Challenges in Consultations with Difficult Patients

"The most important person is always the one who is standing in front of you."

Dr Plamen Latev, PhD, Department of General Medicine, Medical University – Pleven, 2026

The doctor meets a person who brings symptoms, fears, expectations, previous experiences, family pressures, social circumstances, and a particular way of speaking about illness. This is why some consultations become challenging, even when the biomedical problem itself seems simple.

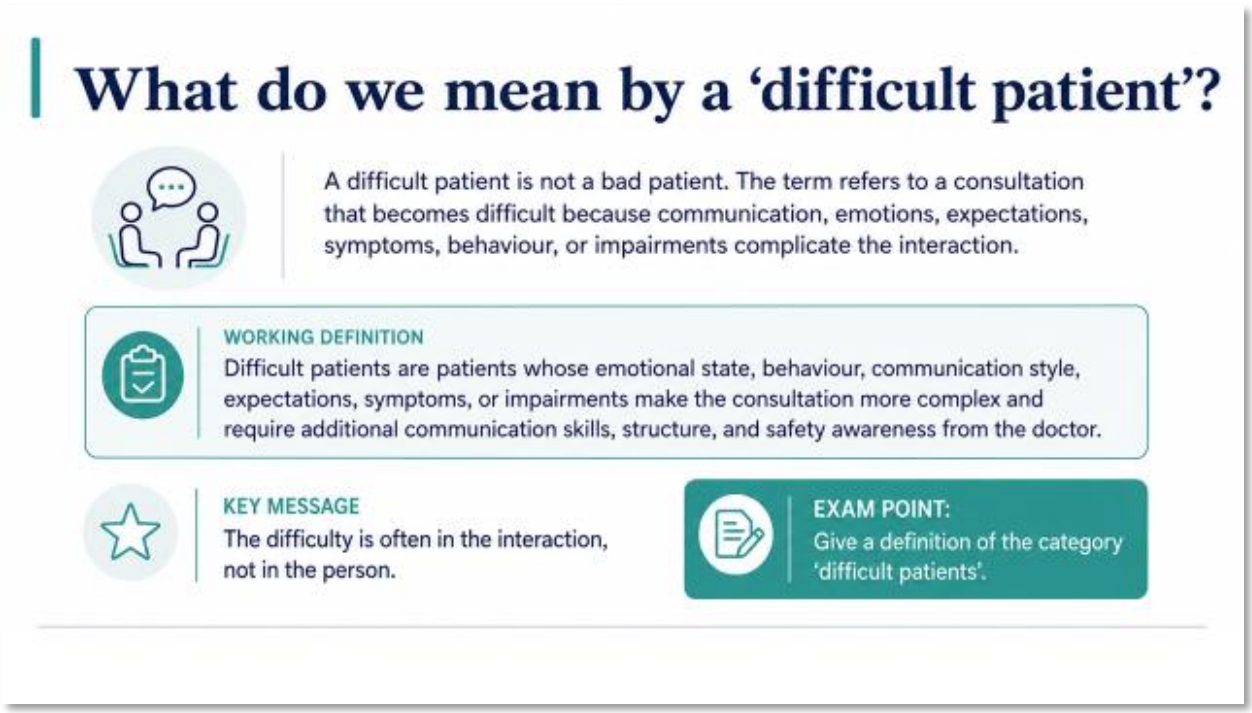
The aim of this session is not to teach you to label patients negatively. Rather, it is to help future doctors recognise what makes communication difficult and how to respond with calmness, structure, empathy and safety awareness. A difficult consultation is not a battle to be won. It is a clinical relationship that needs to be understood and guided.

Learning objectives

By the end of this session, students should be able to recognise the main types of challenging consultations in general practice and choose respectful, safe, and effective ways of communicating with patients.

- define the term "difficult patient" without blaming the patient;
- recognise surface and deep resistance during the consultation;
- explain why a patient may become uncommunicative;
- communicate with anxious, aggressive, and depressed patients;
- adapt communication for patients with speech and/or hearing difficulties;
- understand the basic approach to somatising patients and frequent attenders;
- use simple phrases that reduce tension and preserve the relationship.

These topics are also useful for exam preparation, but they should not be studied as isolated rules. They are part of a wider professional attitude. The GP remains clinically careful, emotionally steady, and humanly present, even when the patient is hard to reach.



I. What do we mean by a "difficult patient"?

Typical clinical situation:

A patient comes to the surgery with a simple medical complaint, for example back pain or headache, but the consultation quickly becomes difficult. The patient interrupts, rejects every suggestion, says that "nobody ever helps", and insists on another referral. At first, the doctor may feel irritated or personally challenged.

A useful first step is not to label the patient as difficult, but to ask internally:

"What is making this consultation difficult at this moment?"

The difficulty may be fear, previous disappointment, lack of trust, unrealistic expectations, or the patient's feeling that they have not been heard. When the GP changes the question from "What is wrong with this patient?" to "What is happening in this interaction?", the consultation becomes easier to guide.

