal information about their doctor and their social life that could have an impact on the doctor-patient relationship and breach professional boundaries.

Doctors are advised, where possible, to try to maintain a professional distance from patients on social media, using appropriate privacy settings to limit access to personal material.

Can I enter a business arrangement or transaction with a patient?

1. There is nothing to prevent doctors from entering into a business arrangement with a patient, where that is completely separate from their clinical relationship, but such arrangements should be approached with caution.
2. It could be perceived as a conflict of interests and whether it could have any impact on the clinical relationship
3. It may be advisable before entering into any such arrangement could put patients under pressure to accept and be seen as the doctor or to seek help or support for their own endeavors.
4. Any such approach doctor to approach a patient about investing in their business enterprise inappropriately using their position to gain personal advantage.
5. This extends to non-financial interests. For example, we have been asked in the past whether it is appropriate for doctors to ask patients to put up posters to support their candidacy in local elections, or to ask patients to sponsor them for a charitable event.

Treating colleagues, friends and family

Can I treat family members and friends? It is not good practice for doctors to treat their family members and friends ?

‘wherever possible, avoid providing medical care to yourself or anyone with whom you have a close personal relationship.’ The BMA therefore advises against prescribing for close friends and family members except in rare circumstances where there is no other reasonable option available; in an emergency, for example, or providing a one-off prescription for antibiotics for a chest infection where there is nobody else available to prescribe.

If you decide to do so, the GMC requires that ‘you must make a clear record at the same time or as soon as possible afterwards;

The record should include your relationship to the patient, where relevant, and the reason it was necessary for you to prescribe.’ Controlled drugs should only ever be provided outside an established clinical relationship where it is necessary to avoid serious harm and no other option is available

Can I give a small gift to my patient or accept gifts from patients?

- Occasionally, doctors are offered gifts by patients or their families who wish to thank them for the care they have provided.

- Small gifts that are culturally appropriate (Chocolate , Plants , Desk frames , Flowers) can be accepted.

- Valuable gifts such as gold and luxury watches should be refused

Trust and mutual respect.

What if a patient asks to record a consultation?

Such requests have been perceived as signalling a lack of trust, or an intention to pursue a complaint, many patients request recording as a form of note taking; particularly if the information is complex, they have cognitive difficulties, or they are distressed or otherwise unable to retain information easily

Doctors should ordinarily encourage patients to make open and contemporaneous recordings to assist them in decision making and selfcare.

Such recordings should, however, be made openly. As with patients, doctors have privacy rights

Covert recording of consultations, as well as any subsequent publication of the recording, or parts of it, in publicly-accessible media, without explicit agreement, is a breach of doctors' privacy rights and may open patients up to legal proceedings

Can I record patients covertly if I have welfare concerns?

The use of covert recording should only be considered where there are no other feasible means to obtain information essential to the investigation or prosecution of a serious crime, or to protect someone from serious harm.

Before you consider making covert recordings, you must discuss this with colleagues, your employing or contracting body, and relevant agencies, except where this would undermine the purpose of the recording, in which case you should seek independent advice. You must follow national or local guidance.

Can I covertly medicate my patients?

covert medication is unacceptable.

It would involve the deliberate deception of a competent patient and clearly breaches the ethical and legal requirement to seek informed consent from capacitous patients for any treatment.

Conscientious objection and personal beliefs

A conscientious objection is when a doctor does not wish to provide, or participate in, a legal and clinically appropriate treatment or procedure because it conflicts with their personal beliefs or values.

There are mainly two areas where there is a statutory right to claim a conscientious objection; these are **abortion** and **fertility treatment.**

Can doctors exercise a right of conscientious objection to patient ‘life-style’ choices?

No. It is not appropriate for doctors to refuse to treat patients whose illnesses are thought to arise from their personal choices, for example, smoking, alcohol, and drugs.

You must treat patients fairly and with respect whatever their life choices and beliefs

You must not refuse or delay treatment because you believe that a patient’s actions or lifestyle have contributed to their condition

Expressing personal beliefs

Can doctors express or discuss their personal beliefs with patients?

You may talk about your own personal beliefs only if a patient asks you directly about them or indicates they would welcome such a discussion. You must not impose your beliefs and values on patients, or cause distress by the inappropriate or insensitive expression of them.’

