Taking care of the hateful patient

and whatever else comes up…

Project ECHO CONNECTICUT Community Health Center, Inc.

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Learning objectives:
By the end of this didactic, the NP Resident will be able to…

- Better explore difficult interactions
  - Patient factors
  - Clinician factors
  - Structural factors

- Come up with approaches to ease the suffering

SPECIAL ARTICLE

TAKING CARE OF THE HATEFUL PATIENT

JAMES E. GROVES, M.D.

Abstract "Hateful patients" are not those with whom the physician has an occasional personality clash. As defined here they are those whom most physicians dread. The insatiable dependency of "hateful patients" leads to behaviors that group them into four stereotypes: dependent *clingers*, entitled *demanders*, manipulative *help-rejecters* and self-destructive *deniers*.

The physician's negative reactions constitute important clinical data that should facilitate better understanding and more appropriate psychological management for each. Clingers evoke aversion; their care requires limits on expectations for an intense doctor-patient relationship. Demanders evoke a wish to counterattack; such patients need to have their feelings of total entitlement rechanneled into a partnership that acknowledges their entitlement — not to unrealistic demands but to good medical care. Help-rejecters evoke depression; "sharing" their pessimism diminishes their notion that losing the symptom implies losing the doctor. Self-destructive deniers evoke feelings of malice; their management requires the physician to lower Faustian expectations of delivering perfect care. (N Engl J Med 298:883-887, 1978)

The difficult patient; the heart-sink patient…

An aside on the art: Lucian Freud

1922-2011
Grandson of Sigmund Freud

Considered the preeminent British artist of his generation.

Most definitely would have qualified as a difficult patient…

Definitions:

Difficult patient: What does that mean?

Hateful?

Heart-sink?

15-30% of patients in primary care…

Case:

Groups of 2-3.

Each discuss a case.

Then discuss w/ whole group.

What are the common characteristics?

Patient characteristics:

- Mental health disorders
- Multiple symptoms / somatic
- Chronic pain
- Unmet expectations
- Angry, defensive, aggressive
- Manipulative and threatening
- Noncompliant
- Self-destructive

Clinician characteristics

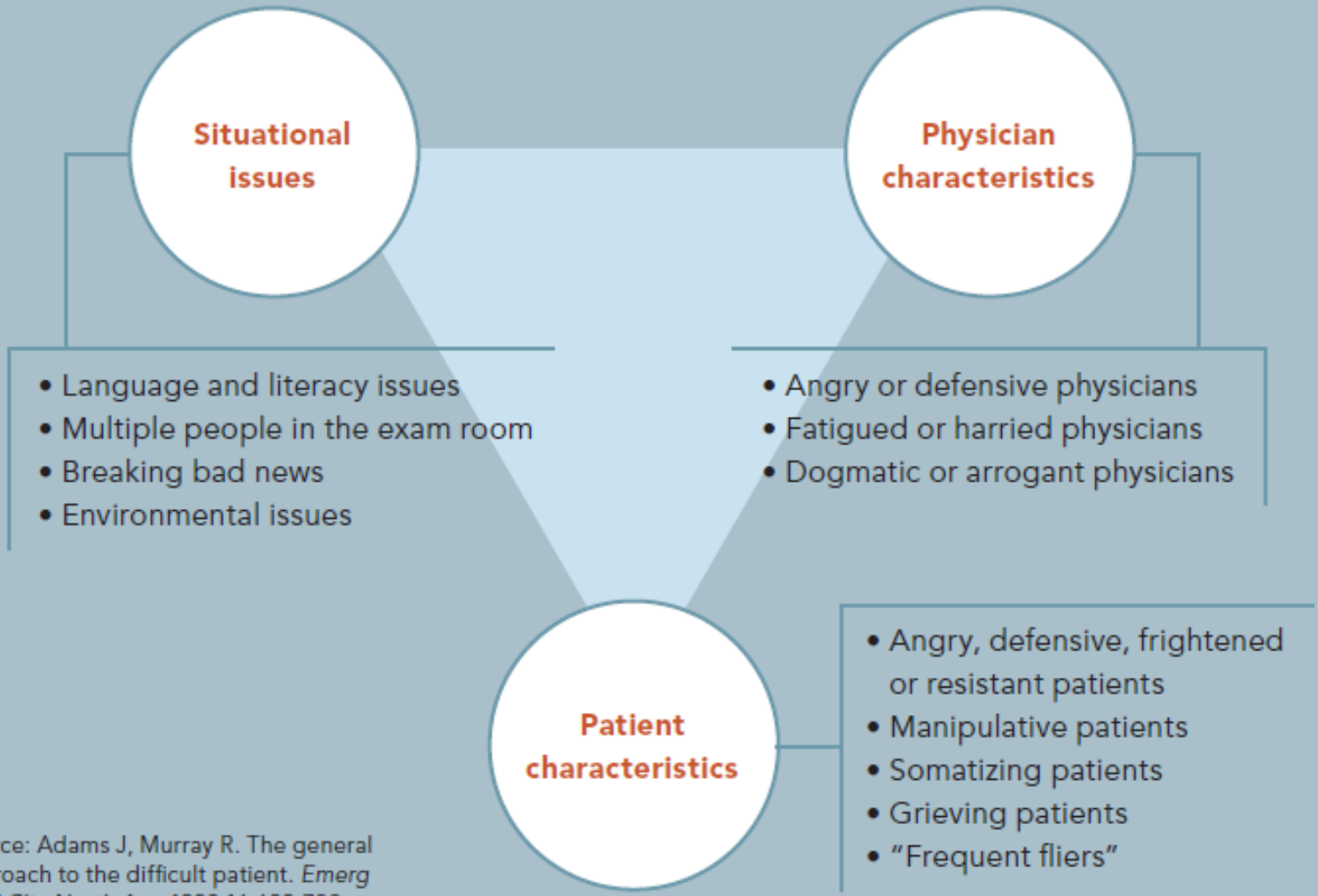
"Rethinking the Difficult Patient Encounter,"
http://www.aafp.org/fpm/2012/0700/p17.html

- Younger age
- Female
- Greater stress
- Heavier workload / sleep deprivation
- Perfectionist tendencies
- A desire to be liked
- Less experience (even 12 years v. 9 years)

Other clinician characteristics:

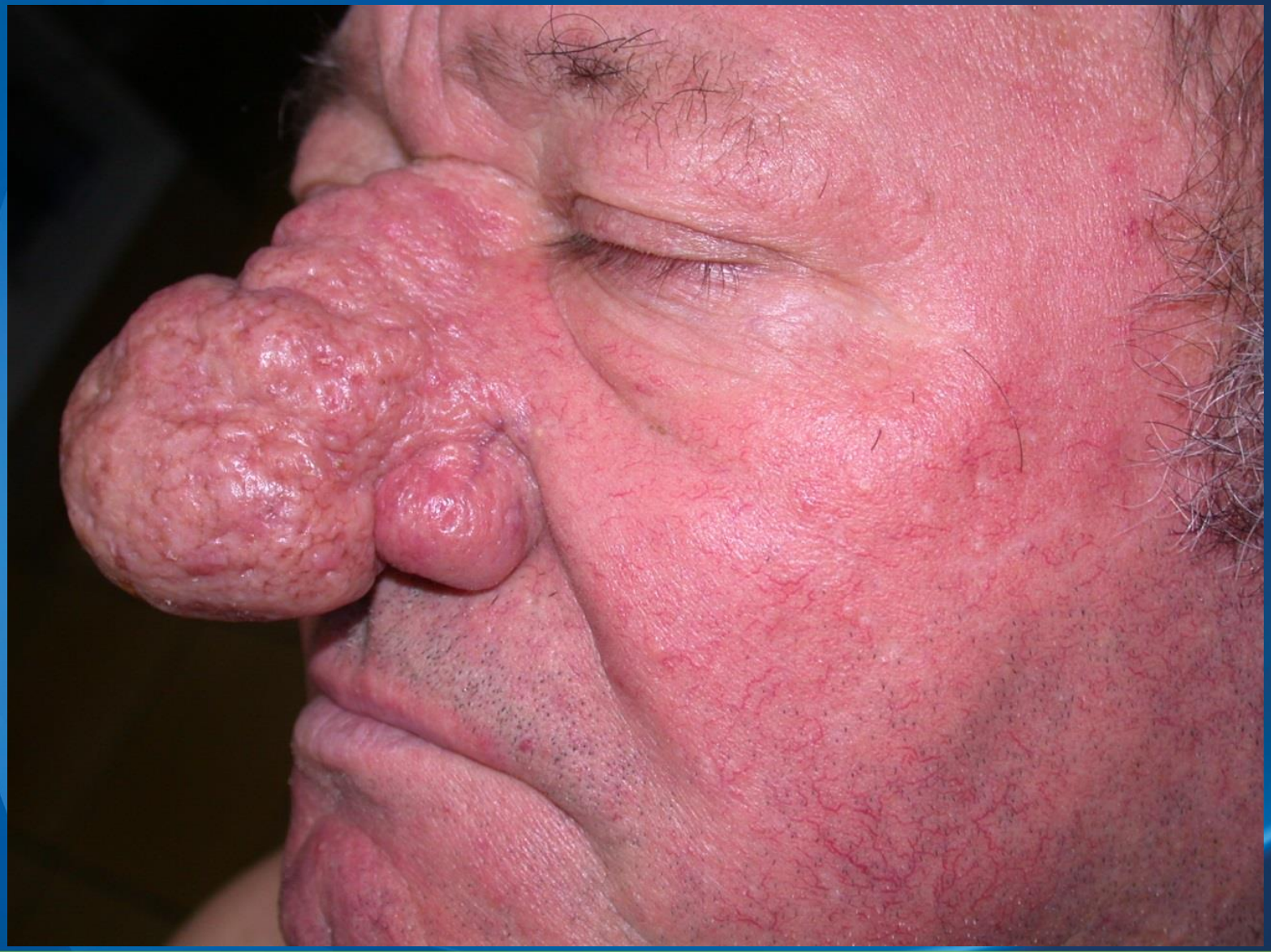
- Greater need for diagnostic certainty
- Rushed interrupted visits
- Emotional burnout
- Negative bias toward specific conditions
- Personal health issues
- Limited knowledge of patient's health condition
- Technology as distraction
  - Listen w/ your eyes

COMPONENTS OF A DIFFICULT CLINICAL ENCOUNTER



Source: Adams J, Murray R. The general approach to the difficult patient. *Emerg Med Clin North Am.* 1998;16:689-700. Adapted with permission from Elsevier Inc.

Imagine this is a difficult patient: what can we do to ease the interaction? to make the visit more productive for both ourselves and the patient?



Caveats:

"Where did all the sages get the idea that a man's desires must be normal and virtuous? Why did they imagine that he must inevitably will what is reasonable and profitable?"

-- Fyodor Dostoyevsky

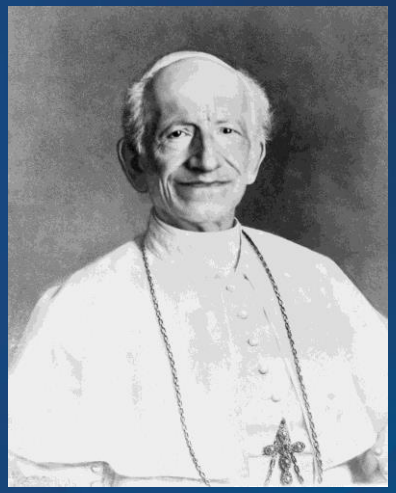
"Problem Patients: A Fresh Look at an Old Vexation,"
Family Practice Management, 2000 Jul-Aug;7(7):57-62

1. Allow patients to vent (within reason).
2. Strengthen your communications skills.
3. Become a more effective history taker.
4. Try not to judge.

"Understand the difference between having high personal standards and trying to impose those standards on patients."

5. Remain calm and confident.
6. Understand your own strengths / vulnerabilities.
7. Be patient. (change is slow, if at all…)
8. Be proactive. (in the face of uncertainty)
9. Avoid becoming an enabler.
10. Respect your patients.

Pope Leo XIII : " Liberty, the highest of natural endowments, being the portion only of intellectual or rational natures, confers on man this dignity–that he is 'in the hands of his counsel' and has power over his actions. But the manner in which such dignity is exercised is of the greatest moment, inasmuch as on the use that is made of liberty the highest good and the greatest evil alike depend. Man, indeed, is free to obey his reason, to seek moral good, and to strive unswervingly after his last end. Yet he is free also to turn aside to all other things; and, in pursuing the empty semblance of good, to disturb rightful order and to fall headlong into the destruction which he has voluntarily chosen."



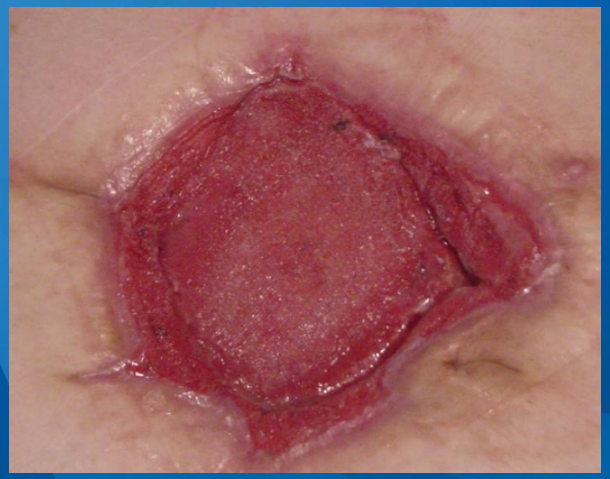
How do we ease suffering?