The term "difficult patient" must be used with caution. It should never mean "a bad patient", "an annoying patient", or "a patient I do not like". In professional language, it is better to understand a difficult patient as a patient with whom the usual flow of the consultation has become blocked.

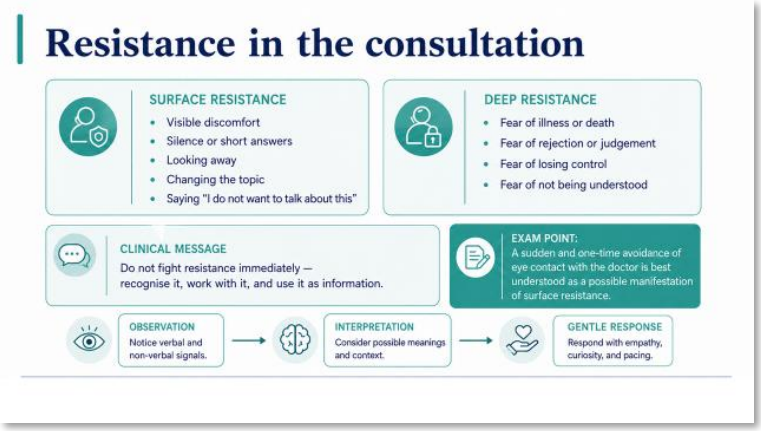
The difficulty may take the form of silence, fear, suspiciousness, anger, excessive dependence, repeated unexplained symptoms, communication impairment, or a mismatch of expectations. Sometimes the patient is not difficult as a person; rather, the consultation becomes difficult because the doctor and the patient cannot yet find a shared way of understanding the problem.

A useful working definition is this: **patients described as difficult are patients whose emotional state, behaviour, communication style, expectations, symptoms, or impairments make the consultation more complex and require the doctor to use additional communication skills, structure, and safety awareness.**

This definition protects the doctor from two common mistakes. The first is blaming the patient too quickly. The second is forgetting that the doctor's own fatigue, irritation, fear, or lack of time may also make the consultation more difficult. The better question is not, "Why is this patient difficult?", but "What is making communication difficult at this moment?"

The GP's task is to understand the obstacle and decide what is needed next: more time, clearer structure, a different communication channel, a safety assessment, firmer boundaries, or help from another professional.

EXAM POINT: Give a definition of the category "difficult patients".



II. Resistance in the consultation

Typical clinical situation:

A patient comes for abdominal pain. When the GP asks about stress at work or problems at home, the patient suddenly looks away and says:

"I do not think this has anything to do with that."

The doctor notices the change. The patient has not refused the consultation, but the conversation has reached a sensitive point. If the GP pushes too hard, the patient may close down. If the GP ignores the signal completely, an important part of the story may be missed.

A gentle response may be:

"I understand. We do not need to go into that immediately. I only asked because stress and physical symptoms sometimes influence each other. We can return to it later if it feels useful."

This keeps the door open without forcing the patient.

Resistance is a common feature of difficult consultations. It is not always a refusal to cooperate. More often, it is a sign that the patient feels uncomfortable, ashamed, anxious, angry, frightened, or not yet ready to speak openly. For this reason, the doctor should not try simply to "remove" resistance. It is better to recognise it, understand what may be behind it, and work with it carefully. Resistance often points to the emotionally important part of the consultation: the place where the patient's fear, shame, anger, or uncertainty is most strongly felt.

Surface resistance

Surface resistance is visible in the consultation. It may appear as silence, short answers, nervous laughter, looking away, changing the subject, moving the chair backwards, irritation in the voice, speaking around the problem, or saying directly: *"I do not want to talk about this."*

EXAM POINT: A sudden and one-time avoidance of eye contact with the doctor is best understood as a possible manifestation of surface resistance.

A single moment of avoiding eye contact should not be overinterpreted as dishonesty. It may mean embarrassment, temporary discomfort, fear of the topic, or simply a need for more time. The GP can notice it without making a judgement and respond gently.

Possible phrase: *"I noticed that this subject seems difficult. We can take it slowly."*

Deep resistance

Deep resistance is connected with more fundamental fears. These may include fear of serious disease, fear of death, fear of losing control, fear of rejection, fear of being misunderstood, or fear of being judged. It may be suspected when one form of surface resistance disappears and another appears almost immediately, or when the patient repeatedly avoids the same area of discussion.

Deep resistance requires patience. Direct pressure may increase the patient's defences. The doctor first has to create enough trust for the patient to feel safe enough to continue.

Working with resistance

Typical clinical situation:

A patient asks:

"Doctor, do you think this could be cancer?"

The GP can respond at different levels. A content-level answer gives medical information:

"At the moment, I do not see clear signs of cancer, but we should examine you and decide whether further tests are needed."

A process-level answer notices the emotion behind the question:

"I can hear that this possibility is really worrying you."

Sometimes the doctor may temporarily move to safer ground:

"Let us first understand exactly how the symptoms started, and then we will return to what they may mean."

