WHEN PATIENT AND CLINICIAN DON'T SEE EYE TO EYE

There may come a time in the clinician-patient relationship when it becomes more or less apparent that "something's wrong." How "that something" gets defined often determines the course of the subsequent relationship and the ultimate outcome of care. It is therefore worthwhile to examine "that something" more closely. From the physician's point of view, it usually gets defined as something about the patient. For example, the clinician may begin to suspect the patient isn't as sick as they present, or that emotional issues are playing a central role, that the patient may be malingering, or that no detectable disease is apparent. From the patient's point of view, it may be something about the clinician: s/he doesn't care about them, isn't interested in them, and doesn't know what's going on with them.

Our formulation? The bouncing ball of medical uncertainty is getting juggled across the clinician-patient relationship.

In the clinician-patient relationship, both parties have a natural desire to turn uncertainty into certainty. Both are motivated to know what is wrong, because both believe that by knowing what is wrong, they will know what to do. Generally, most people have a low tolerance for ambiguity and uncertainty because it tends to generate anxiety. This is especially true in health care because the stakes are so high for the patient: health versus illness, life versus death. The stakes can also be high for the clinician; for example, professional competence and trust in his/her judgment. Uncertainty in this situation therefore creates powerful urges to reduce it. There are numerous ways to make anxiety go away. One of the quickest and easiest ways is to reduce the other party to a label: e.g. quack or crock, uncaring or difficult.

Several factors place the burden squarely on the clinician to resist this temptation:

- Obviously, the patient is the only one with something essential at stake, his or her health.
- The clinician has more experience with uncertainty than the patient does.
- The clinician is responsible and bound by ethical and legal codes to place patient welfare first.

Most of the time the clinician can and must successfully tolerate the uncertainty and anxiety and act in the best interest of the patient. When it doesn't go well, however, the clinician and patient may have entered into a win-lose struggle over legitimate medical uncertainty. The clinician may not acknowledge uncertainty and instead try to convince the patient of something the patient rejects (e.g., there is nothing wrong, you do or don't have disease X.). The clinician may try to convince the patient to tolerate an uncertainty, which the patient finds unacceptable (e.g., there is nothing that can be done, the clinician doesn't know what's wrong). Under these and other circumstances, a clinician-patient "contest" may evolve. In this contest, the patient tries to "prove" his/her perspective (e.g., there is truly something wrong, the clinician doesn't understand, is uncaring, or is incompetent). The physician may take similar steps to discredit the patient, the patient's complaints, or the patient's symptoms.

The struggle that develops between the patient and the clinician is sometimes subtle and out of either party's awareness. The clinician may discredit the patient using labels like malingering, somatizing, hypochondriacal, or hysterical. The clinician may refuse appointments, become brusque in the interview, or refer the patient to a psychiatrist without reasonable explanation. On the other hand, the patient may become insistent,

demand additional tests the clinician deems unnecessary, show up for visits unexpectedly, challenge the clinician's diagnosis, or file complaints. The relationship deteriorates to the point of mutual alienation, distrust, rejection, frustration, and distress.

As we portray, there is certainly two sides to this conflict. However, *it is virtually always incumbent on the physician to craft an acceptable solution*. It is the physician's responsibility to find a way to avoid a destructive win-lose struggle and meet the patient's need for care.

There are some general things the physician can do to help find a win-win solution:

1. SUBORDINATE the need to be "right" to the obligation to alleviate suffering. Remember, the patient is there because they need help. This clinical mess would not exist if the patient was not ill or didn't need help.
2. LISTEN to the patient. The patient tells you what he or she needs if you listen carefully. Even if you cannot cure what ails them, the willingness to lend an ear to their suffering will provide comfort AND win them over.
3. CONFIRM what you hear. Listen for confirmation or correction.
4. OFFER a potentially useful strategy. Then ask them what they think or feel about the strategy (Prepare for rejection…Celebrate acceptance).
5. NEGOTIATE clinician-patient differences and/or treatment objectives in good faith.
6. REMEMBER that the patient is the one who is ill. The patient is responsible for change or lack of it and is ultimately free to accept or reject your help. They pay for this privilege in the currency of personal suffering. Your task is to frame your assistance in terms they can understand and accept.