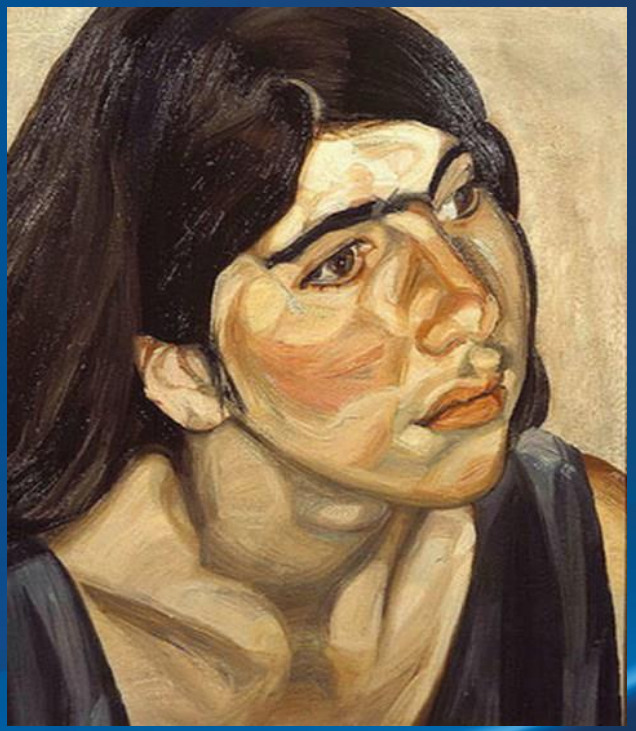
- Suffering of the patient, and our own angst…
  1. Recognize fallacies.
  2. Accept personal factors that contribute.
  3. How do we find compassion?
  4. Recognize strong negative emotions as useful.

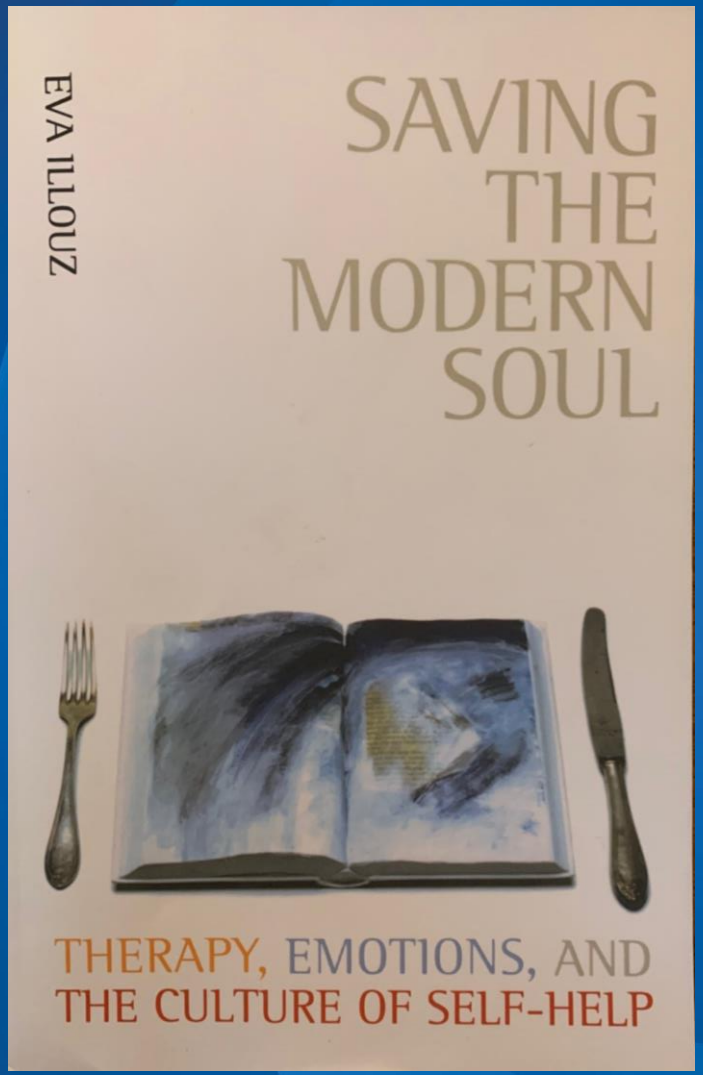
Linear fallacy

Problem → History → Exam → Tests → Treatment → Cure

Problem is, some people don't want to be cured.







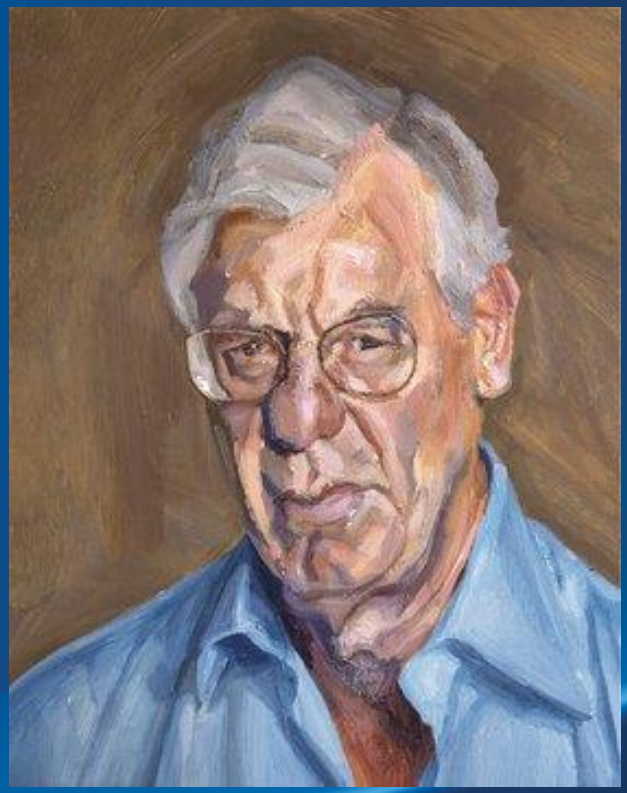
"The [therapeutic] narrative makes one responsible for one's psychic well-being, yet does so by removing any notion of moral culpability. It enables one to mobilize the cultural schemes and values of moral individualism and of self-improvement. Yet by transposing these to childhood and deficient families, it exonerates the person from the moral weight of being at fault for living an unsatisfactory life."

"the therapeutic narrative emerges from the fact that the individual has become embedded in a culture saturated with the notion of rights…. This mechanism can transform suffering into victimhood and victimhood into identity."

Toolbox: deflection

"a soft answer turneth away wrath."

"You've kept me waiting for more than half an hour! My time is just as valuable as yours. How can you people be so rude?!"

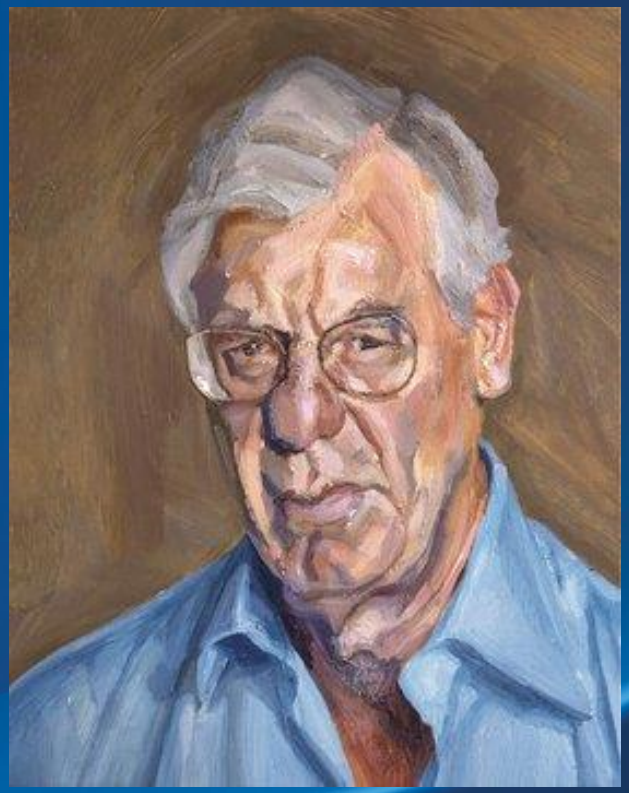


Toolbox: deflection

"You seem quite upset. Could you help me understand what you are going through?"

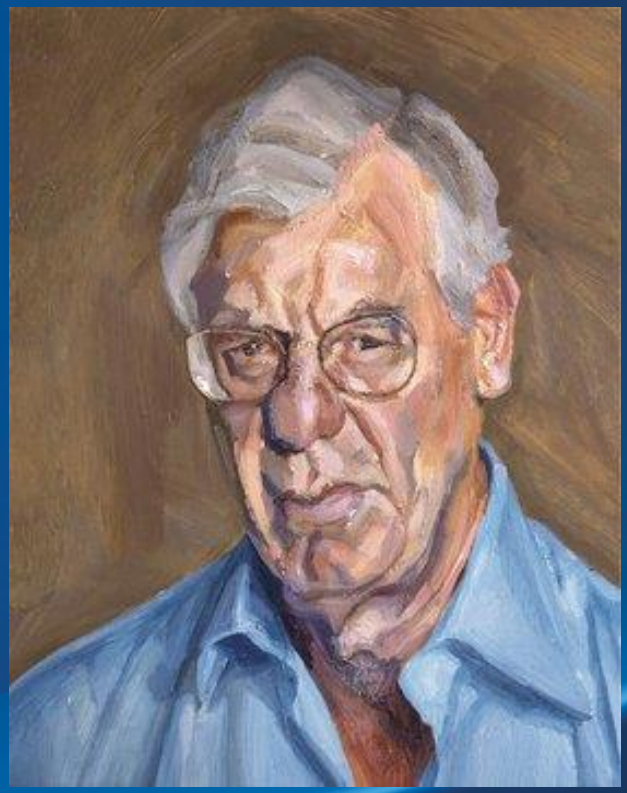
Attempt to name the patient's emotional state.

Confrontational response…



Toolbox: deflection

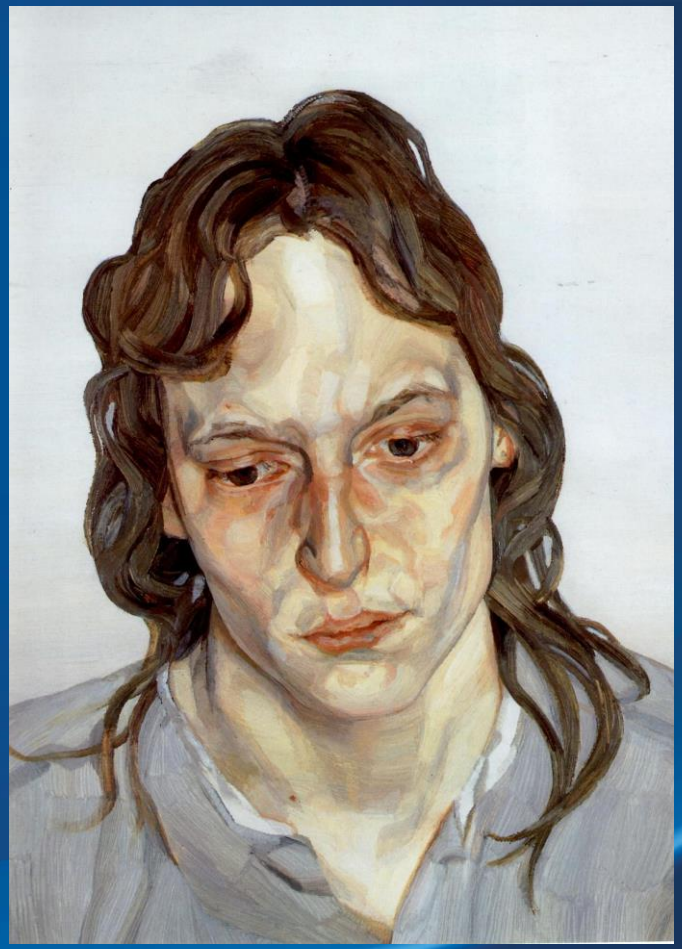
"Have these problems made it more difficult for you to manage your everyday activities or get along with other people?"



Strategy	*Physician actions*	*Examples*
Active listening	Understand the patient's priorities, let the patient talk without interruption, recognize that anger is usually a secondary emotion (e.g., to abandonment, disrespect)	"Please explain to me the issues that are important to you right now." "Help me to understand why this upsets you so much."
Validate the emotion and empathize with the patient (understanding, not necessarily sharing, the emotion with the patient)	Name the emotion; if you are wrong, the patient will correct you; disarm the intense emotion by agreement, if appropriate	"I can see that you are angry." "You are right—it's annoying to sit and wait in a cold room." "It sounds like you are telling me that you are scared."
Explore alternative solutions	Engage the patient to find specific ways to handle the situation differently in the future	"If we had told you that appointments were running late, would you have liked a choice to wait or reschedule?" "What else can I do to help meet your expectations for this visit?" "Is there something else you need to tell to me so that I can help you?"
Provide closure	Mutually agree on a plan for subsequent visits to avoid future difficulties	"I prefer to give significant news in person. Would you like early morning appointments so you can be the first patient of the day?" "Would you prefer to be referred to a specialist, or to follow up with me to continue to work on this problem?"