The skill is not choosing one method forever, but choosing the right response for the moment.

There are three practical ways to respond to resistance. A good GP may use all three, depending on the moment. The choice is not mechanical. It depends on the level of risk, the quality of the relationship, the time available, and the patient's emotional state.

Respond at the content level. This means answering the patient's direct question or statement. It is often necessary, because patients need clear information. However, if the doctor responds only at the content level, the emotional meaning behind the question may be missed.

> *Patient: "Is this pain dangerous?"*
>
> *Doctor: "At the moment, I do not see signs of immediate danger, but we should monitor it carefully."*

Respond at the process level. This means commenting on what is happening in the consultation itself: the silence, the tension, the sudden change of tone, or the patient's difficulty in continuing. A process-level response helps the patient notice what is happening without feeling attacked.

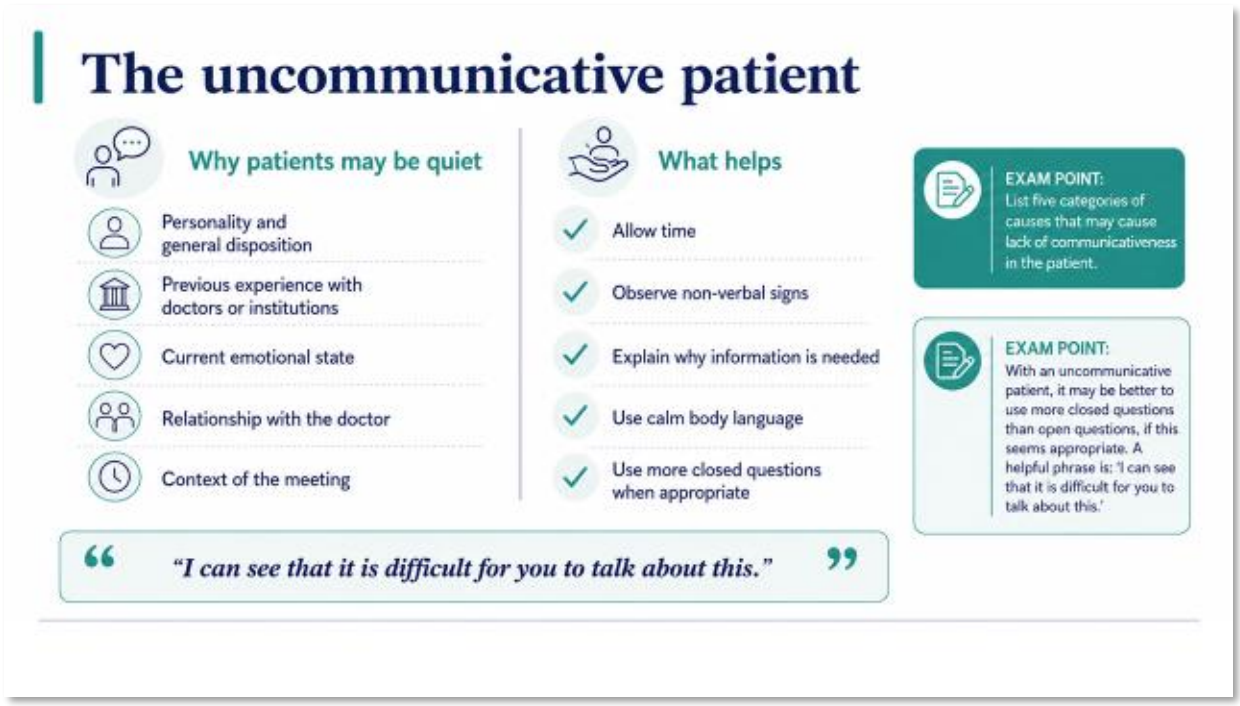
> *Patient: "..."*
> *Doctor: "I notice that it became difficult to continue just now. Would it help if we paused for a moment?"*
>
> Child example — process-level response
> *Child: "..."*
> *Doctor: "I can see that injections worry you. Today there will be no injection. We will just talk and have a gentle look."*

Temporarily bypass the resistance. Sometimes the doctor can move to a less emotionally charged subject and return later, when the patient is calmer or feels safer. This should be done carefully, because repeated avoidance of the patient's real concern may damage trust.

Process-level comments are especially useful because they do not accuse the patient. They describe the interaction and invite reflection. Instead of asking repeatedly, "Why do you not answer?", the doctor may say:

Possible phrase: "I have the feeling that we have reached a difficult point in the conversation. What would make it easier for us to continue?"

The aim is not to force the patient to speak before they are ready. The aim is to keep the consultation open enough for clinical work to continue.



III. The uncommunicative patient

Typical clinical situation:

A young adult comes to the surgery because of tiredness and poor sleep. The GP asks open questions, but the patient gives only short answers:

"I don't know."

"Maybe."

"It's nothing."

The doctor feels that something important is present, but the patient is not ready to speak freely. Instead of showing impatience, the GP slows down and says:

"I can see that it is difficult for you to talk about this. We do not have to rush. Would it be easier if I asked you a few more specific questions?"