Care at a distance

Doctors should:

1. Make patient safety the first priority.
2. Understand how to identify vulnerable patients and take appropriate steps to protect them.
3. Tell patients their name, role and (if online) professional registration details, establish a dialogue and make sure the patient understands how the remote consultation is going to work.
4. Explain that:

a. They can only prescribe if it is safe to do so.

b. It’s not safe if they don’t have sufficient information about the patient’s health or if remote care is unsuitable to meet their needs.

c. It may be unsafe if relevant information is not shared with other healthcare providers involved in their care.

d. If they can’t prescribe because it’s unsafe, they will sign post to other services.

Care at a distance

5. Obtain informed consent and follow relevant mental capacity law and codes of practice.

6. Undertake an adequate clinical assessment and access medical records or verify important information by examination or testing where necessary.

7. Give patients information about all the options available to them.

8. Make appropriate arrangements for after care and, unless the patient objects, share all relevant information with colleagues and other health and social care providers involved in their care to support ongoing monitoring and treatment.

9. Keep notes that fully explain and justify the decisions they make

10. Stay up to date with relevant training, support and guidance for providing healthcare in a remote context.'

When is a remote consultation appropriate?

In general, they are most obviously suitable for straightforward requests for treatment from patients with capacity, where a physical examination is not necessary, and when there is access to the patient's notes.

Can patients insist on a face-to-face consultation?

when it is within your power, you should agree with the patient which mode of consultation is most suitable for them.

When might remote consultations and prescribing not be appropriate or additional caution might be required?

The GMC advises that a face-to-face consultation may be more appropriate when a doctor:

1. Is unsure about a patient's capacity to consent to treatment
2. Needs to physically examine the patient
3. Is not the patient's usual doctor or GP and the patient has not given their consent for the sharing of information from the consultation with their regular prescriber
4. Is concerned that the patient is not able to access the consultation safely and confidentiall
5. Is concerned the patient may be unable to make a free and voluntary decision, for example if they are under pressure from others.

Prescribing remotely

Can I prescribe remotely?

Yes. As with any prescription, health professionals take full legal and ethical responsibility for the decision

When prescribing controlled drugs remotely, the GMC advises that doctors must ensure that additional safeguards are in place, including robust patient identity checks, confirmation that the patient has given consent for their regular prescriber to be contacted about the prescription, and that all relevant information is shared with the patient's GP or primary care record.

Can I prescribe to patients who are overseas?

Yes

Although depending on the circumstances, doctors should approach such requests with caution and carefully assess the risks involved.

Doctors will need to consider how the patient will be monitored, differences in a product's licensed name, indications and dosage, and the indemnity and registration requirements that may be necessary to both practice and prescribe in the countries involved.

Doctors are also expected to follow overseas legal requirements as well as relevant guidance on import and export for safe delivery.

DOCTOR'S HEALTH AND HEALTHCARE

Doctors' responsibility:

Your responsibility as a doctor is to ensure that your health does not compromise patient care or safety. This includes:

Managing Health Risks – Being proactive about your own health, including seeking medical advice if you suspect a serious condition that could affect patients.

Following Professional Guidance – Consulting qualified colleagues and adhering to their recommendations regarding necessary adjustments to your practice.

Preventative Measures – Staying up to date with immunizations against serious communicable diseases, unless contraindicated.

Recognizing and Addressing Stress & Burnout – Being aware of the impact of long hours, workload pressures, and emotional strain, and seeking support when needed.

Using Available Resources – Engaging with local and national support services, such as the BMA's well-being service, to maintain both physical and mental well-being.

Taking care of your own health is not just a personal responsibility—it is a professional duty that ensures the highest standard of patient care.

CONCERNS ABOUT COLLEAGUES

CONCERNS ABOUT A COLLEAGUE'S HEALTH: When concerns arise about a colleague's health affecting their ability to practise safely, it is crucial to take appropriate action to protect both patient safety and the colleague's well-being.

Offering support and encouraging the colleague to seek professional help is the preferred approach, as early intervention significantly improves the chances of recovery and rehabilitation.