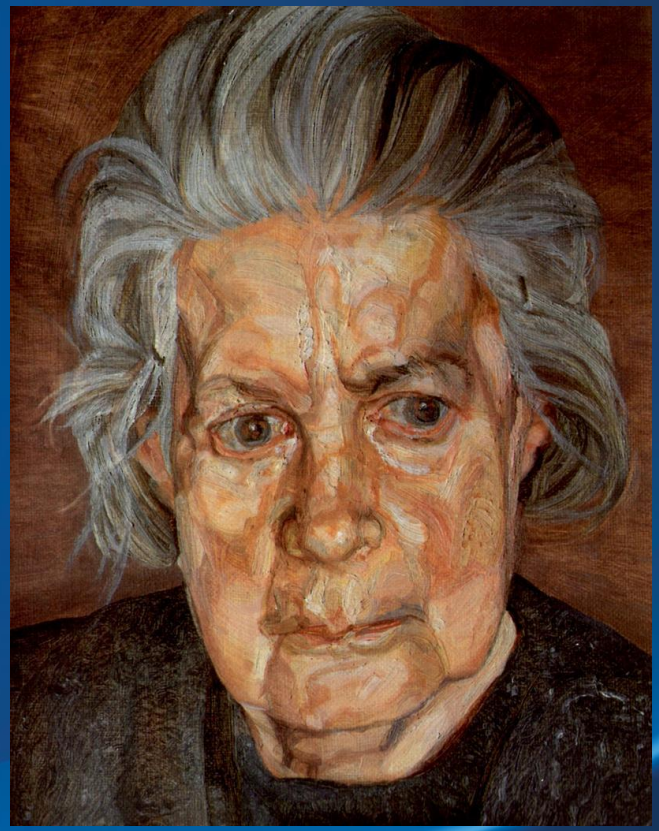
Toolbox: improve partnership

"How do you feel about the care you are receiving from me? It seems to me that we sometimes don't work together very well."



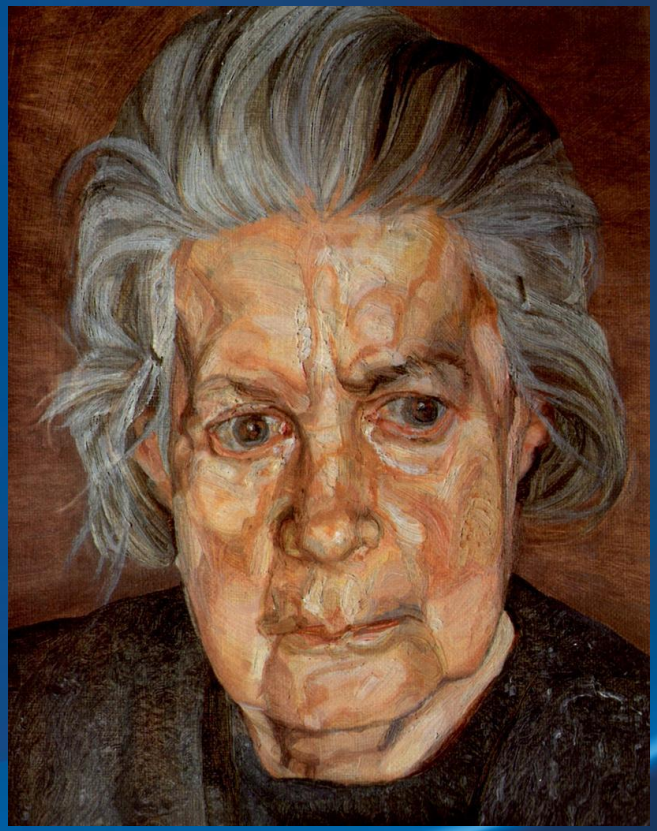
Toolbox: revise expectations

"What's your understanding of what I am recommending, and how does that fit with your ideas about how to solve your problems?"



Toolbox: revise expectations

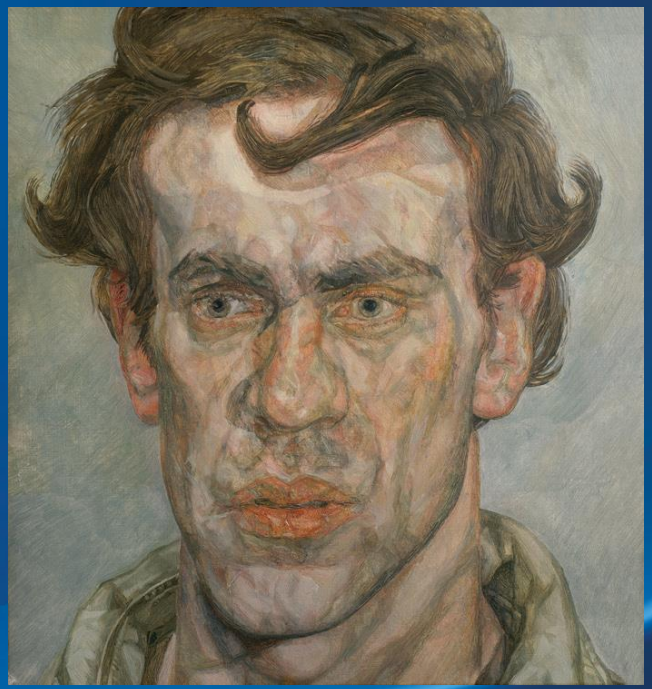
"I wish I could solve this problem for you, but the power to make the important changes is really yours."



Patient type	*Characteristics of the clinical encounters*	*Approach*
Dependent clinger: insecure, desperate for assurance, worried about abandonment	Patient initially plays to physician's sympathies and praises him or her, making the physician feel special As the relationship develops, the patient becomes needy, wants/demands increasing personal time from the physician; the physician may feel resentful	Maintain a professional demeanor Establish boundaries early and consistently maintain them Involve the patient in decision making Assure the patient that you will not abandon him or her Schedule regular follow-up appointments

"Early signs of the clinger are the patient's genuine gratitude, but to an extreme degree, and the doctor's feelings of power and specialness to the patient, an emotion not unlike puppy love."

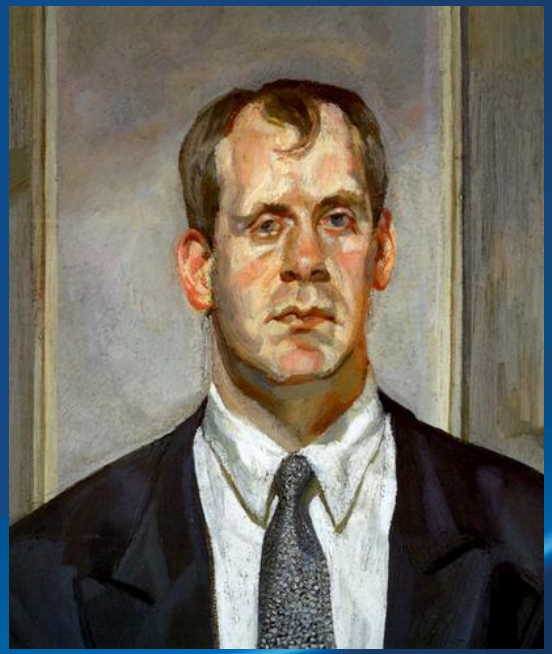
- "The Hateful Patient"



Entitled demander: often angry, does not want to go through necessary steps of assessment or treatment, may be reacting to fear and loss	Patient is aggressive and intimidating, forges a negative relationship with the physician Patient sees physician and health system as barriers to his or her needs Physician may feel anger, guilt, doubt, or frustration	Suspend judgment, and examine your own feelings Recognize that the patient's hostility may be his or her way of maintaining self-integrity during a devastating illness or other trauma If a specific emotion is evident, address it with the patient; do not react defensively when the patient expresses concerns Reinforce that the patient is entitled to good medical care, but that anger should not be misdirected at those trying to help

"The most helpful therapeutic strategy with the entitled demander is to support the entitlement but to re-channel it in the direction of the indicated regimen."

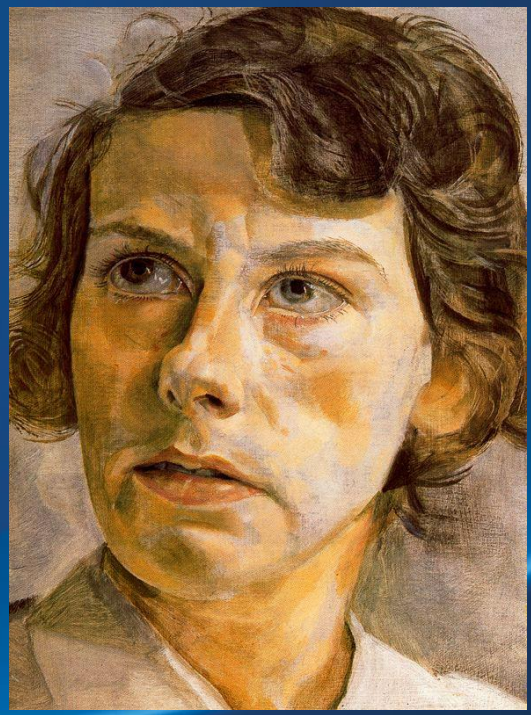
- "The Hateful Patient"



Manipulative help-rejecter: wants attention, has been rejected previously and has difficulty with trust, often has undiagnosed depression	Patient engages physician by subconscious manipulation Patient returns to the office often in cycles of help-seeking/rejecting treatment and does not improve despite appropriate advice Patient is confident that his or her health cannot improve Physician may be concerned about overlooking a serious illness	Recognize that the patient wants to stay connected to the physician, not necessarily to recover Engage the patient by sharing frustrations over poor outcomes Work with the patient to set limits on expectations Reformulate the health plan with the patient to focus on alleviating symptoms rather than curing the condition

"These behaviors elicit first in the physician anxiety that a treatable illness has been overlooked, next irritation with the patient and, finally, depression and self-doubt in the doctor."

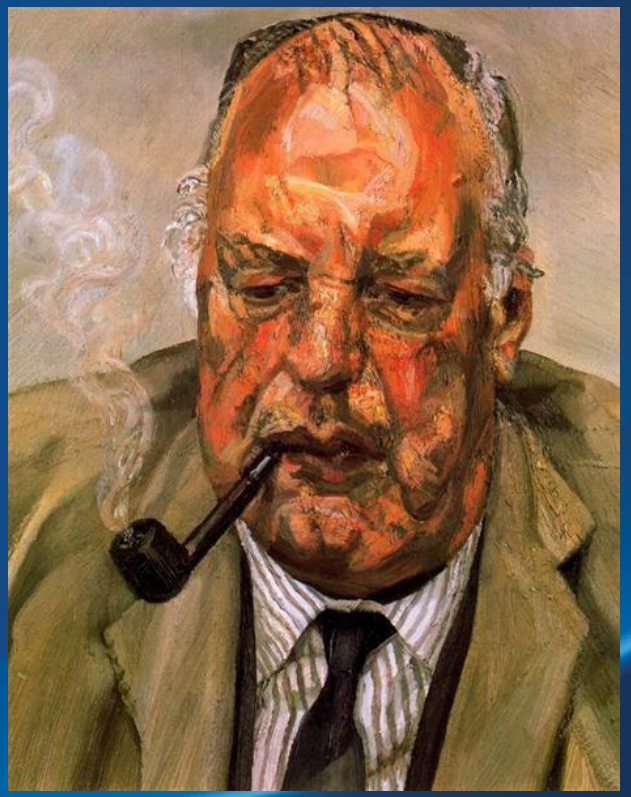
- "The Hateful Patient"