The patient nods. The GP continues gently:

"Is the main difficulty sleep, worry, low mood, pain, or something else?"

A focused question may give the patient a safer beginning.

An uncommunicative patient may be silent, withdrawn, evasive, reluctant to answer, or difficult to engage. This can be frustrating for the doctor, but visible frustration usually makes the patient withdraw even further. The first step is not to push harder, but to ask what may be making communication difficult.

Five broad categories are especially important:

- personality and general disposition, such as shyness, reserve, caution, or self-consciousness;
- previous experience with doctors, institutions, or other people, especially if the patient has felt judged, ignored, rushed, or not taken seriously;
- current emotional state, such as anxiety, shame, sadness, anger, depression, confusion, pain, or exhaustion;
- the relationship with the doctor, including cultural expectations, preconceptions, mistrust, and the doctor's own behaviour;
- the context of the meeting, including privacy, noise, seating, the presence of another person, and the patient's feeling of safety.

EXAM POINT: List five categories of causes that may cause lack of communicativeness in the patient.

The GP should prepare for a longer consultation when possible, observe non-verbal signals, explain why the information is needed, and show empathy through posture and tone. A slightly forward posture, calm eye contact, and a quiet voice may sometimes help more than another series of questions.

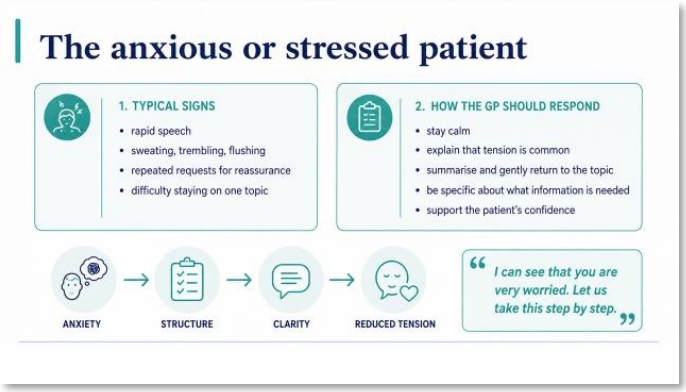
Open questions are usually valuable, but for a very withdrawn patient they may feel too broad, demanding, or difficult to answer. In such cases, a closed or focused question can reduce pressure and give the patient an easier starting point.

Possible phrase: "Would it be easier if I asked you a few more specific questions?"

> *Patient: "I don't know… I just don't want to talk about it."*
> *Doctor: "I can see that it is difficult for you to talk about this. We do not have to rush. Would it be easier if I asked you a few more specific questions?"*
> *Patient: "Maybe."*
> *Doctor: "All right. I will go slowly. Is the main difficulty pain, worry, tiredness, or something else?"*

EXAM POINT: With an uncommunicative patient, it may be better to use more closed questions than open questions, if this seems appropriate. A helpful phrase is: "I can see that it is difficult for you to talk about this."

The doctor should not treat silence as laziness, hostility, or lack of interest. Sometimes silence is the patient's way of testing whether the doctor is safe enough to trust.



IV. The anxious or stressed patient

Typical clinical situation:

A patient arrives worried about chest discomfort. He speaks quickly, moves from one symptom to another, and repeatedly asks:

"Are you sure it is not something serious?"

The GP should not become irritated by the repetition. Repeated reassurance often means that the patient is still frightened, not that he has failed to understand. The doctor remains calm and gives structure:

"I can see that you are very worried. Let us go step by step: first the pain, then the examination, then the need for tests."

The patient may still be anxious, but structure reduces the feeling of chaos. In anxious consultations, calm organisation is part of treatment.

Anxiety is a normal human response, and medical settings often increase it. A patient may be afraid of pain, bad news, dependence, hospitalisation, disability, or loss of control. Some anxious patients speak too much; others become tense and quiet. Both reactions may be signs of the same inner alarm.

Typical signs include rapid speech, sweating, trembling, flushing, restlessness, repeated reassurance-seeking, and difficulty staying on one topic. The doctor should consider whether the anxiety is related to the illness, a previous medical experience, another life problem, or a long-standing anxious style.

The GP's response should reduce arousal without losing direction. Structure is therapeutic here. It helps the patient feel that the doctor is not lost in the anxiety.

- stay calm and be prepared to take time when possible;
- explain that tension is common during medical consultations;
- if the patient talks too much, summarise and gently return to the topic;
- be specific about what information is needed and why;
- support the patient's confidence and capacity for self-reflection;
- avoid becoming defensive if the patient asks repeatedly for reassurance.

Possible phrase: *"I can see that you are very worried. Let us take this step by step. First, I need to understand when the symptoms started."*

V. The aggressive patient



Typical clinical situation:

A patient enters the room angry because he has waited for a long time. He speaks loudly and says:

"This is always the same here. Nobody cares about patients."

The GP feels the pressure to defend the practice, but a defensive answer may escalate the situation. The first task is safety and de-escalation, not proving who is right.

