Challenges in the doctor–patient relationship: 12 tips for more effective peer group discussion

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ABSTRACT

In New Zealand, almost all general practitioners are members of peer groups, which provide opportunities for both clinical discussion and collegial support. This article proposes that peer groups can also be a useful medium for exploring specific challenges within the doctor–patient relationship. However, the peer group culture needs to be receptive to this particular goal. Structured discussion can help peer group members explore interpersonal issues more thoroughly.

KEYWORDS: Balint group; continuing medical education; general practitioners; peer group; physician-patient relationship

Introduction

Two of the main tasks in clinical practice are being medically proficient (making the right diagnosis and offering the best treatment), and being interpersonally proficient (interacting well with different patients and thoughtfully responding to more challenging situations). Doctors need up-to-date technical and biomedical information to fulfill the first task well; they also need considerable professional flexibility if they are to work effectively with the usual range of personalities in clinical practice.

However, there are relatively few methods for thinking about and reviewing those more troublesome situations, where certain patients are perceived as 'annoying,' 'worrying,' 'has nothing wrong with them,' 'heart-sinking' and so on. These labels are clues to unwanted feelings and responses to the patient such as annoyance, embarrassment, confusion, anxiety, emotional distress, frustration, and even anger. Mostly, these clinical incidents are openly acknowledged as being challenging or difficult. At other times, a hint to the underlying affect is a subtle change in one's normal clinical behaviour, either using a different style of communication or not providing one's usual treatment. Seeing a particular name in the appointment book can sometimes generate a negative feeling or 'heart-sink' sensation.[1,2]

In New Zealand, most general practitioners (GPs) belong to peer groups, meeting regularly to improve clinical expertise.[3] Compared to Balint groups[4] that focus solely on the doctor–patient relationship, peer groups have a wider brief. Latest medical information can be reviewed; members drive the choice of topics, including clinical audit; experienced GPs can guide and mentor those new to community-based practice; there is a sense of shared purpose.[5] Usually, both biomedical and interpersonal issues are discussed at length, although some peer groups tend to focus more on biomedical content. This article provides some general tips for peer groups that would like to explore challenges within the doctor–patient relationship, the goal being more interpersonal flexibility in these difficult situations.

12 tips for more effective discussion

Tip 1: Discuss whether the clinical situation raises predominantly biomedical questions, interpersonal challenges, or both

It is useful for the peer group to differentiate between strictly biomedical issues and the more relationship or interactional ones, noting that often, both will be present. The example below is drawn from several clinical stories and modified to preserve patient confidentiality.

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> The patient, Bernard, is a 45-year-old man with paraplegia. His wife, Ursula, rings and asks his GP, Helen, for a home visit, as he is complaining of feeling generally unwell. Helen visits, diagnoses a urinary tract infection and provides oral antibiotics. Bernard is subsequently admitted to hospital overnight with sepsis. In her next peer group meeting, Helen wonders if she handled this clinical situation correctly, given a similar previous admission. She hints at challenges in negotiating the patient's medical care with his wife, who is also her patient.

Biomedical discussion might relate to diagnostic difficulties in a patient with paraplegia, the most effective oral antibiotic, and indications for referral to hospital. However, a clue to affect and relationship issues was the GP's acknowledgement that she found this patient 'demanding'. Any small clue to feelings arising from patient or doctor is an indication that there will be important relationship issues present, noting that they will not be resolved by discussing biomedical questions alone.

Tip 2: Explore possible feelings within each clinical situation

The clinical story above provides useful prompts about underlying feelings, both in the patient and in the doctor. One aim of peer discussion is to identify these feelings more accurately.

> The GP, Helen, has been Bernard's doctor for two years. Helen has always felt somewhat excluded, as Bernard is quite independent, self-managing his paraplegia-related issues. Past history for Bernard includes a cholecystectomy complicated by wound abscess and an admission to hospital a year ago with pyelonephritis, when he was also diagnosed with Type 2 diabetes.
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> During this home visit, Bernard had stated that he hated being in hospital. Helen had concerns about a possible ascending infection, but felt these were overridden by Bernard and his wife. Helen now feels disappointment and irritation that she hadn't followed her own instincts.

Exploring these personal disclosures further, however, can only occur if the 'culture' of the peer group is supportive for this GP and is open to engaging in discussion about non-biomedical factors.

Tip 3: Be aware of values within your peer group

The values and culture of general practice are quite different to the predominant training culture of medicine, which includes elements of hierarchy, competitiveness, and unhealthy perfectionism.[6] In order to create a safe learning environment, it is important that peer groups are nurturing and supportive. Members need to be honest about challenges to their composure, acknowledging the usual 'roller-coaster' of thoughts and feelings within day-to-day clinical life.

General practice utilises relationship skills to provide longitudinal care for enrolled patients, including taking into account their family and social contexts.[7] Peer groups are an opportunity to embody a 'whole-person' orientation, not only in their approach to patient discussion, but also towards each of the other GPs within the peer group. Over time, the values of respect, positive regard and active listening can be powerfully supportive, providing a sense of inclusion to general practice and to the medical profession more generally.

Tip 4: Include the personal and social context in case discussion

Such complex clinical scenarios usually involve a significant 'back story' that emerges as GPs get to know a patient and their family.[8] In relation to the example presented earlier, the GP, Helen, revealed that the patient had had great faith in his previous GP who had become a family friend. After that GP's sudden retirement, his patients were allocated to other members of the practice. There was no formal handover of each patient's care to Helen as the new doctor, something that Bernard had resented. Helen expressed the feeling that she had never quite 'matched up' to the patient's expectations. Often, there is also a 'significant other' person in the background.