CONCERNS ABOUT A COLLEAGUE'S CONDUCT OR PERFORMANCE: If you have concerns about a colleague's conduct or performance, you should offer support where possible but must prioritize patient safety. If there is a risk to patients, the GMC advises seeking advice from a trusted colleague, your defence body, or the GMC. If concerns persist, you must report them following workplace policy and GMC guidance, ensuring proper documentation. Raising concerns responsibly helps maintain professional standards and protects patient care.

Patients' Responsibilities and Engagement in Healthcare

These include maintaining their own health and well-being, registering with a GP, respecting staff and fellow patients, and providing accurate health information.

Patients must also adhere to agreed treatment plans, attend appointments, and participate in public health initiatives like vaccinations.

While doctors should encourage adherence to treatment through clear communication and support, they cannot refuse care based on a patient’s lifestyle choices.

Ensuring patients understand their treatment options and addressing any barriers to compliance can lead to better health outcomes and a more efficient healthcare system.

Access to medical reports

Do patients have the right to see medical reports written about them?

The Access to Medical Reports Act 1988 and the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991 grant patients the right to view medical reports written for employment or insurance purposes by their GP or specialist.

Patients can review reports before or after they are sent, dispute factual inaccuracies, and either append their disagreement or withdraw consent for release. Independent medical examiners' reports are excluded, but all registered doctors must follow GMC guidance, offering patients access unless they have opted out, disclosure poses harm, or it would reveal third-party information without consent.

THE DIFFICULT PATIENT

Difficult Patient

- A difficult patient is defined as one with whom the physician has trouble forming an effective working relationship. However, it is more appropriate to refer to difficult problems rather than difficult patients—it is the patients who have the problems while doctors have the difficulties.

- The proportion of consultations that are taken up by difficult patients (also called heartsink or hateful patients) has been measured as being 15%. While in the minority, by their nature they can often take up a disproportionate amount of the doctor’s time, energy and emotional reserves. One difficult patient may disrupt an entire consulting session

The "Heartsink" Patient

- This term describes patients who evoke a feeling of dread or sinking of the heart when a doctor sees their name on the appointment schedule.
- They are also referred to as "difficult," "hateful," or "frequent attenders.“
- While they constitute a minority (approximately 15% of consultations), their impact is disproportionate.

- A single difficult encounter can consume a disproportionate amount of a clinician's time, emotional energy, and cognitive resources, potentially disrupting the entire flow of a clinic session.

- There are several types including

a. The Dependent Clinger

b. The Entitled Demander

c. The Manipulative Help- Rejecter

d. The Self-Destructive Denier

The Dependent Clinger

- Presents with a need for reassurance, affection, and attention. They may become overly attached and dependent on the physician.

Typical Actions:

- Frequent, unplanned visits or phone calls.
- Calling the doctor at home or breaking other professional boundaries.
- Requests endless explanations for minor symptoms.

- **Doctor's Emotional Response**: Feeling threatened, smothered, or drained.
- Underlying Driver: Often a profound fear of abandonment and insecurity.

Management Strategy:

- Provide empathy and validation to build trust.
- Establish and consistently enforce clear boundaries (e.g., "I can see you for 15 minutes every two weeks").
- Avoid fostering further dependency; the goal is supportive autonomy.

The Entitled Demander

Core Behavior: Uses intimidation, guilt, and threats to control the clinical encounter. Projects an air of superiority and entitlement.

Typical Actions:

- Demands specific tests, treatments, or immediate attention.
- Withholds payment.
- Frequently uses complaints or threats
- Doctor's Emotional Response: Fear, anger, resentment, and despair.

Underlying Driver: Often a deep-seated insecurity and fear of losing control. The bluster is a defense mechanism.

Management Strategy:

- Remain calm, respectful, and non-confrontational.
- Use your professional authority clearly and confidently.
- Politely but firmly state when a boundary is being crossed (e.g., "I understand you're upset, but I cannot have a productive conversation if you raise your voice.").

The Manipulative Help-Rejecter

Core Behavior: Appears to seek help but consistently rejects all medical advice and suggestions, ensuring that their problems are never resolved.