A possible response is:

"I can see that you are very angry. I want to understand what has made you most upset. We also need to keep the conversation safe for everyone."

If the patient continues shouting, the GP may add:

"I am ready to listen, but I cannot continue if there are threats. We have two choices: we speak calmly now, or we pause and arrange help."

Boundaries and respect must go together.

Aggression is one of the most difficult and potentially unsafe situations in general practice. The patient may be angry because of waiting, bad news, fear, feeling ignored, previous humiliation, pain, alcohol or drug use, psychiatric illness, or a sense of helplessness. Aggression is not acceptable, but it often has meaning. It may be a transformed cry for help from a person who feels powerless or frightened.

The doctor's first task is to preserve safety. Clinical content comes second. The GP should keep a safe distance, avoid blocking the exit, avoid sudden movements, know how to call for help, and avoid working alone in high-risk situations.

EXAM POINT: When communicating with an aggressive patient, it is recommended to ask more open than closed questions, not to take personally the things the patient says, and to help the patient realise that he or she has a choice.

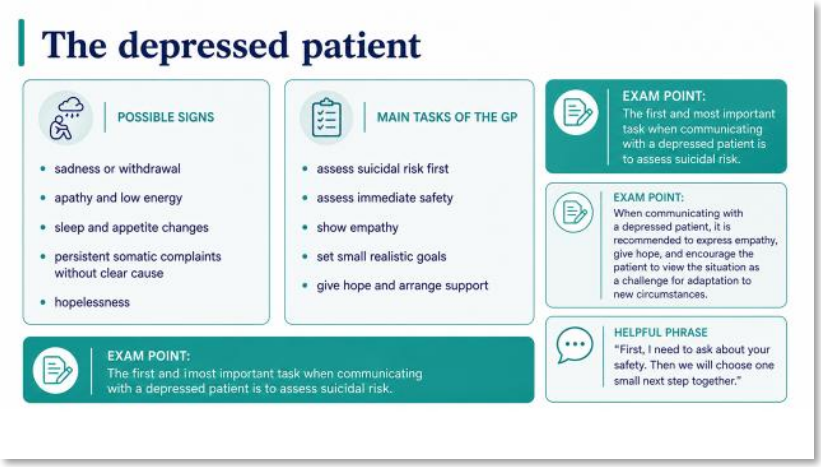
The doctor should not become combative or defensive. It is usually unhelpful to stop the patient's verbal flow immediately or to interrupt the outpouring of anger too early. Talking is safer than acting, provided that safety is preserved.

- do not become belligerent and do not mirror the patient's aggression;
- show willingness to listen, but maintain boundaries;
- do not correct profanity or argue about the choice of words;
- do not make threats or promises that cannot be kept;
- use open questions to keep the patient talking rather than acting;
- help the patient see possible choices;
- call for help if there is a real risk of violence.

Possible phrases: "I want to understand what made you angry." / "We need to keep everyone safe, and I am ready to listen." / "Let us look at the choices we have right now."

De-escalation is not surrender. It is a way of protecting the patient, the doctor, the staff, and the consultation itself.

VI. The depressed patient



Typical clinical situation:

A patient comes with tiredness, poor sleep and vague body pains. Nothing in the examination suggests an urgent physical illness. During the conversation she says quietly:

"I am just useless. My family would be better without me."

This sentence must not be treated as a passing complaint. The GP should respond calmly and directly:

"I am very sorry you are feeling this way. When people feel so low, they sometimes think life is not worth living. Has this happened to you?"

Asking about suicidal thoughts does not create the danger. It allows the patient to speak about it. After safety has been assessed, the GP can move to empathy, support, treatment options and one small realistic next step.

In depression, kindness is essential, but safety comes first.

Depression is not always obvious. Some patients cry, speak slowly, look hopeless and describe loss of interest. Others mask depression with irritability, refusal of medication, lack of energy for washing or shaving, excessive sleep, persistent somatic complaints without clear organic cause, or constant dissatisfaction. The GP should be careful not to interpret these behaviours simply as laziness, bad character or lack of gratitude.

EXAM POINT: The first and most important task when communicating with a depressed patient is to assess suicidal risk.

This is the central safety gateway. Empathy, hope, and small realistic goals are very important, but they come after the doctor has considered safety. Asking about suicidal thoughts does not create those thoughts. It gives the patient permission to speak about something frightening.

When depression is suspected, the GP should ask about suicidal thoughts, plans, and self-harm; assess immediate safety; seek psychiatric or psychological consultation when necessary; and document what has been assessed and done.

