

Introduction

In 1998, a shy, athletic, twelve-year-old girl with long brown hair and wirerimmed glasses was diagnosed with acute lymphoblastic leukemia. Her subsequent struggle to swallow life-saving medication set in motion a series of events that resulted in this book. Bridget's inability to take her medicine mobilized a small army of caregivers, all with the same primary goal. Her parents, nurses, doctors, a psychologist, and even the woman who cleaned her hospital room, all tried to coax, reward, threaten, and even beg her to take the drugs. Everyone had a theory that was sure to work. They were all wrong.

What was clear during that several-week struggle was that, while everyone agreed on the desired outcome, no one agreed on how to get there. When the traditional methods failed—methods such as crushing the pills into chocolate pudding, or rewarding her for taking the pills—there was no Plan B. As Bridget continued unsuccessfully to try to take her medicines, her parents and caregivers were rendered utterly helpless.

The failed attempts to help Bridget are one example of the sort of impasse that can develop between doctors and patients. Doctors want to help their patients, and they utilize all of their knowledge, skills, and experience to this end. Patients, in turn, want to be helped by their doctors. They seek out medical expertise for the purpose of diagnosing and hopefully resolving medical problems. In most cases, the system of patients seeking aid and advice from doctors and doctors providing this assistance works smoothly. Where possible, medical issues are resolved in a satisfactory manner. Sometimes, however, as with the case of Bridget, things do not flow so smoothly. Despite the best efforts of both patient and doctor, sometimes bumps occur in the process that can make it hard to navigate, or even hard to understand. After all, why would an ill young girl struggle so mightily to take her medication? And yet struggle she did.

Sometimes the impasses doctors face are about small issues; other times they relate to problems that are truly about life and death. And often, when doctors come to these impasses, they get stuck, as did Bridget's caretakers. After using all of their resources to no effect, they didn't know where to turn next. In Bridget's case, her psychologist, Dr. George Blackall, realized that he was outmatched by a twelve-year-old. Desperate, he called a friend and colleague, Dr. Steve Simms, for help. Steve, a psychologist who had been studying systems interventions for families in trouble with master family therapist John Brendler, suggested a framework to understand, approach, and ultimately resolve the impasse between Bridget and her caregivers. It is the framework that he suggested that has led to this book.

The framework Steve recommended is called the "Symptomatic Cycle," and in the ten years since that hot, frustrating summer, George and Steve have worked together to expand this approach used in family therapy for use in doctor/patient relationships. This work led to the development of the Physician-as-Collaborator Model, which we rely on to resolve impasses between doctors and patients. In 2000, Dr. Michael Green joined us, adding his perspective as a practicing internist and medical ethicist. Since then, we have

successfully used the Symptomatic Cycle framework and the Physician-as-Collaborator Model thousands of times to help understand and resolve a wide variety of problems in doctor/patient relationships. This approach has become our Plan A, essentially eliminating the need for a Plan B.

In this book, we will demonstrate how to successfully use the Physician-as-Collaborator Model to resolve doctor/patient impasses. We will begin by illustrating the underlying structure of the doctor/patient relationship. By showing how this relationship works, we hope to demonstrate how impasses arise and then how to navigate and resolve them. On the pages ahead you will meet doctors and patients who are stuck in a variety of impasses. You will see how the physicians struggle with their patients and, ultimately, how they use our models to overcome their frustrations and resolve their impasses.

While the sources of frustration faced by physicians in daily practice are numerous (insurance companies, paperwork, malpractice worries, regulations, etc.), our focus is on the relationships with patients that have reached an impasse. Our aim is to help doctors successfully navigate difficult patient encounters that can evolve into cycles of conflict and struggles for control. By using a therapeutic process based on "systems principles" from family therapy, we will present models that focus on three main areas: 1) seeing/recognizing, 2) understanding, and 3) responding to difficult relationships in clinical medicine. This is not a book that will tell you how to "get the patient to change." In fact, we will do just the opposite. The focus will be on how changes in the physician's thinking can help improve challenging interactions with patients and their families.

