EDITORIAL

Cultivating the Physician-Patient Relationship in Ophthalmology

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A STRONG PHYSICIAN-PATIENT RELATIONSHIP IS AN integral component of providing patient care. Although the frequency of difficult patient encounters is not well described in ophthalmology, multiple studies have found that challenging encounters account for at least 15% of ambulatory physician-patient interactions.[1,2] Importantly, difficult clinical encounters have the potential to take a toll on provider satisfaction[3] as well as clinical outcomes.[4,5] As physicians, we have a fundamental ethical responsibility to provide the best care possible for our patients. Given the effects of difficult encounters on patient outcomes and physician well-being, it is important to recognize that the interventions necessary to heal our patients come not only from medications or surgery but also in the form of interpersonal interaction.[6] With this in mind, the question remains: what are the best ways for ophthalmologists to manage difficult encounters and strengthen challenging clinical relationships?

The first step may be to reframe the concept of a "difficult patient." Although studies have shown that a number of patient characteristics (such as co-morbid or complex conditions, mental illness, or neurocognitive disorder, or threats of legal action against the provider) are more common in patients considered difficult by physicians, systemic factors (such as high workload or increasing pressure to work efficiently) and provider factors (such as inexperience, fatigue, or burnout) also contribute significantly to the difficulty of a clinical encounter.[1,7,8] The impact of those factors can be seen in a variety of common clinical scenarios. For instance, if a patient is seen when the clinic is running smoothly, the physician may not consider the visit difficult. However, if the same patient is seen when the clinic is running an hour late or if the physician is experiencing burnout, the clinical interaction is far more likely to be perceived as difficult. Therefore, instead of labeling a patient as "difficult," we suggest using terminology that acknowledges the multifaceted nature of clinical difficulty, such as "challenging clinical interaction," to describe such encounters.

Accepted for publication Nov 18, 2020.

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Developing strategies for managing such dynamic interpersonal encounters is no easy task, especially considering that many patient and systemic factors are outside of physicians' control. However, several such practices have been described. The "breathe-out" technique, for example, is a strategy that aims to modulate factors such as provider bias and physician emotion regulation by encouraging physician self-reflection and patient centeredness.[9] The technique consists of 2 sets of questions answered by physicians before and after a patient visit that the physician predicts will be difficult. A study of this technique found that answering those questions improved clinician satisfaction after visits with patients who were perceived as difficult by the clinician.[9]

To date, very little has been written about challenging clinical interactions in ophthalmology specifically, and many questions remain unanswered. Does serving a population with a high level of visual impairment lead to miscommunication? Could this contribute to the difficulty of clinical encounters? Ophthalmic clinic wait times are often longer because of imaging and dilation. To what degree might this affect the physician-patient relationship, if at all?

Some insights into the factors that contribute to difficult encounters in ophthalmology can be found in a recent study in which ophthalmology residents reflected about a challenging story or conversation with a patient, patient's family, or colleague. Qualitative narrative analysis of resident answers identified "differing expectations" as 1 of 4 main themes expressed in resident narratives.[10] As suggested by these findings, when considering difficult encounters within our specialty, one of the most important dynamics to consider is that of expectation management. Vision plays a central role in our ability to perform many aspects of daily life. In fact, 1 study showed that patients with low vision scored lower in physical functioning and role limitations than did patients with congestive heart failure or depression.[11] Therefore, even if visual acuity is significantly improved with treatment, it is very possible that any residual disturbance could still noticeably limit a person's activities or impact their quality of life.

An example of such a scenario can be seen in the discussion section of Ravin's paper describing the case of impressionist painter Claude Monet.[12] For years, Monet suffered

0002-9394/$36.00
https://doi.org/10.1016/j.ajo.2020.11.009

from bilateral cataracts, which significantly diminished his vision and impaired his ability to paint. In 1922, Monet was pronounced blind, and he decided to undergo cataract surgery on his right eye. Although his visual acuity was markedly improved after surgery, the painter experienced visual distortion and changes in his color vision. This was probably caused by high astigmatism, aphakia, and chromatic aberrations from his aphakic glasses. Monet's vision caused him great distress over a number of years, as shown by the many letters he wrote to his ophthalmologist.[12] In reviewing the correspondence between Monet and his physician, it is clear that, despite his significantly improved visual acuity, Claude Monet's expectations for his functional visual outcome were not met.

Although, techniques and outcomes for ophthalmic procedures have improved tremendously since the time of Claude Monet, unmet visual expectations still understandably cause significant distress for modern ophthalmology patients. Several studies have demonstrated that ophthalmology patients often have high functional expectations. For example, a study of 722 patients undergoing their first eye cataract surgery found that only 61% of patient's functional outcomes met or passed their predicted functional outcomes.[13] This trend has been found in studies of other procedures as well. Another study measured 466 patients' expectations before undergoing laser-assisted in situ keratomileusis (LASIK) and their perceptions after the procedure. The study found that, although both expectation and perception scores were high, patients had significantly higher expectation scores than perception scores, indicating a "quality gap."[14]

In addition to the general functional importance of vision in day-to-day life, there are several possible reasons for the high functional expectations described above. Recently, many young, healthy patients have been opting to undergo elective procedures for non–vision-threatening conditions.[15] A high level of functional expectation is very understandable in those patients, as they often require a high level of visual acuity to function day to day without corrective lenses. Additionally, unlike many other surgical procedures, some surgeries in ophthalmology are, at times, marketed directly to patients. Other procedures can carry high out-of-pocket costs. It is possible that these factors may also contribute to increased expectation of functional results.

Even if outcomes for a procedure are outstanding, a gap between expectation and reality could easily strain the physician-patient relationship and lead to a challenging interaction. Therefore, along with adopting practices such as the breathe-out technique, aimed at reframing clinical interaction goals and physician emotion regulation,[9] actively managing patient expectations is a strategy for decreasing difficult encounters that may be particularly important in ophthalmology. Furthermore, a recent study identified the following successful strategies as related by ophthalmology residents during challenging conversations with patients, patients' families, and colleagues: formulating clear explanations, taking time, and cultivating interpersonal and relational skills.[10] Examples of using these strategies could include conducting a thorough and documented informed consent at a health literacy level appropriate for the patient, spending some extra time with a patient who is upset,[10] and a using kind and empathetic tone during difficult conversations.[10]

Cultivating the physician-patient relationship is an important component of improving physician satisfaction while providing the best possible care to patients. In the face of many factors outside of the physician's control, it is helpful to reflect on the literature surrounding challenging clinical integrations in ophthalmology and other areas of medicine. However, based on the very limited literature available in this area, it is clear that further research is needed to fully describe the factors that impact difficult clinical encounters in ophthalmology. In the meantime, we must continue the conversation about this important, complex, and multifactorial topic while striving to strengthen our challenging patient-physician relationships.

ACKNOWLEDGMENTS

THE AUTHORS HAVE COMPLETED AND SUBMITTED THE ICMJE FORM FOR DISCLOSURE OF POTENTIAL CONFLICTS OF INTEREST and none were reported. This study received no outside funding or support. The authors have reported that they have no relationships relevant to the contents of this paper to disclose.

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