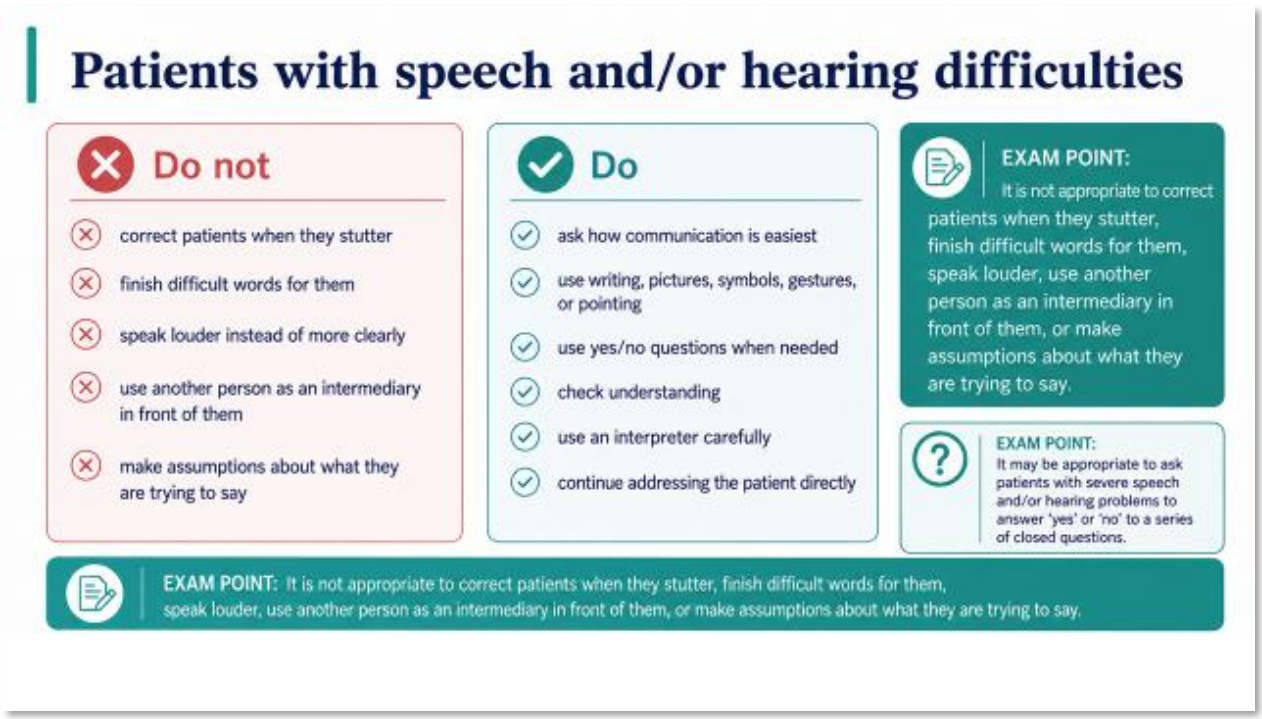
Possible questions: “When people feel this low, they sometimes think life is not worth living. Has this happened to you?” / “Have you thought about harming yourself?” / “Do you feel safe today?”

> **EXAM POINT:** When communicating with a depressed patient, it is recommended to express empathy, give hope, and encourage the patient to view the situation as a challenge for adaptation to new circumstances.

The GP should listen carefully, avoid pressure if the patient resists talking, reflect both content and feeling, and use kindly firmness. Kindly firmness means that the doctor is warm, but not passive. The doctor accepts the patient’s suffering and at the same time supports one small realistic step.

- listen carefully and do not rush the patient;
- express empathy for the patient’s feelings;
- use paraphrase and summary;
- set small goals that can be achieved soon;
- show choices and possibilities, even if they are modest;
- give hope, but never use hope as a substitute for safety assessment.

Possible phrase: *“First, I need to ask about your safety. Then we will choose one small next step together.”*



VII. Patients with speech and/or hearing difficulties

Typical clinical situation:

An elderly patient with hearing difficulty comes with her daughter. The daughter begins to answer every question, while the patient sits silently. It would be easy for the GP to speak only to the daughter, but this may make the patient feel invisible.

The doctor turns towards the patient and says clearly:

"I would like to speak with you first. If it is easier, we can write things down or ask your daughter to help when needed."

The GP uses short sentences, faces the patient, avoids shouting, and checks understanding:

"Can you show me how you will take this medicine?"

The aim is not only to collect information. The aim is to preserve the patient's dignity and participation in the consultation.

Patients with speech or hearing difficulties are at risk of being misunderstood, ignored, or treated as less competent than they really are. The problem may be congenital or acquired, temporary or permanent. It may be related to hearing loss, stroke, dementia, neurological disease, developmental problems, or another

condition. The method of communication may need to change, but respect must remain unchanged.

A common mistake is to treat the patient as absent while speaking to a relative. Another mistake is to speak louder instead of speaking more clearly. Louder speech is not necessarily better communication.

EXAM POINT: It is not appropriate to correct patients when they stutter, finish difficult words for them, speak louder, use another person as an intermediary in front of them, or make assumptions about what they are trying to say.