For example, imagine receiving a telephone call one busy afternoon from Deborah Rowland. Her husband Al is a long-standing patient of yours and he has a drinking problem. Deborah has called numerous times in the past, and as with prior calls, today she pleads with you to "do something" to help her husband stop drinking. As the conversation progresses, Deborah becomes increasingly agitated and angry. As a physician, you can interpret her anger in several ways. One way is to view Deborah's behavior as rude and disrespectful. If that view dominates your thinking, the natural response will be to become tense and try to control or pull away from her. An alternative way to view her behavior is as the frightened and desperate response of a woman who feels powerless to help her husband. If you have this understanding, you will be more likely to respond in an open and nurturing manner. While Deborah's behavior is the same in both scenarios, your response to her behavior is quite different.

Even when physicians try hard to respond to patients in thoughtful ways, impasses with patients and families inevitably occur. We bring the collective experience of an internist, a health psychologist, and a family therapist to help resolve these impasses. In our combined experiences working at a variety of academic medical centers, we have been impressed by the interpersonal skills that physicians harness to help their patients and their families. Despite witnessing the stresses of pain, suffering, and even death, the vast majority of physicians are humane and compassionate with their patients. They are smart, motivated, and caring people who do their best to help. Yet, even when physicians have motivation and compassion, problems still occur. There are times when these situations escalate, and ruptures develop in relationships. As emotions flare, physicians

feel isolated and ineffective, leaving them wondering: "How did these problems develop? What can I do to prevent them?" We will present two models that will help answer those questions.

The first model is the traditional model of the doctor-patient relationship. We call it the "Physician-as-Expert Model," and it is described in detail in Chapter 1. In this model, the doctor listens, diagnoses, and prescribes with the intent of helping the patient feel better. The patient, hoping to feel better, follows the doctor's recommendation. This model generally works well and is the most common way that doctors interact with patients. But sometimes the Physician-as-Expert Model gets derailed by a stalemate that develops between the patient and the physician. When these impasses persist, they lead to repeating patterns of frustration and counterproductive behaviors.

In Chapter 2 we introduce the "Symptomatic Cycle" as a framework to help physicians see and overcome the forces that perpetuate frustrating impasses. We use this framework as a map to guide physicians as they develop strategies for resolving difficult encounters in their daily practice. This framework also serves as the bridge between the Physician-as-Expert Model and our second model, The Physician-as-Collaborator.

In Chapter 3 we describe the Physician-as-Collaborator Model, which views the patient and physician as partners in the process of trying to achieve the patient's health goals. Each partner brings expertise to the relationship, and this Model demonstrates how to best use that expertise to help the patient. This is where we help a physician determine a course of action by describing specific principles that can be applied with patients and their families.

In Chapter 4, we present some basic guidelines for effectively communicating with patients and their families that, if used, will improve your clinical skills and help to prevent many impasses. Yet even when a physician has strong communication skills, impasses can still occur.

In Chapters 5 through 10 we apply the models and principles to difficult cases to bring it all together in a way that busy practitioners can use in daily practice. For example, in Chapters 5 and 6 we introduce two patients who are each driving their physicians to their wits end. Both patients have chronic medical problems, and their physicians are frustrated by the increasing demands being placed upon them. Chapter 7 addresses the problem of chronic pain in a pediatric patient, while Chapter 8 illustrates how to use our models in a crisis in the intensive care unit. Chapter 9 deals with a thorny ethical issue around a patient's wish to die, and Chapter 10 demonstrates how to successfully apply the models to a patient with multiple medical complaints driven by considerable psychological factors.

All of these cases have practical and generalizable aspects that can be applied to a range of different cases, not just the ones presented in the chapters. When we teach medical students how to handle difficult encounters with patients and families, they often say: "Teaching us about communication is nice. Learning about theories of human behavior is fine, too. But what we really need to know is, how do we use these theories in our daily work with patients?" The way we help medical students is the same way we

will help you. We use clinical case examples to illustrate how impasses develop and how our models can be used to understand and resolve the gridlock. The cases are drawn from our experiences and combine actual with fictitious patient encounters. Some cases have been adapted from interviews with physician colleagues who generously shared their experiences with us. Others are our own, with personal details altered to protect the privacy of patients and caregivers. Our goal is to provide physicians with a clear, practical, and engaging book that will offer a new understanding and set of skills to respond to and help patients.

Whether the challenge arises in a routine office visit or the ICU, whether it is pediatrics or geriatrics, the tools we present in this book will enable physicians to overcome challenges and bring greater insight and skills to their practice of medicine.