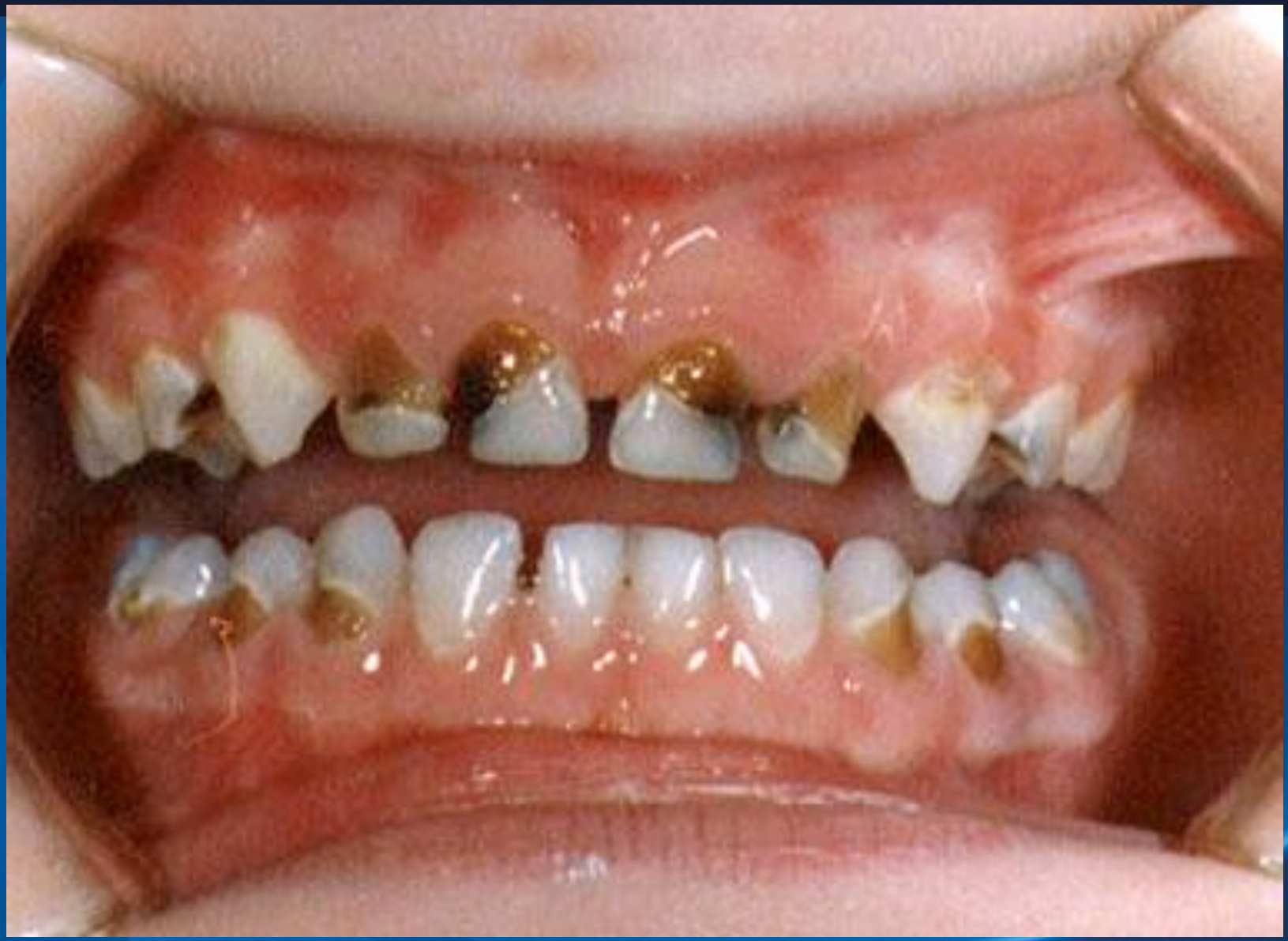


Self-destructive denier: feels hopeless about changing the situation, unable to help himself or herself, fears failure, may have untreated anxiety or depression	Health problems persist despite adequate counseling and treatment Patient continues self-destructive habits Physician may feel ineffective and responsible for lack of progress	Recognize that complete resolution of issues is limited Set realistic expectations Redirect patient's behavior to identify causes of nonadherence (e.g., money, time, access to medical care or appropriate treatment) Celebrate each small success with the patient Offer/arrange for psychological support

"The starting point for the care of such a patient is to recognize without shame or self-blame that they provoke in the their caregivers the fervent wish that they would die and 'get it over with.'"

- "The Hateful Patient"



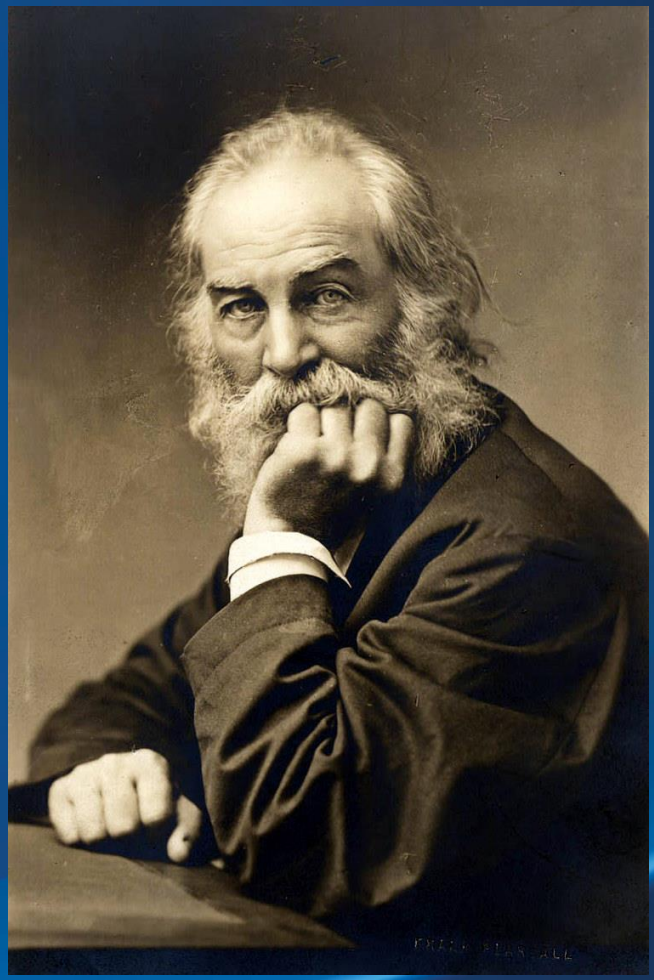


Whitman:

"I swear the earth shall surely be complete to him or her who shall be complete,

The earth remains jagged and broken only to him or her who remains jagged and broken."

Which is fine, but we shouldn't discount the power of negative thoughts, nor assume that the fault is always only within ourselves…



Risk Categories:

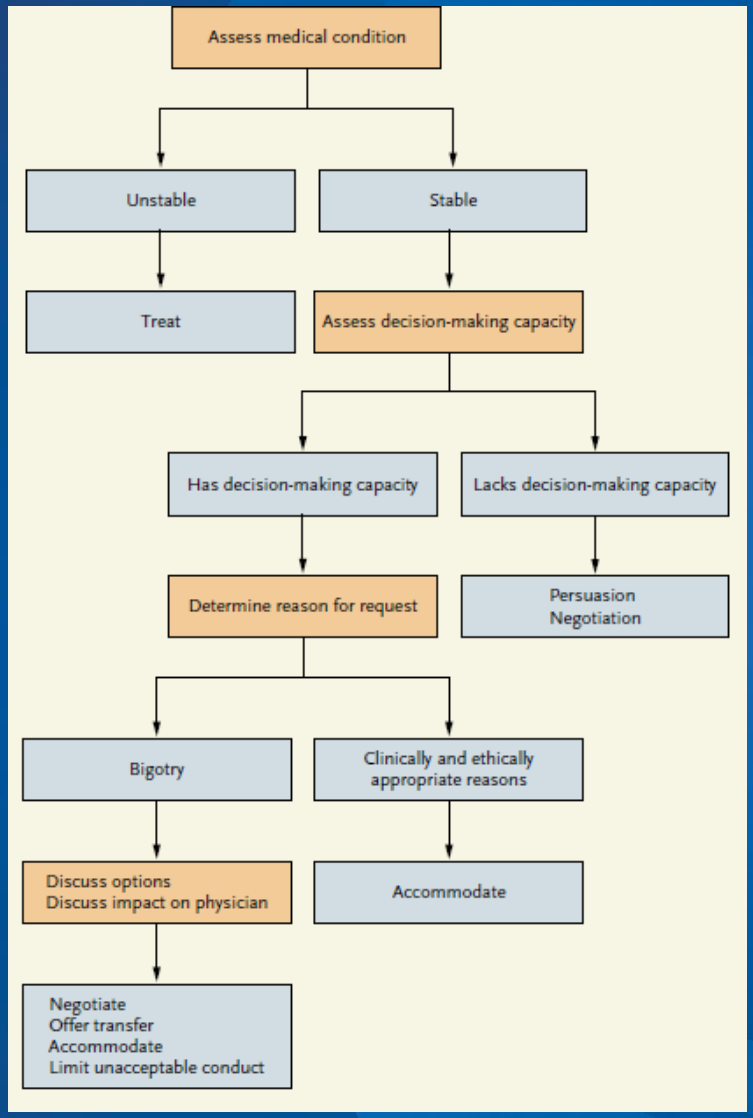
Dealing with Racist Patients

Kimani Paul-Emile, J.D., Ph.D., Alexander K. Smith, M.D., M.P.H., Bernard Lo, M.D., and Alicia Fernández, M.D.

A 77-year-old white man with heart failure arrives in the emergency department of an urban hospital at 3 a.m. with shortness of breath and a fever. When a black physician enters, the man immediately announces, "I don't want to be cared for by a %$#!{& doctor!" Taken aback, the physician retreats from the room. She's offended by the man's rejection and demeaning language — but knows that he may have a serious medical condition and that she cannot treat him against his will. How should the physician proceed?

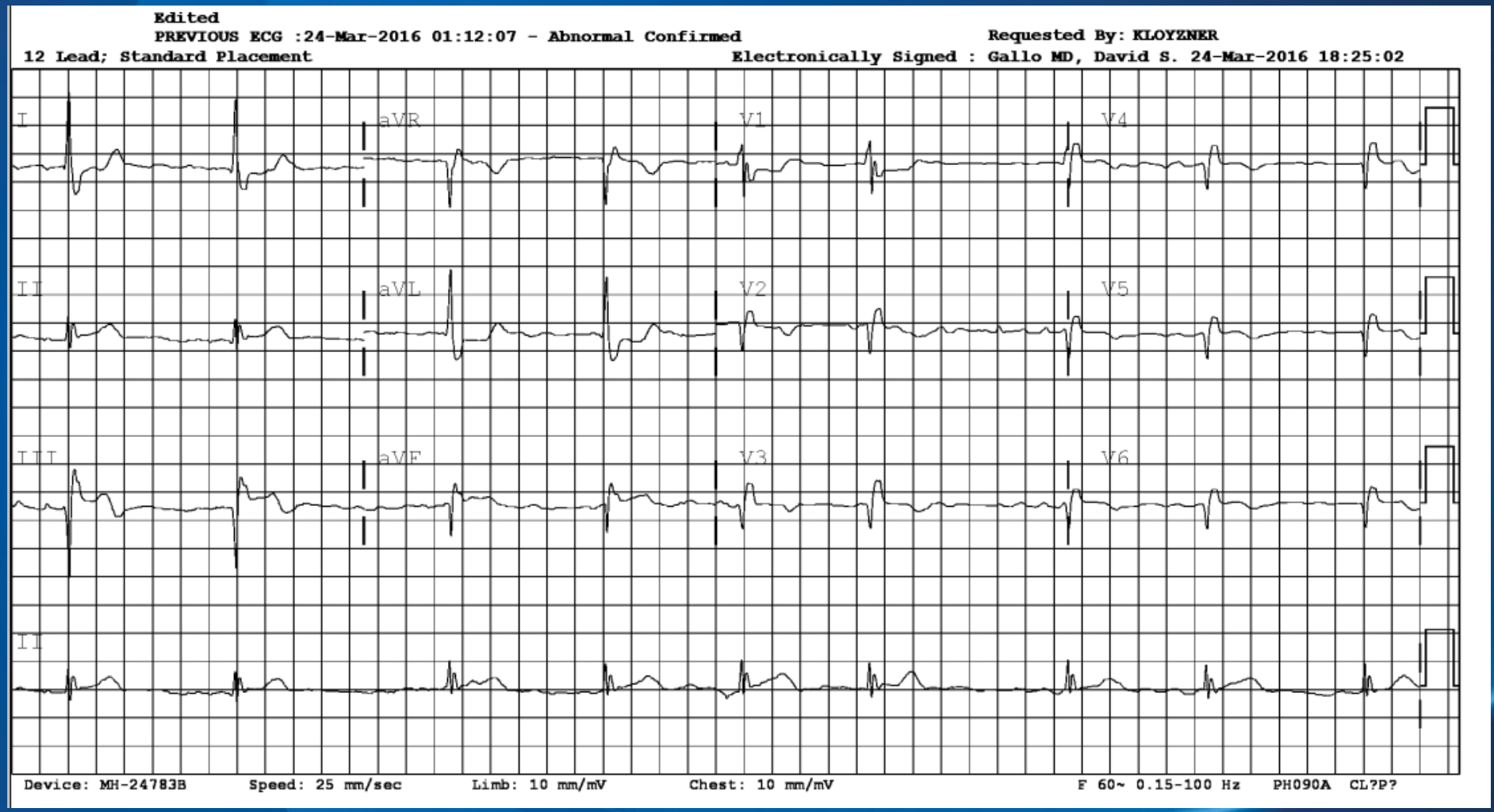
A patient's refusal of care based on the treating physician's race or ethnic background[1] can raise thorny ethical, legal, and clinical issues — and can be painful, confusing, and scarring for the physicians involved. And we fear that race-based reassignment demands will only increase as the U.S. physician population becomes more racially and ethnically diverse. So we've created a framework for considering and addressing such demands.

Competent patients have the right to refuse medical care, including treatment provided by an unwanted physician. This right is granted by informed-consent rules and common law that protects patients from battery. Patients presenting with an emergency



"Racism may indeed carry out the doom of the western world and, for that matter, of the whole of human civilization. When Russians have becomes Slavs, when Frenchman have assumed the role of commanders of a force noir, when Englishmen have turned into "white men," as already for a disastrous spell all Germans were Aryans, then this change will itself signify the end of Western man. For no matter what learned scientists may say, race is, politically speaking, not the beginning of humanity but its end, not the origin of peoples but their decay, not the natural birth of man but his unnatural death."