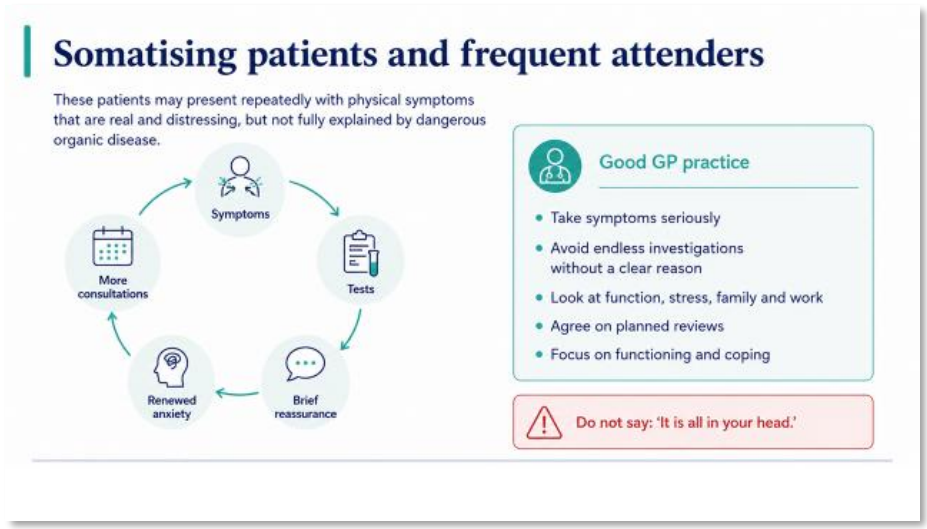
The GP should first ask how the patient prefers to communicate. Writing, pictures, symbols, gestures, or pointing may be more useful than repeated verbal explanations. If an interpreter or relative is involved, confidentiality and accuracy must be considered, and the doctor should still address the patient directly.

- do not ignore the patient;
- do not guess what the patient is trying to say;
- use writing, pictures, symbols, gestures, or pointing when useful;
- use yes/no questions when open communication is too difficult;
- check understanding by asking the patient to repeat, show or summarise the plan;
- use an interpreter when needed, but be aware of confidentiality and summarising;
- continue speaking even to unconscious or intubated patients, because hearing may be preserved.

EXAM POINT: It may be appropriate to ask patients with severe speech and/or hearing problems to answer “yes” or “no” to a series of closed questions.

Possible phrase: *“What is the easiest way for us to communicate: speaking, writing, gestures, or yes/no answers?”*

Checking understanding is essential. It is not an examination of the patient. It is a safety check on the doctor’s communication.



VIII. Somatising patients and frequent attenders

Typical clinical situation:

A patient comes for the fourth time in two months with abdominal discomfort, tiredness, and shifting pains. Previous tests have been normal. The patient says: *"There must be something wrong. Maybe we should do more tests."*

The GP should not dismiss the symptoms, but also should not automatically repeat investigations without a clear reason. A balanced response may be:

"I believe your symptoms are real and distressing. The tests so far do not show a dangerous disease. Instead of repeating them, let us make a plan: what to monitor, when to review you, and what warning signs to watch for."

This approach takes the patient seriously while avoiding unnecessary medicalisation.

Somatising patients and frequent attenders are important in general practice, but remain a short additional topic in this session. They may present repeatedly with physical symptoms that are real and distressing, but not fully explained by dangerous organic disease. The doctor may feel pressured to order more tests, while the patient may feel that nobody takes the symptoms seriously.

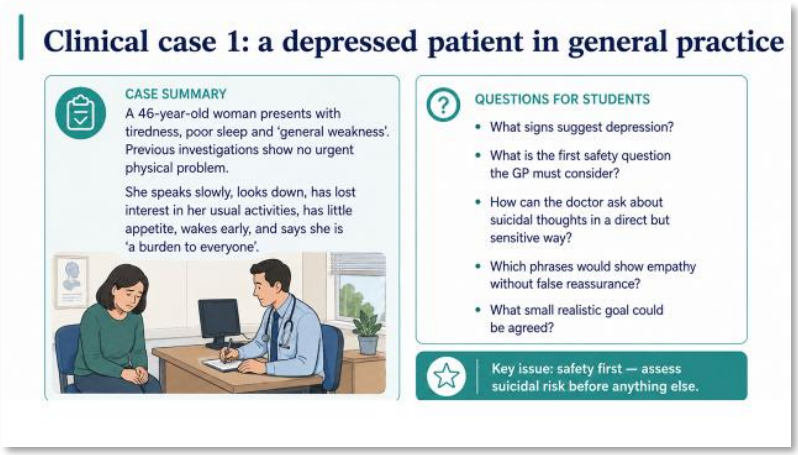
The danger is a cycle of medicalisation: symptoms lead to tests, reassurance is short-lived, anxiety returns, and more investigations are requested. The GP should avoid both extremes: dismissing the patient and investigating endlessly.

- take the symptoms seriously and avoid saying "it is all in your head";
- avoid investigations without a clear clinical reason;
- look at function, stress, family, and work, not only at symptoms;
- agree on planned reviews instead of repeated fear-driven visits;
- set realistic goals focused on functioning and coping.