Typical Actions:

- Presents with chronic, vague symptoms (e.g., chronic pain, persistent fatigue).
- Engages in substance abuse or clear non-compliance.
- Every proposed solution is met with a "Yes, but..." response.

- **Doctor's Emotional Response**: Frustration, demoralization, and a sense of incompetence.
- **Underlying Driver**: The patient may crave the ongoing *relationship* with the caregiver more than a cure.
- Getting better would end the connection.

Management Strategy:

- Reflect on your own expectations—giving up the need to "cure" them is often the first step.
- Focus on maintaining the relationship without the pressure of solving the unsolvable.
- Acknowledge the difficulty of their situation without endorsing ineffective treatments.

The Self-Destructive Denier

Core Behavior: Engages in overtly harmful behaviors (e.g., continued heavy drinking with cirrhosis) and appears indifferent to their own well-being.

Typical Actions:

- Actively continues lifestyle choices that worsen their condition.
- Denies the severity of their illness or the consequences of their actions.

- **Doctor's Emotional Response**: Feelings of indifference, hatred, or helplessness because the patient seems to refuse help.

- **Underlying Driver**: Often profound self-loathing, depression, or a sense of hopelessness.

Management Strategy:

- An empathic, non-judgmental approach is crucial but can be emotionally draining.
- Avoid power struggles over their behavior.
- Focus on small, achievable goals and consistently convey that they are worthy of care, regardless of their actions.

How to Deal with those Patients

The Critical First Step: Rule Out Organic & Psychiatric illness

- A Vital Caution: What presents as "difficult" behavior may be a symptom of an undiagnosed condition.
- Do not misattribute symptoms to personality alone. A "difficult" patient can still have a serious organic disease.
- Common Masqueraders: Always consider and screen for:

Generalized Anxiety Disorder

Major Depression

Panic Disorder

Dysthymia (Persistent Depressive Disorder)

Drug or Alcohol Dependency

Somatic Symptom Disorder

- Our Duty: Continue to practice traditional, high-quality medicine: update databases, perform appropriate physical exams, and investigate new symptoms discriminately.

General Management

- **Shift Your Goal**: Give up trying to "cure" them. Accept that the goal is often management and support, not resolution.
- **Reframe Symptoms**: View their complaints as an expression of their underlying distress or neurosis, rather than a purely biomedical puzzle to be solved.
- **Structure the Relationship**:
- Implement scheduled, time-limited appointments (e.g., "Let's meet for 20 minutes on the first Tuesday of each month").
- This contains the problem and provides predictability for both parties.

Redirect the Conversation:

- Show genuine interest in *them* as a person—their life, work, hobbies.
- Become politely less engaged with their repetitive list of physical complaints.
- Be Honest and Trustworthy: Admit when you don't have an answer. Avoid placebo therapies or misleading labels.
- Set Clear Limits: Be polite yet assertive about the boundaries of your time and role.
- The Consultation is the Therapy: Often, the act of listening and bearing witness is the most therapeutic intervention. A prescription is not always needed.
- Have Limited Objectives: Small, realistic steps are victories. Zealous attempts to fix everything will lead to burnout.
- Do Not Abandon the Patient: Despite the challenges, continuity of care is critical. If you are not the right person to provide counseling, refer while maintaining medical oversight.

The "Heartsink" Survival Kit: A 3-Stage Model

Stage 1: Feeling Understood

- Conduct a full history of symptoms.
- Actively explore psychosocial cues and the patient's health beliefs.
- Perform a brief, focused physical examination to show you take their concerns seriously.

Stage 2: Broadening the Agenda

- Gently introduce emotional and life factors into the conversation.
- Reframe their symptoms to help them see the link between physical complaints and stress, anxiety, or life events (e.g., "It's very common for stress to manifest as severe back pain.").

Stage 3: Making the Link

- Use simple patient education to explain how emotions can cause or exacerbate physical symptoms.
- Use examples of other sufferers to help them feel less alone and to normalize their experience.

The Angry Patient

- Anger in patients and their relatives is a common reaction in the emotive area of sickness and healing.
- The anger, which may be concealed or overt, might be a combination of fear and insecurity.
- It is important to bear in mind that many apparently calm patients may be harbouring controlled anger.
- The practice of our healing art is highly emotive and can provoke feelings of frustration and anger in our patients, their friends and their relatives.