> Helen revealed she had struggled to get alongside Ursula, the patient's wife, especially now that Bernard had developed diabetes. In a recent consul-

tation, Helen had asked Ursula about her cooking. Since then, Ursula had become quite defensive, seeming to respond as if she felt her cooking was somehow responsible for her husband's diabetes, and as if Helen was blaming her for its onset.

Tip 5: Use past experience of similar situations

These social factors can be quite challenging for the clinician. As family carers are often crucial to ongoing care, they are often engaged in clinical decisions. The peer group could discuss how to negotiate these three-way conversations between doctor, patient, and family carer, being a common interpersonal challenge within family practice.

Tip 6: Encourage diversity of opinions and ideas about the main players

It is reasonably common in peer discussions to refer to the patient or their partner in somewhat judgmental terms such as 'controlling', 'abusive', 'manipulative' and so on. These black/white adjectives, however, belie the complexity of personalities and relationships and may indicate how clinical frustration can interfere with curiosity about the patient-as-person.

In Balint groups, for example, participants are encouraged to come up with other ideas about the patient, to wonder about less obvious possibilities or about other potential back stories.[9] These offers to the group (not strictly accurate to the 'real' story) are called 'speculations': creative ideas that pick up on subtle hints within the case presentation. Their purpose is to encourage imagination and more diverse thinking about the patient, as often the doctor feels 'stuck' about what to do.[10]

Returning to the distinction between biomedical and relationship issues, it is often possible to find specific data that define a patient's condition (haemoglobin, HbA1c, ECG, and so on). Such quantifiable precision is not so achievable, however, in discussion about feelings, where the patient's and the doctor's behaviour can be driven by both conscious and unconscious factors. Exploring such feelings and behaviours is intended to increase participants' intuition and capacity for lateral ideas and wider perspectives, to provide more perception and understanding of patient-as-person and to increase insight into how doctors are responding themselves to the patient. Furthermore, the peer group's gentle exploration of feelings commonly provides the doctor with a sense of being personally heard and supported (a welcome, but somewhat uncommon experience in medical practice).

It cannot be stated too strongly that this style of discussion is in contrast to the usual biomedical search for a unifying diagnosis: in discussing relationships, there is no single 'correct' answer or ultimate truth.

Tip 7: Don't try and 'fix' challenges within the doctor–patient relationship

Relationship issues are complex. If there had been a simple solution, the doctor would not be presenting this patient. Sharing ideas about possible diagnostic puzzles is useful in peer groups, but giving the doctor well-meaning advice about clinical relationships is often unhelpful. Instead, wide-ranging peer group discussion can act as a smorgasbord of possibilities that the doctor can consider over time. The doctor's subsequent clinical behaviour can change after perceptive discussion, sometimes in unexpected ways.

A few days later, Helen surprised her patient Bernard by visiting him in hospital; he seemed quite appreciative. Bernard told Helen about his work in disability education, where he runs awareness workshops. Helen gained a new appreciation of Bernard and his medical difficulties, resolving to learn more about barriers to effective patient care faced by those with disability.

Tip 8: The goal of peer group work is 'practical wisdom' rather than textbook knowledge

As Lillis stated, 'peer groups work on the basis of internally driven contemporaneous learning needs, based on difficult work experiences.'[5] That is, specific clinical challenges provide stimuli for peer group discussion, aimed not necessarily at better theoretical knowledge, but at practical wisdom for medical practice. It is well known that there may be little correlation between the

outcomes of randomised trials and the clinical care of individual patients in the community. If relationship-based problems are added, then peer groups have an important role in exploring and validating the complex tasks of the modern GP.

Tip 9: Protect your time together and value it

Most GPs value their peer group, being protected time to focus less on the patient perhaps, and more on how each doctor is doing within their own career path. It is useful to discuss 'ground rules', including confidentiality, as these are helpful reference points if the work becomes unproductive or there is peer group tension. Peer groups usually vary the format, tasks and content of group meetings in order to keep everyone engaged and enthusiastic. A sense of humour is required, given the often serious nature of medical work. Whether discussing biomedical or relationship issues, a well-defined structure to the peer group (with respect to attendance and time management) helps achieve both educational and supportive goals, such as validation and inclusion.

Tip 10: Give updates on what happened

Discussion of follow-up stories contributes to a more nuanced understanding of the 'narrative' nature of clinical practice,[11] including the ongoing issues with a 'difficult' patient.[12]

> Later, Helen talked further with Bernard about his previous GP, asking what he wanted in his 'ideal' doctor. However, Helen was yet to 'make peace' with Bernard's wife Ursula, who remained rather frosty and distant.

Tip 11: Talk about the 'tougher' issues

A marker perhaps of peer group culture is whether participants can share experiences of the more challenging issues in modern practice: receiving a complaint, making a clinical mistake, having 'fights' with colleagues or other staff, and so on. Given how stressful these situations can be,[13] it is helpful to share such difficulties in a safe and impartial space, especially as GPs may have few other opportunities to do so. Attending carefully to the peer group's boundaries and structure can enable a sufficiently supportive forum for these more difficult discussions.

Tip 12: Reflect regularly

After presenting a challenging case, it may be useful for presenters to make notes, returning to them before the next consultation. Some peer groups keep a confidential record of peer group work, providing insights into how the content and process of the peer group are changing over time.

Summary

Medical students and registrars are now taught consulting and communication skills. Arguably, however, this training still falls short of more explicit coaching about the interpersonal skills required for modern practice in family medicine. This article introduces the idea that peer groups can legitimately and usefully focus on the doctor–patient relationship. However, this focus requires a clear understanding of how it differs from more common biomedical topics. Further articles could usefully explore the subskills of doctor–patient relationships and how peer groups might make the transition to more effective discussion.

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COMPETING INTERESTS
None declared.