Possible phrase: *"I believe that your symptoms are real. The tests so far do not show a dangerous disease, so let us make a clear plan for what will help you function better."*

IX. Clinical application: two consultation scenarios

The purpose of these cases is not to find a single perfect sentence, but to help students practise clinical judgement, communication, safety awareness, and professional self-control.



Case 1. A depressed patient in general practice

A 46-year-old woman comes to see her GP because of tiredness, poor sleep, and "general weakness". She has visited the practice twice in the last month with headaches and chest discomfort, but previous examination and basic investigations have not shown an urgent physical problem.

During the consultation she speaks slowly and gives short answers. She looks down most of the time. When the doctor asks how things are at home, she says:

"I do not know what is wrong with me. I am useless. I cannot do anything properly any more."

She says that she has lost interest in her usual activities, has little appetite, and wakes early in the morning. Her husband has recently lost his job, and she feels that she is "a burden to everyone".

Questions for students

- What signs in this case suggest depression?
- What is the first safety question the GP must consider?
- How can the doctor ask about suicidal thoughts in a direct but sensitive way?
- Which phrases would show empathy without giving false reassurance?
- What small and realistic goal could be agreed with the patient?
- When should the GP seek psychiatric or psychological consultation?
- What should be documented after this consultation?

Suggested discussion points

The GP should first recognise that the patient's physical complaints may be part of a depressive presentation. However, the doctor must not stop at empathy only. The immediate clinical priority is safety.

Possible questions include:

"When people feel this low, they sometimes think that life is not worth living. Has this happened to you?"

"Have you had thoughts of harming yourself?"

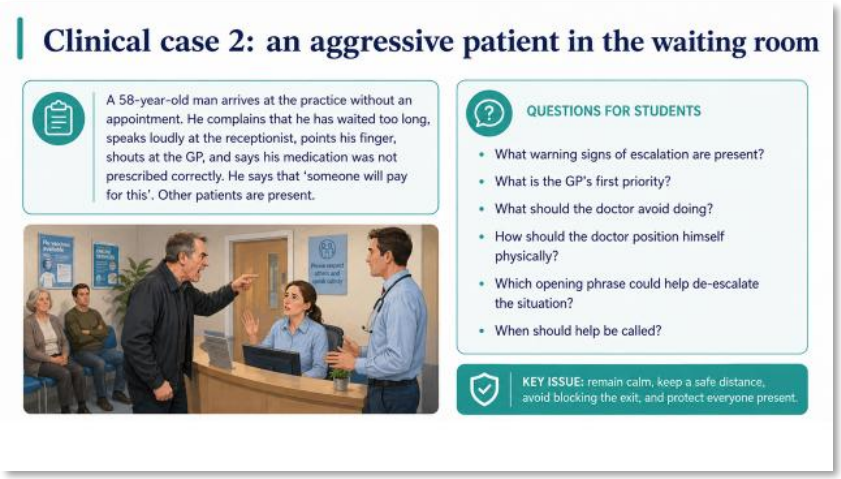
"Have you made any plan?"

"Do you feel safe today?"

After safety has been assessed, the doctor can use empathy and kindly firmness:

"I can hear that you feel exhausted and discouraged. We will not try to solve everything today. First, I want to make sure you are safe. Then we will agree on one small next step."

The plan may include follow-up, family support if appropriate, referral when needed, and clear documentation of risk assessment and decisions.



Case 2. An aggressive patient in the waiting room

A 58-year-old man arrives at the practice without an appointment. He says he has been waiting "too long" and that nobody cares about him. His voice becomes louder. He stands close to the reception desk, points his finger at the receptionist and says:

"You always ignore me. I want to see the doctor now!"

When the GP comes out, the patient turns towards him and continues shouting. He says that his medication was not prescribed correctly and that "someone will pay for this". Other patients are present in the waiting room.

Questions for students

- What warning signs of escalation are present in this case?

- What is the GP's first priority?
- What should the doctor avoid doing?
- How should the doctor position himself physically?
- Which opening phrase could help de-escalate the situation?
- How can the GP help the patient see that he has choices?
- When should help or security be called?
- What should be documented afterwards?

Suggested discussion points

The first priority is safety. The GP should remain calm, keep a safe distance, avoid blocking the exit, and make sure that other people are not put at unnecessary risk.

The doctor should avoid saying:

"Calm down immediately."

"Stop shouting or I will not speak to you."

"You have no right to behave like this."

These phrases may increase confrontation.

More useful phrases are:

"I can see that you are very angry. I want to understand what has made you most upset."

"We need to keep everyone safe. I am ready to listen, but we need to speak without threats."

"There are a few things we can do now. Let us look at the choices."

The GP should not promise something impossible simply to stop the anger. If the patient becomes physically threatening, refuses to calm down, blocks movement, or creates danger for staff or other patients, help should be called immediately.

Closing message for students

Difficult consultations test not only medical knowledge, but also the doctor's ability to remain structured, calm, and safe. In depression, safety begins with suicide risk assessment. In aggression, safety begins with de-escalation and protection of everyone present. In both situations, empathy and boundaries must work together.