-- H. Arendt


Edited
PREVIOUS ECG :24-Mar-2016 01:12:07 - Abnormal Confirmed
Requested By: KLOYZNER
12 Lead; Standard Placement
Electronically Signed : Gallo MD, David S. 24-Mar-2016 18:25:02
I
II
III
aVR
aVL
aVF
V1
V2
V3
V4
V5
V6
II
Device: MH-24783B
Speed: 25 mm/sec
Limb: 10 mm/mV
Chest: 10 mm/mV
F 60~ 0.15-100 Hz
PH090A CL?P?

How can
you tell
at the start
what you
can give away
and what
you must hold
to your heart.
What is
the well
and what is
a cup. Some
people get
drunk up.

--Kay Ryan

Specific "difficult" scenarios…

- The splitter and the rub of confidentiality.
- Pain meds.
- Hard news.
- The many forms of resistance…
  - Denigration
  - Denial
  - Complaints

MICHELLE KANE, PsyD, AND LEE CHAMBLISS, MD

Getting to No: How to Respond to Inappropriate Patient Requests

The five-step "FAVER" approach can help you say no to uncomfortable requests while preserving the patient relationship.

FPM | January/February 2018

When patients ask, "Hey, doc, can you do me a favor?" and that favor is an inappropriate request for opioids, work excuses, expensive tests, etc., this five-step "FAVER" approach can help you respond effectively while preserving the patient relationship.

F: **Recognize any uncomfortable *feelings* that stem from the patient's request.** These feelings are the cue that you may need to think carefully about the situation.

A: ***Analyze* why the patient's request makes you feel uncomfortable.** Your discomfort can usually be mapped to one of the following reasons – fulfilling the request would be poor medical care, illegal, dishonest, or against policy.

V: ***View* the patient in the best possible light.** If you assume the patient knows that his or her request is "wrong," this can compound negative feelings and complicate the interpersonal interaction further, so begin the discussion with good intent.

E: ***Explicitly* state why the request is inappropriate.** For example, state that it would be poor medical care, illegal, dishonest, or against policy. Be careful to avoid lengthy explanations, which invite debate.

R: **Reestablish *rapport*.** Try using empathic but decisive language such as "I know this is not what you wanted" or "I wish I could write you an excuse. It would not be honest, though, so I can't."

How to say no…

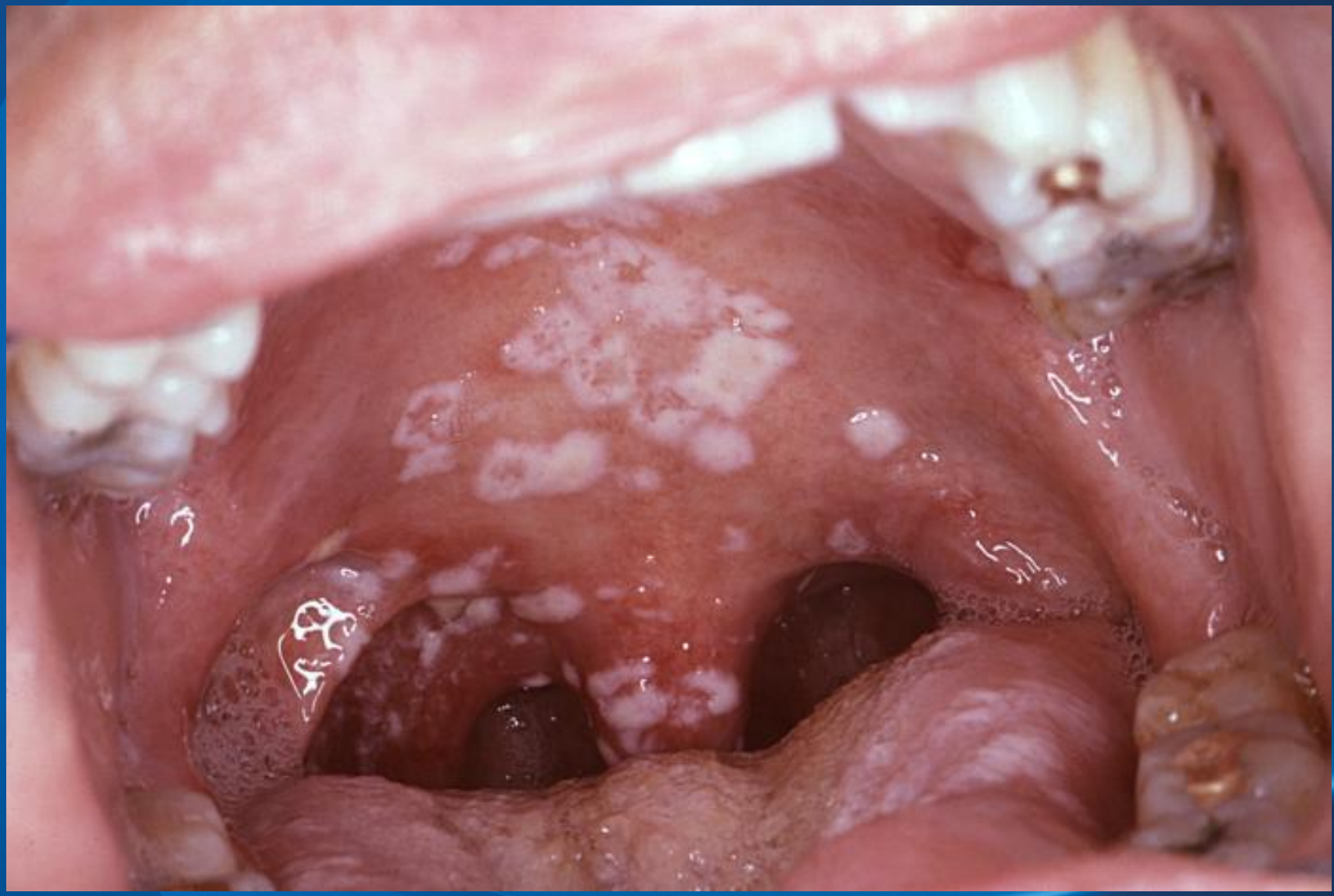
- Recognize that “no” hurts…
- Bait and switch
- Accept responsibility
  - (won’t v. can’t)
- Repeat, repeat, repeat
- Show faith

Ease the suffering: before the visit

- Ask yourself, “Why do I consider this patient difficult?”
- What biases and assumptions do I have?
- What is my agenda?
- Take three deep breaths
  - Relieve tension
  - Be present

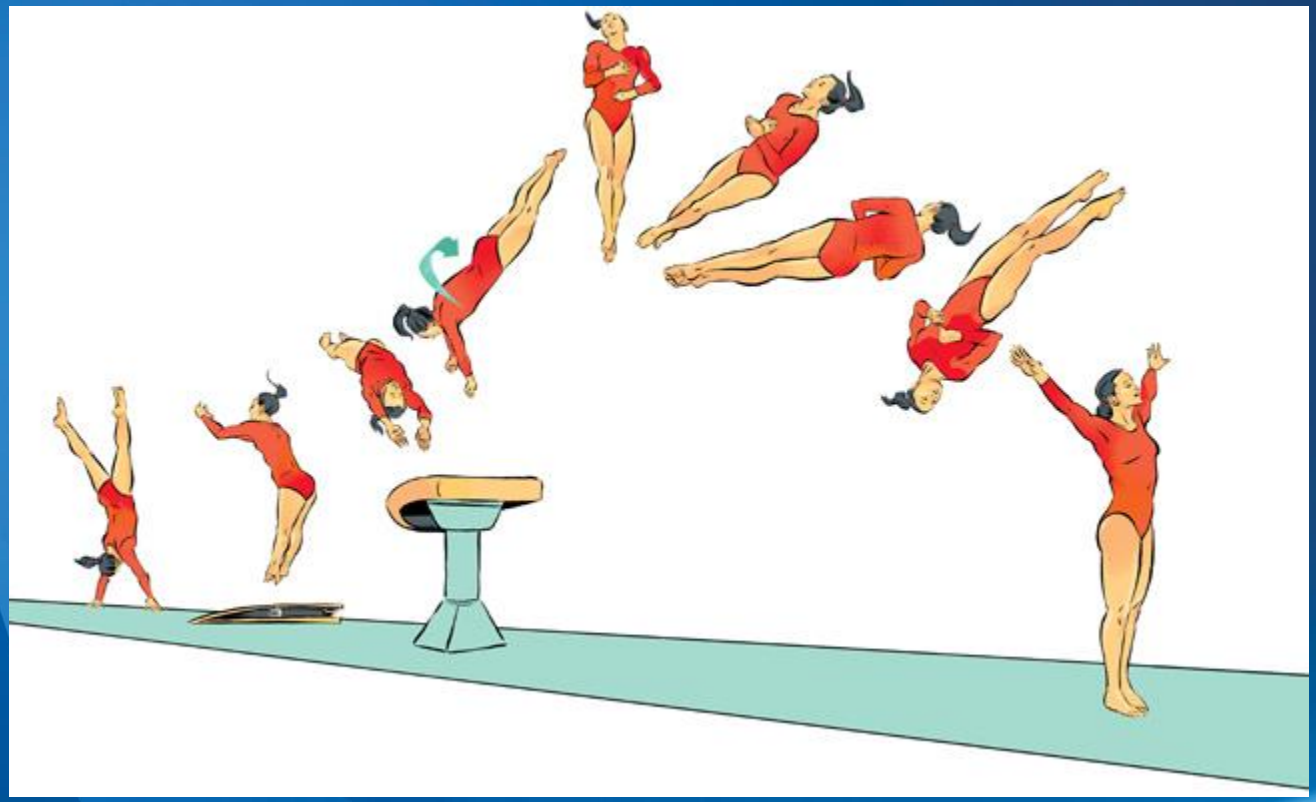
Ease the suffering: during the visit

- Be aware of body language.
- Figure out the patient's agenda.
- What social history can I gather to help explore potentially unhelpful assumptions?



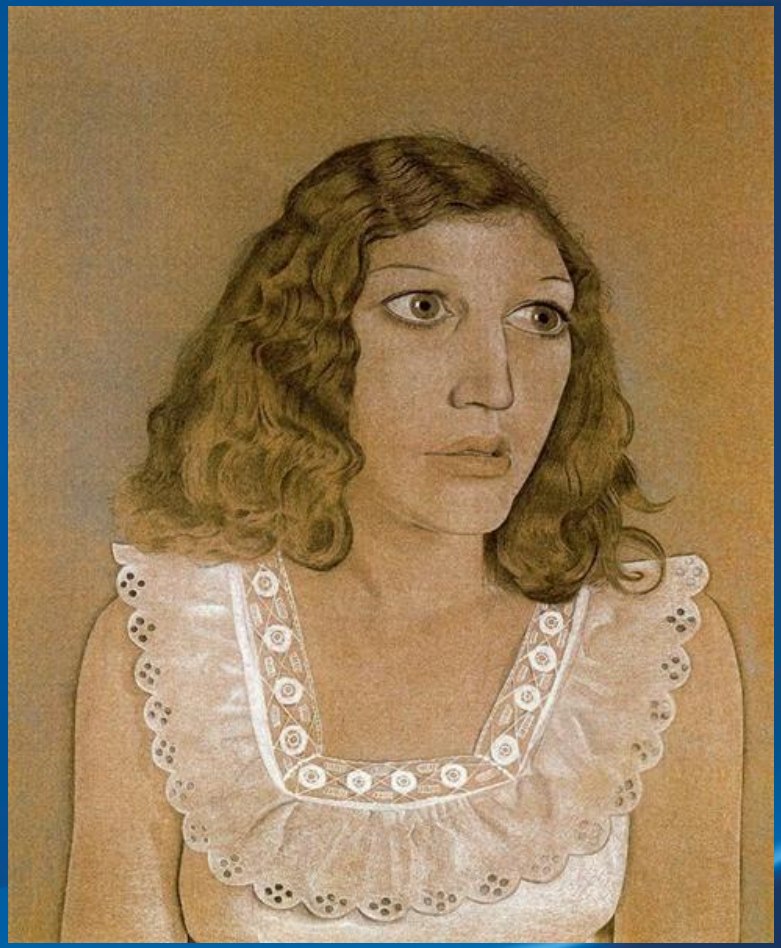
"Sticking the Landing: How to Create a Clean End to a Medical Visit,"

Fam Pract Manag. 2004 Jul-aug; 11(7):51-53



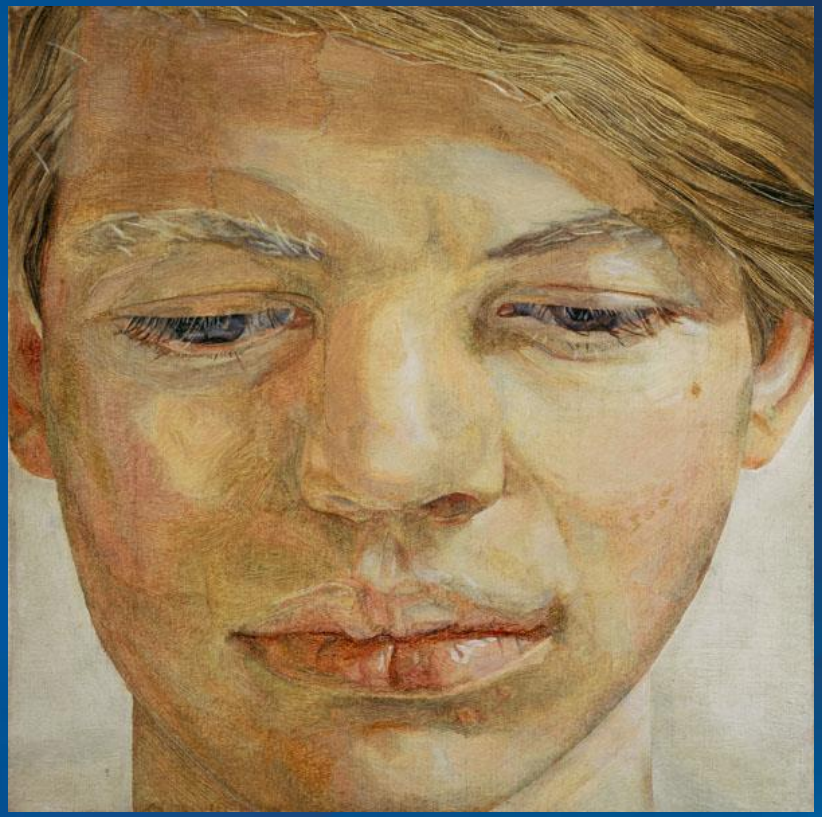
Start with an Agenda:

- Exhaust the agenda:
  - Why are you here?
  - And what else?
  - And what else?