- Anger is a normal and powerful emotion, common to every human being, yet with an enormous variety of expression. The many circumstances in medicine that provoke feelings of anger include:
- Disappointment at unmet expectations crisis situations, including grief any illness, especially an unexpected one the development of a fatal illness iatrogenic illness chronic illness, such as asthma.
- Financial transactions, such as high cost for services referral to colleagues, which is often perceived as failure, poor service, such as long waits for an appointment problems with medical certificates, poor response to treatment, inappropriate doctor behaviour (e.g. superiority)

Consulting strategies

- When one feels attacked unfairly, to react with anger is a natural human response. This response, however, must be avoided since it will damage the doctor–patient relationship and possibly aggravate the problem.
- The initial response should be to remain calm, keep still and establish eye contact. ‘Step back’ from the emotionally charged situation and try to analyze what is happening.
- Ask the patient to sit down and try to adopt a similar position (the mirroring strategy) without any aggressive pose.
- Address the patient (or relative) by the appropriate name, be it Mr or Mrs Jones or a first name.
- Appear calm, comfortable and controlled

- Be interested and concerned about the patient and the problem. Use clear, firm, non-emotive language.
- Listen intently.
- Allow patients to ventilate their feelings and help to relieve their burdens.
- Allow patients to ‘be themselves’.
- Give appropriate reassurance
- Avoid a judgmental approach
- Allow time (at least 20 minutes).
- For the threatening aggressive patient, sit closest to the door to allow escape should the patient turn violent.

- Analyzing the responses: Search for any ‘hidden agenda’. Recognize the relationship between anger and fear.
- Recognizing distress signals: It is important to recognize signs of deteriorating emotional distress
- body language (demonstrative agitated movements or closing in) speech (either becoming quiet or more rapid and louder) colour (either becoming flushed or pale) facial expression (as above, tense, tightening of muscles of eye and mouth, loss of eye contact) manner(impatient, threatening

Strategies

- **Rapport building**: ‘I can appreciate how you feel.’ ‘It concerns me that you feel so strongly about this.’ ‘Tell me how I can make it easier for you

- **Confrontation**: ‘You seem very angry.’ ‘It’s unlike you to be like this.’ ‘I get the feeling that you are upset with . . .’ ‘What is it that’s upsetting you?’ ‘What really makes you feel this way?

- **Facilitation, clarification**: ‘I find it puzzling that you are angry with me.’ ‘So you feel that . . .’ ‘You seem to be telling me . . .’ ‘If I understand you correctly . . .’ ‘Tell me more about this . . .’ ‘I would like you to enlarge on this point—it seems important

- **Searching**: ‘Do you have any special concerns about your health?’ ‘Tell me about things at home.’ ‘How are things at work?’ ‘How are you sleeping?’

Angry Patient Management

- When confronted with an angry patient, the practitioner should be prepared to remain calm, interested and concerned. It is important to listen intently and allow time for the patient to ventilate his or her feelings.

- A skillful consultation should provide both doctor and patient with insight into the cause of the anger and result in a contract in which both parties agree to work in a therapeutic relationship.

Consulting "Dos"	DO: Remain calm, make eye contact, and use a neutral tone.
	DO: Listen intently and allow them to ventilate their feelings without interruption.
	DO: Acknowledge their emotion: "I can see you are very angry about this."
	DO: Search for the hidden agenda: "What is the main thing that is upsetting you today?"
	DO: Ensure your own safety (e.g., sit near the door).
Consulting "Don'ts"	DON'T: Meet anger with anger.
	DON'T: Touch the patient unexpectedly.
	DON'T: Be a "wimp" and give in to unreasonable demands.
	DON'T: Be judgmental or patronizing.
	DON'T: Reject the patient.

Conclusion

- Managing "heartsink" patients is one of the most challenging aspects of clinical practice.
- The key is to manage your own reactions and expectations first.
- By understanding the underlying archetypes, ruling out medical causes, and employing structured communication strategies, we can transform draining encounters into professionally manageable, and even rewarding, relationships.
- Final Message: Your professional responsibility is not to cure every patient, but to provide compassionate and boundaried care to all.

THANK YOU