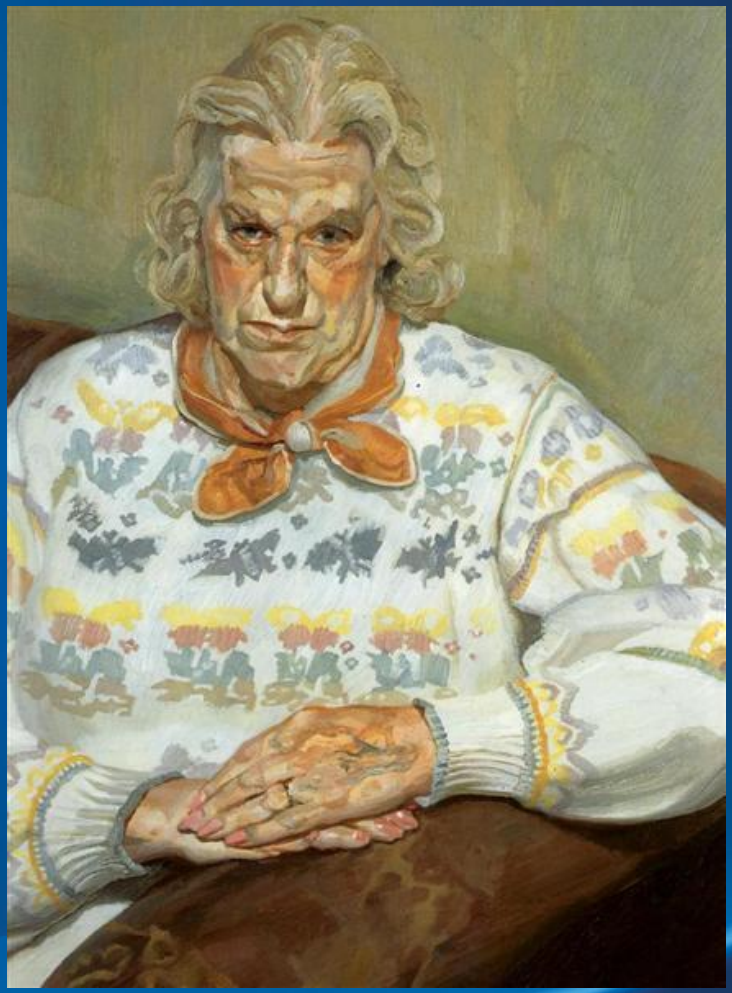
Use verbal cues:

- “Let me do this and then we’ll do that…”
- Foreshadowing.
- Give notice of the visit’s end…



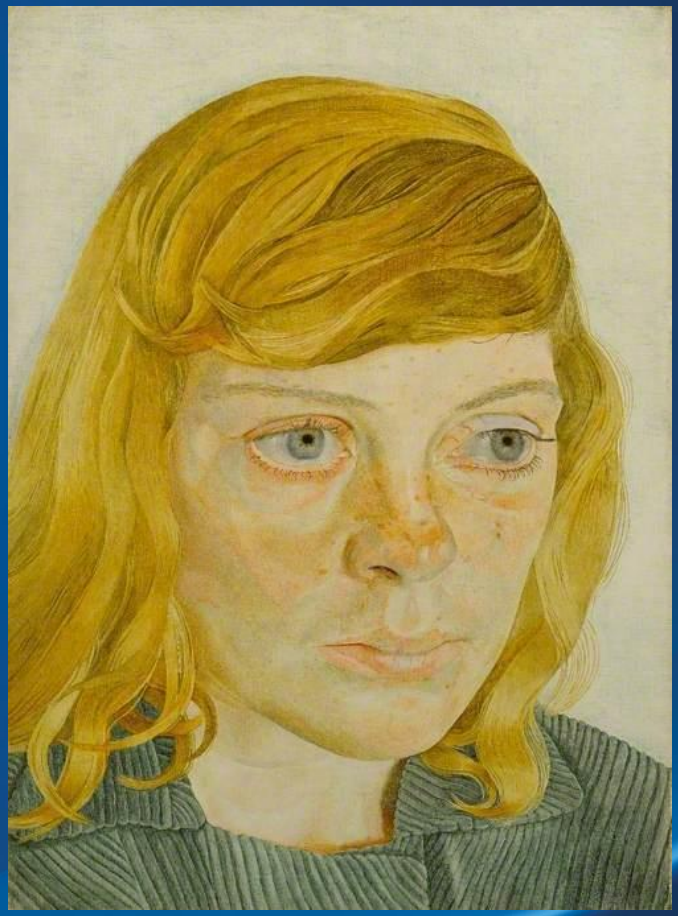
Address the pt's emotions up front:

- BATHE technique
  - Background
  - Affect
  - Troubles
  - Handling
  - Empathy



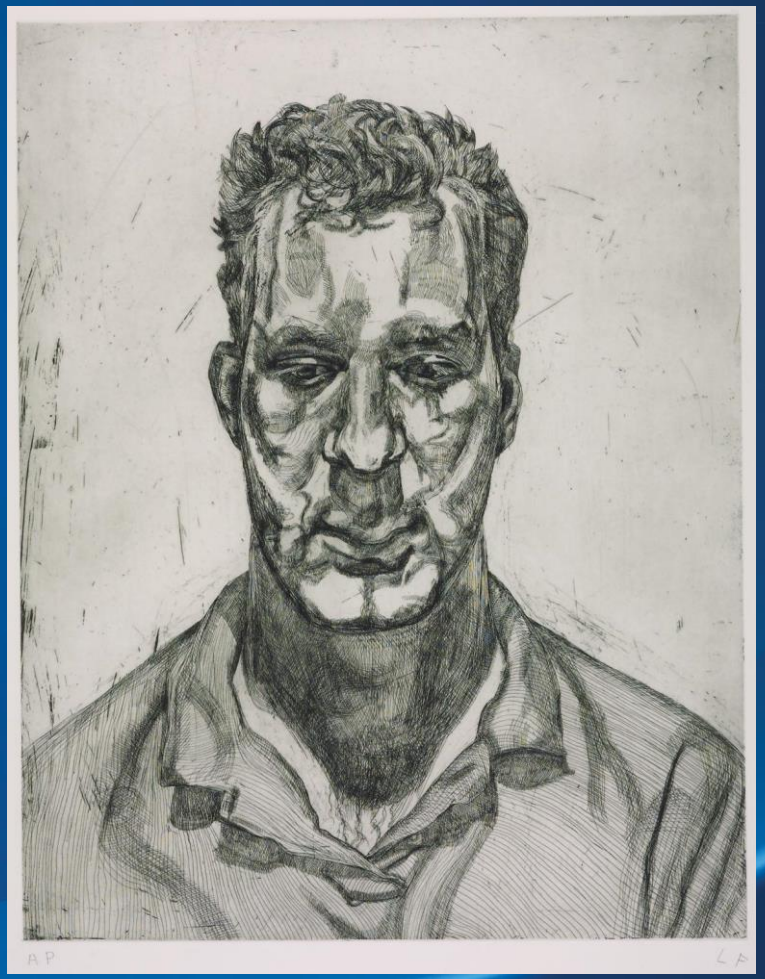
Address the pt's emotions up front:

- BATHE technique
  - What's going on in your life?
  - How do you feel about that?
  - What troubles you most about it?
  - How are you handling this?
  - That must be difficult for you.



Address your own emotions:

- Guilt.
- Inadequacy.
- Cognitive distortions.



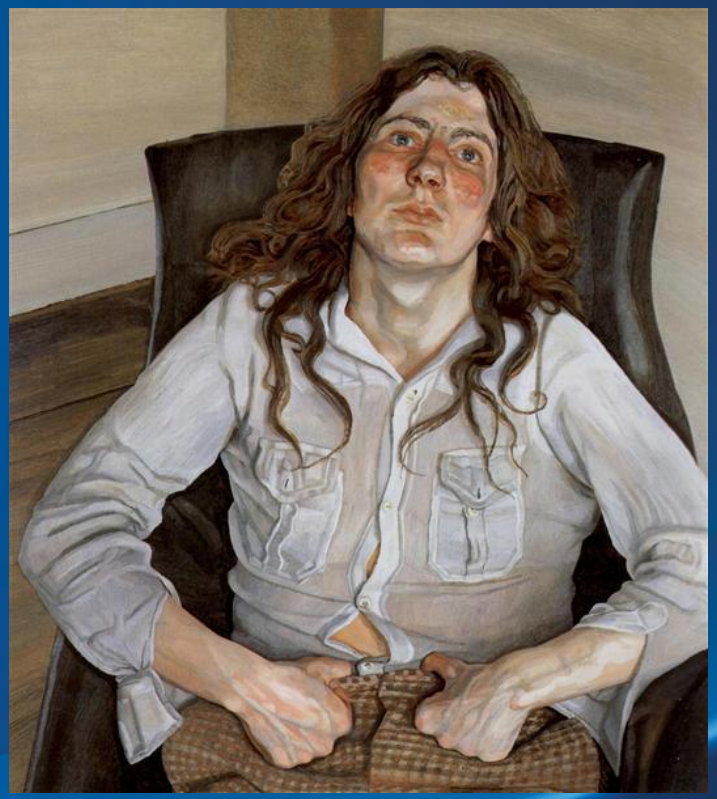
Have a seat:

- Time perception.
- Body language.

- "I paint people not because of what they are like, not exactly in spite of what they are like, but how they happen to be." - Lucian Freud

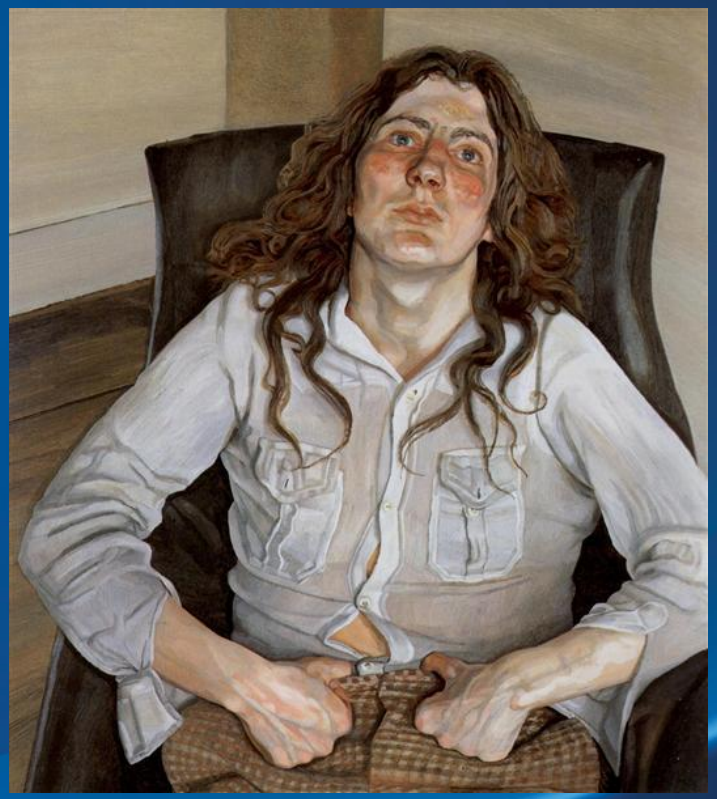
Be prepared for “oh by the way”:

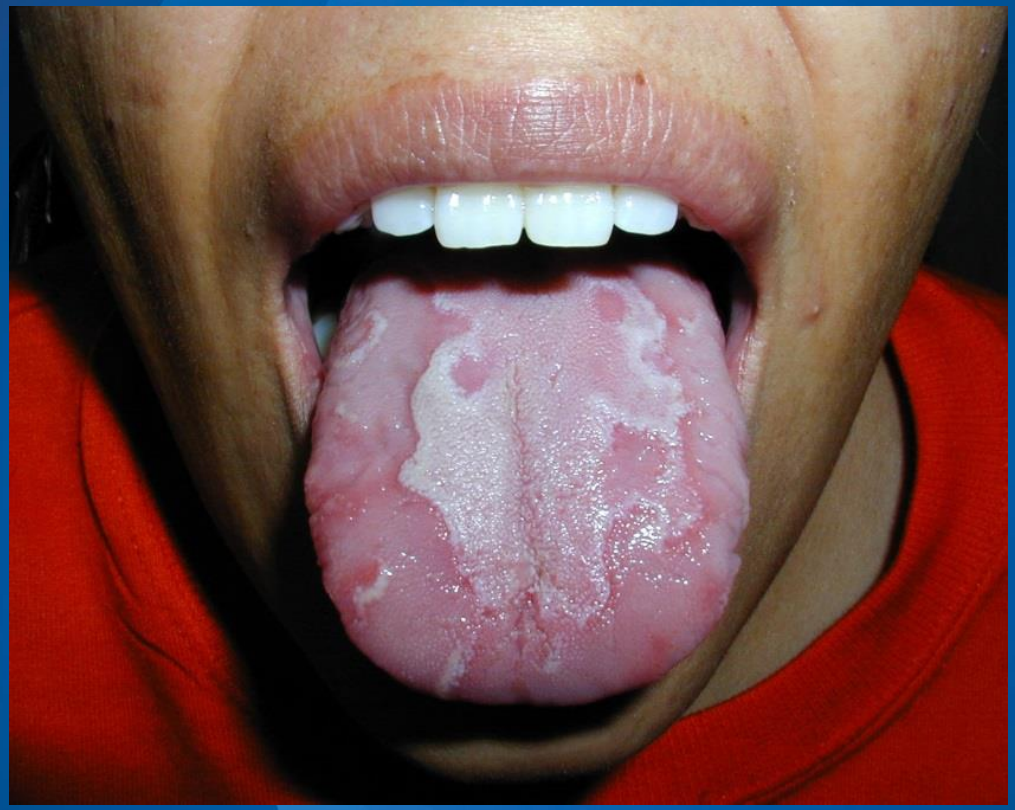
- “I know this can be uncomfortable to discuss, and I am glad you brought it to my attention. In order to deal with it adequately, I am going to need more time to talk to you. I’d like to schedule an appointment so that we can give it the attention it deserves. How does that sound?”

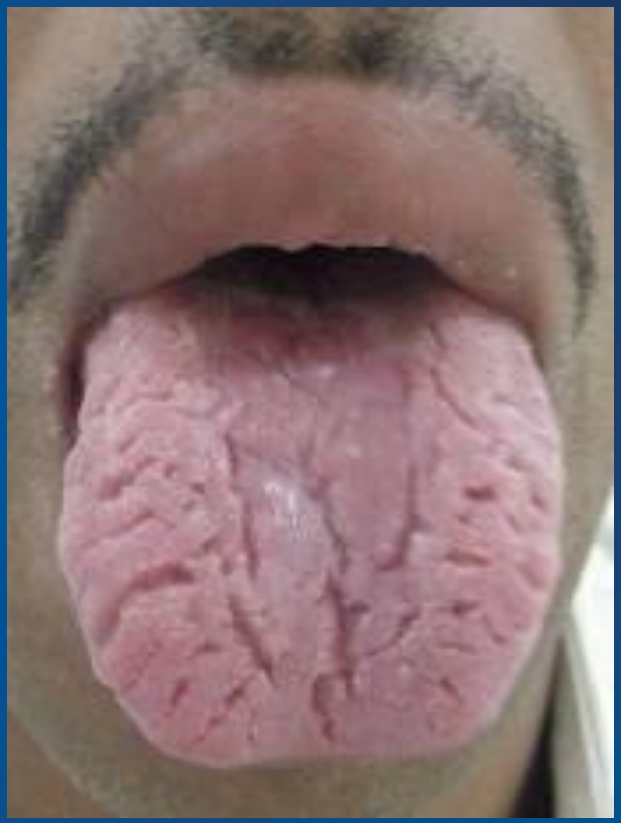


Be more specific: the ending

- "Is there anything else you want to talk about?"
- "Is there something else you want to talk about?
- "Do you have any questions about what we discussed today?"







a. Geographic tongue (benign migratory glossitis)
b. Fissured tongue (scrotal tongue, lingua plicata)

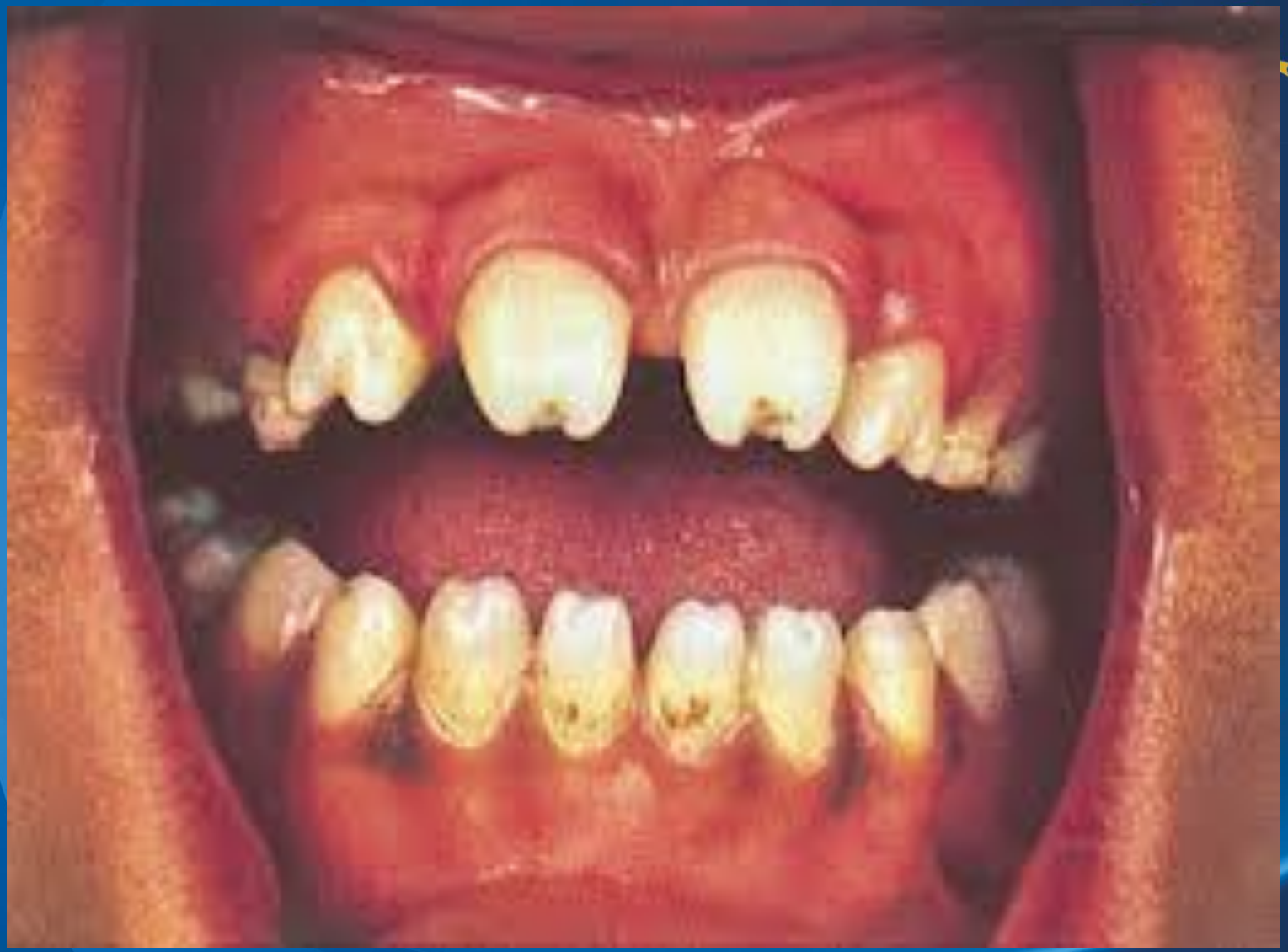
Patient-Centered Communication: Basic Skills

M. JAWAD HASHIM, MD, *United Arab Emirates University College of Medicine and Health Sciences, Al Ain, Abu Dhabi*

Communication skills needed for patient-centered care include eliciting the patient's agenda with open-ended questions, especially early on; not interrupting the patient; and engaging in focused active listening. Understanding the patient's perspective of the illness and expressing empathy are key features of patient-centered communication. Understanding the patient's perspective entails exploring the patient's feelings, ideas, concerns, and experience regarding the impact of the illness, as well as what the patient expects from the physician. Empathy can be expressed by naming the feeling; communicating understanding, respect, and support; and exploring the patient's illness experience and emotions. Before revealing a new diagnosis, the patient's prior knowledge and preferences for the depth of information desired should be assessed. After disclosing a diagnosis, physicians should explore the patient's emotional response. Shared decision making empowers patients by inviting them to consider the pros and cons of different treatment options, including no treatment. Instead of overwhelming the patient with medical information, small chunks of data should be provided using repeated cycles of the "ask-tell-ask" approach. Training programs on patient-centered communication for health care professionals can improve communication skills. (*Am Fam Physician*. 2017;95(1):29-34.

Table 2. Verbal and Nonverbal Methods for Facilitating Patient-Centered Communication

Method	*Examples*
Verbal	
Continuers	"Go on," "I hear you," "Hmmm," "Aha"
Legitimation	"That makes sense."
Open-ended questions	"Tell me more about..."
Understanding	"It seems like ..."
Exploration	"I wonder if you ..."
Rephrasing	"Let me summarize what you have told me so far..."
Checking the patient's understanding	"Could you summarize what we have discussed so far?"
Nonverbal	
Attention	Judicious eye contact
Responsiveness	Facial expressions such as grinning, lip biting, concerned frowning
Attentiveness	Holding of chin, keeping index finger on temple
Openness	Palms exposed, avoiding crossed arms or legs
Interest	Leaning forward
Active listening	Head nodding
Focus	Purposefully turning away from the computer or medical file
	Tactful silent pauses
	Avoiding interrupting or completing sentences



SPECIAL ARTICLE

TAKING CARE OF THE HATEFUL PATIENT

JAMES E. GROVES, M.D.

Abstract "Hateful patients" are not those with whom the physician has an occasional personality clash. As defined here they are those whom most physicians dread. The insatiable dependency of "hateful patients" leads to behaviors that group them into four stereotypes: dependent *clingers*, entitled *demanders*, manipulative *help-rejecters* and self-destructive *deniers*.

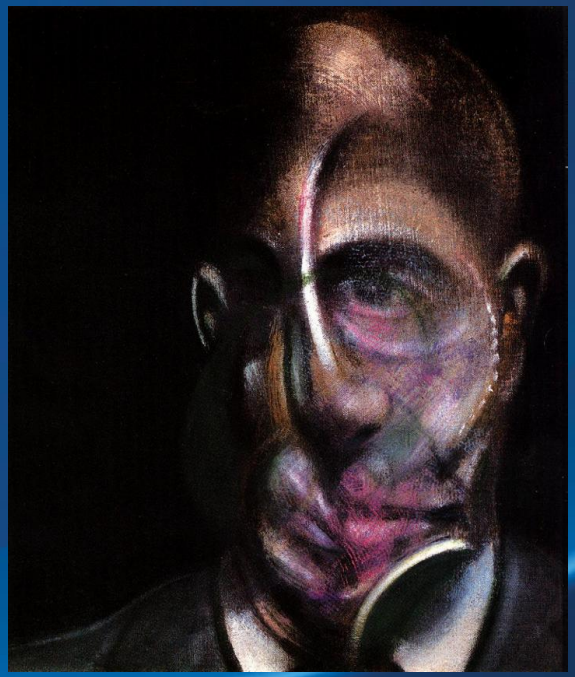
The physician's negative reactions constitute important clinical data that should facilitate better understanding and more appropriate psychological management for each. Clingers evoke aversion; their care requires limits on expectations for an intense doctor-patient relationship. Demanders evoke a wish to counterattack; such patients need to have their feelings of total entitlement rechanneled into a partnership that acknowledges their entitlement — not to unrealistic demands but to good medical care. Help-rejecters evoke depression; "sharing" their pessimism diminishes their notion that losing the symptom implies losing the doctor. Self-destructive deniers evoke feelings of malice; their management requires the physician to lower Faustian expectations of delivering perfect care. (N Engl J Med 298:883-887, 1978)

The difficult patient; the heart-sink patient…

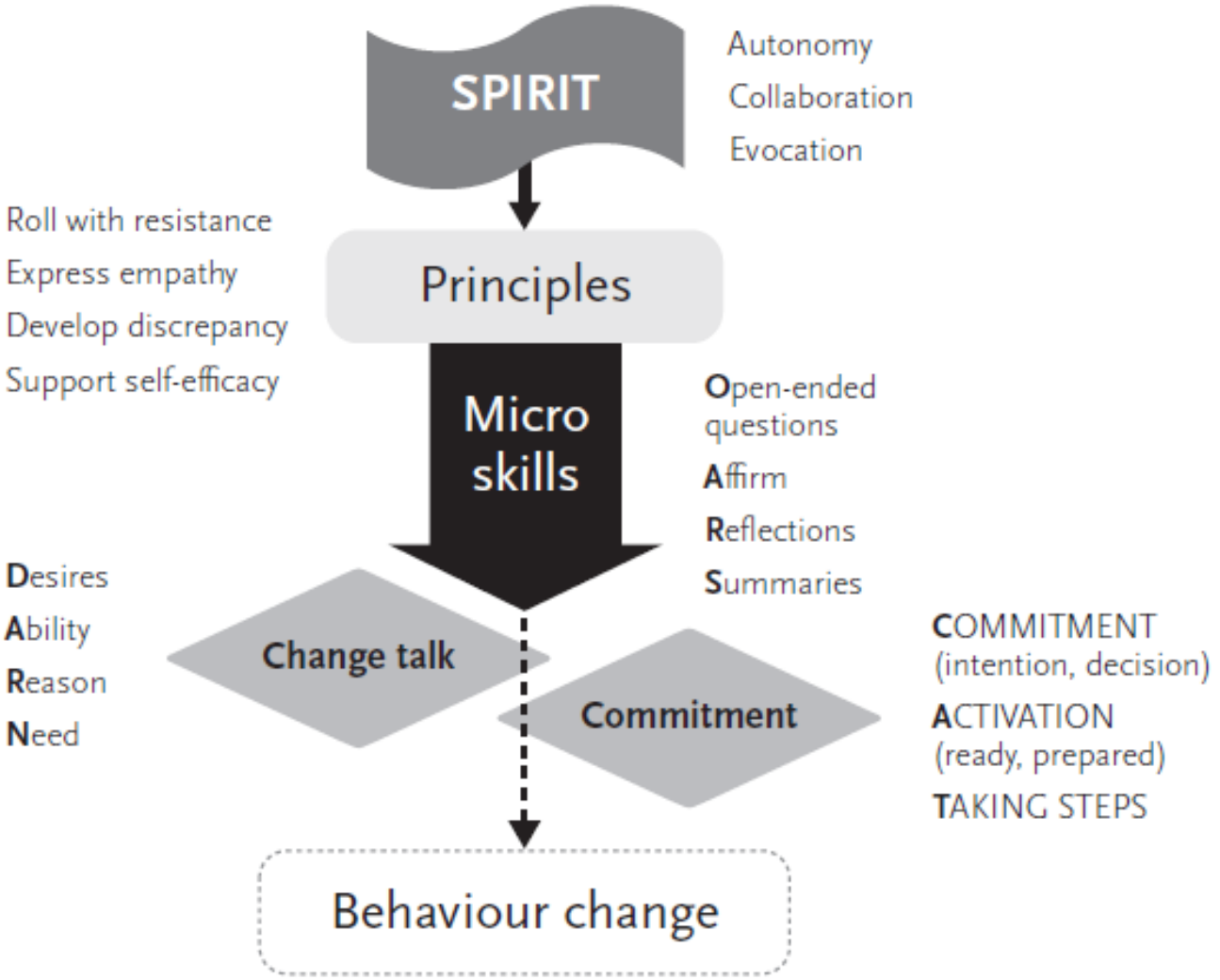
So let's move on from 1978…

- Goals
  - Talk about motivational interviewing
  - Resistance
  - Ambivalence
  - Stages of change
  - Confrontational interviewing

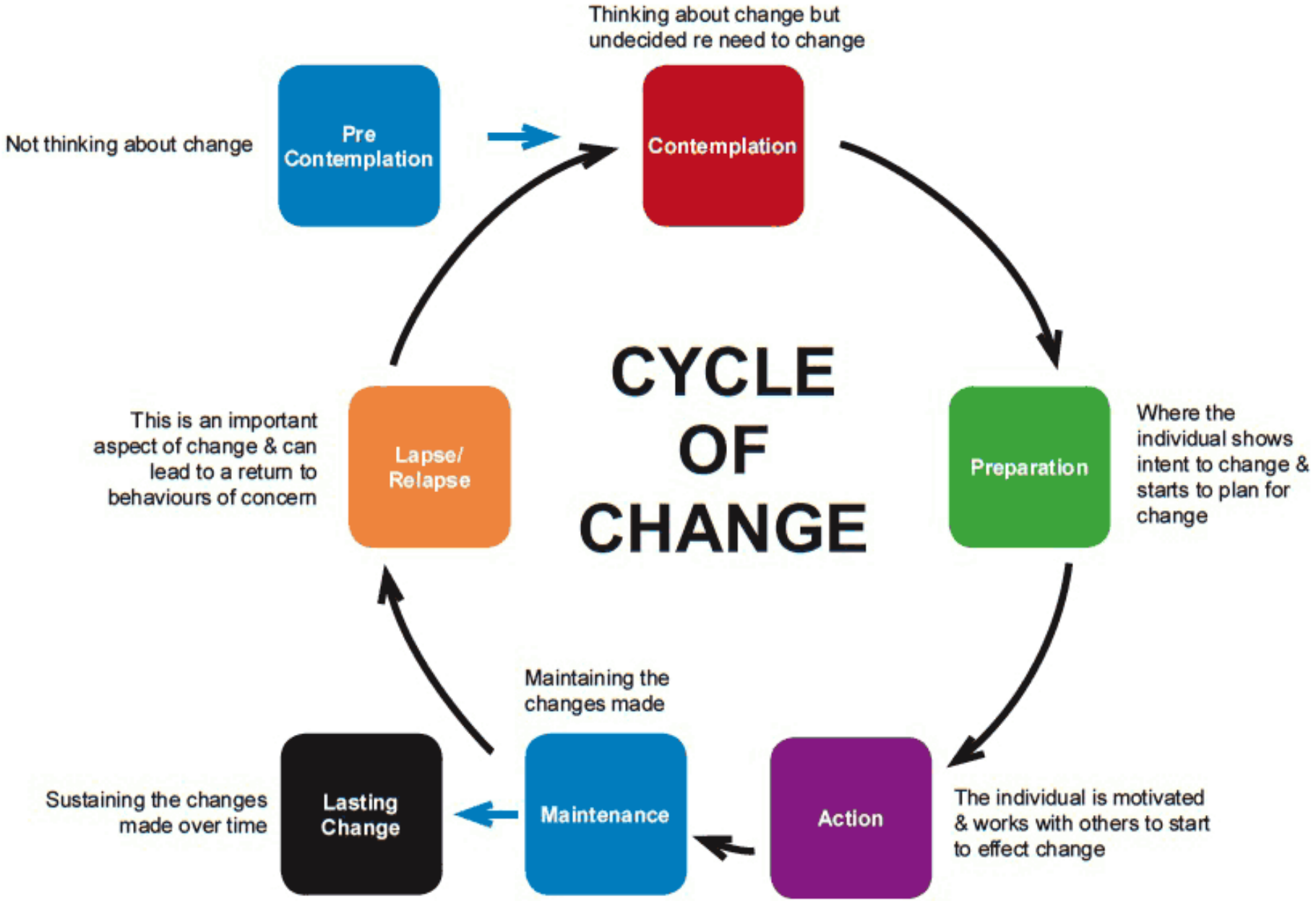
  - (and we'll move quickly because…)



The Framework of Motivational Interviewing



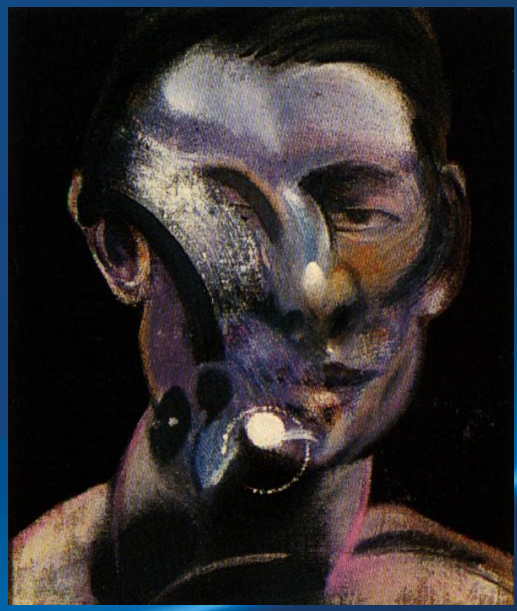
Source: MINT Training, Centre for Addiction and Mental Health.


CYCLE OF CHANGE
Not thinking about change
Pre Contemplation
Thinking about change but undecided re need to change
Contemplation
Preparation
Where the individual shows intent to change & starts to plan for change
Action
The individual is motivated & works with others to start to effect change
Maintenance
Maintaining the changes made
Lasting Change
Sustaining the changes made over time
Lapse/ Relapse
This is an important aspect of change & can lead to a return to behaviours of concern

Extreme reframing and reflection:

- 54 year old smoker who doesn't want to quit. He has COPD, DM, and a history of a heart attack. "It's the only thing I enjoy…"
- How do you approach this?

- (and who is this painter?)



Caveats:

"Motivational interviewing is a method of communication rather than a set of techniques. It is not a bag of tricks for getting people to do what they don't want to do. It is not something that one does to people; rather, it is fundamentally a way of being with and for people."

Caveats:

"Humiliation, shame, guilt and angst are not the primary engines of change."

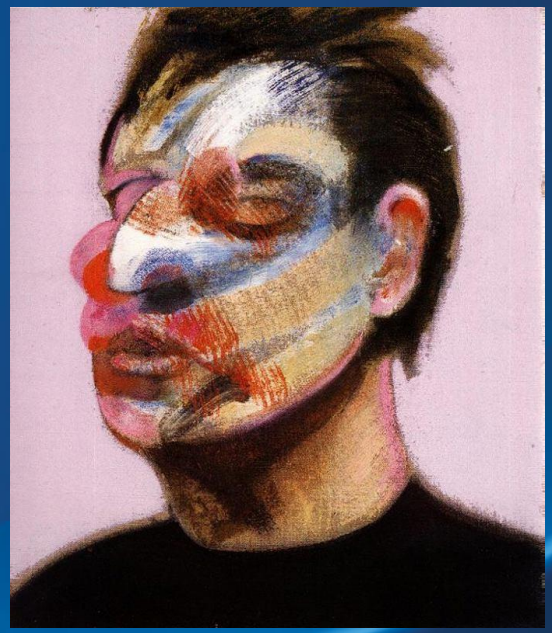
Caveats:

"reflection is not a passive process."

- simple reflection
- amplified reflection
- double-sided reflection

To recap:

- Goals
  - Motivational Interviewing is an approach.
  - Resistance can be difficult
    - Contributes to difficult encounters
  - Ambivalence is universal
  - Stages of change: a construct
  - Confrontation
    - As the opposite of MI…



A few last thoughts on thriving in medicine:

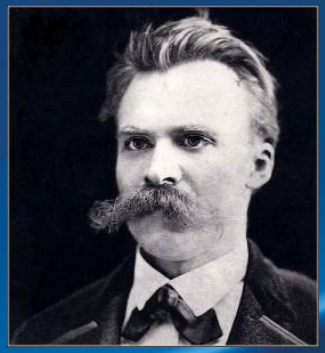
Because difficult encounters reflect difficulties in our engagement with the world…

Is that a true statement?

How cultivate compassion?

How do we care for ourselves?

- "Every sufferer, in fact, searches instinctively for a cause of his suffering; to put it more exactly, a doer, –to put it still more precisely, a sentient responsible doer, –in brief, something living, on which, either actually or in effigie, he can on any pretext vent his emotions. For the venting of emotions is the sufferer's greatest attempt at alleviation, that is to say, stupefaction, his mechanically desired narcotic against pain of any kind." -- Nietzsche



Proust and rough empathy…

"Later on, when, in the course of my life, I have had occasion to meet with, in convents for instance, literally saintly examples of practical charity, they have generally had the brisk, decided, undisturbed, and slightly brutal air of a busy surgeon, the face in which one can discern no commiseration, no tenderness at the sight of suffering humanity, and no fear of hurting it, the face devoid of gentleness or sympathy, the sublime face of true goodness." – Swann's Way

Compassion:

Image of pt. as child…

Centering…

Meditate on your mother's bones…

all that is built crumbles
all that is gathered in disperses
everyone we meet will disappear
everyone born will die

Experience…

Art, music, nature: self care: being present

- Groves, James, MD, "Taking Care of the Hateful Patient," NEJM 298:883-887, 1978
- Edgoose, Jennifer, MD MPH, "Rethinking the Difficult Patient Encounter," Fam Pract Manag., July/August 2012
- Hull, Sharon, MD MPH, "How to Manage Difficult Patient Encounters," Fam Practice Manag., June 2007
- Gillette, Robert, MD, "Problem Patients: A Fresh Look at an Old Vexation," Fam Pract Manag., Jul-Aug 2000
- Haas, Leonard, PhD et al., "Management of the Difficult Patient," Am Fam Physician 2005; 72: 2063-8
- Lorenzetti, MD, et al., "Managing Difficult Encounters: Understanding Physician, Patient, and Situational Factors," Am Fam Physician, 2013; 87 (6): 419-425
- Spickerman, Frances, PhD, "The Fine Art of Refusal,' Fam Pract Manag., 2004 Feb; 11(2)80
- Lutton, Michelle, PsyD, "Sticking the Landing: How to Create a Clean End to a Medical Visit," Fam Pract Manag., 2004 Jul-Aug; 11(7): 51-53