Scandinavian Journal of Primary Health Care

ISSN: 0281-3432 (Print) 1502-7724 (Online) Journal homepage: http://www.tandfonline.com/loi/ipri20

What happens when the doctor denies a patient's request? A qualitative interview study among general practitioners in Norway

Stein Nilsen & Kirsti Malterud

To cite this article: Stein Nilsen & Kirsti Malterud (2017) What happens when the doctor denies a patient's request? A qualitative interview study among general practitioners in Norway, Scandinavian Journal of Primary Health Care, 35:2, 201-207, DOI: 10.1080/02813432.2017.1333309

To link to this article: https://doi.org/10.1080/02813432.2017.1333309

Published online: 05 Jun 2017.

SCANDINAVIAN JOURNAL OF PRIMARY HEALTH CARE, 2017
VOL. 35, NO. 2, 201–207
https://doi.org/10.1080/02813432.2017.1333309

Taylor & Francis
Taylor & Francis Group

RESEARCH ARTICLE

OPEN ACCESS Check for updates

What happens when the doctor denies a patient's request? A qualitative interview study among general practitioners in Norway

Stein Nilsen[a] and Kirsti Malterud[a,b,c]

[a]Research Unit for General Practice, Uni Research Health, Bergen, Norway; [b]Department of Global Public Health and Primary Care, University of Bergen, Bergen, Norway; [c]The Research Unit for General Practice and Section of General Practice, Department of Public Health, University of Copenhagen, Copenhagen, Denmark

ABSTRACT

Objective: To explore general practitioners (GPs') experiences from consultations when a patient's request is denied, and outcomes of such incidents.

Design and participants: We conducted a qualitative study with semi-structured individual interviews with six GPs in Norway. We asked them to tell about experiences from specific encounters where they had refused a patient's request. The texts were analysed with Systematic Text Condensation, a method for thematic cross-case analysis.

Main outcome measures: Accounts of experiences from consultations when GPs refused their patients' requests.

Results: Subjects of dispute included clinical topics like investigation and treatment, certification regarding welfare benefits and medico-legal issues, and administrative matters. The arguments took different paths, sometimes settled by reaching common ground but more often as unresolved disagreement with anger or irritation from the patient, sometimes with open hostility and violence. The aftermath and outcomes of these disputes lead to strong emotional impact where the doctors reflected upon the incidents and sometimes regretted their handling of the consultation. Some long-standing and close patient–doctor relationships were injured or came to an end.

Conclusions: The price for denying a patient's request may be high, and GPs find themselves uncomfortable in such encounters. Skills pertaining to this particular challenge could be improved though education and training, drawing attention to negotiation of potential conflicts. Also, the notion that doctors have a professional commitment to his or her own autonomy and to society should be restored, through increased emphasis on core professional ethics in medical education at all levels.

ARTICLE HISTORY
Received 11 December 2016
Accepted 1 February 2017

KEYWORDS
Family practice; disputes; decision-making; shared; doctor patient relation; personal autonomy; professional autonomy; qualitative research

Introduction

The patient–doctor relationship has undergone a great transformation during the last decades. A paternalistic tradition was during the 1970s challenged by increased attention towards clinical communication and the patient's views, introducing the patient-centred clinical method [1]. Ideas of patient autonomy gradually evolved and are today accepted as the prevailing philosophy for the patient–doctor relationship throughout the Western world. Shared decision-making (SDM) developed gradually as an approach to secure patient autonomy and maintain the impact of the doctor's expertise and assumed benevolence [2,3].

It has been argued that this development has put the doctor's professional autonomy under pressure, giving the doctor the role as a passive provider who merely presents different options from which the patient may choose [4]. Pellegrino stated that autonomy is a moral right for the patient as well as the doctor [5]. He argues that autonomy is the most powerful principle shaping the patient–doctor relationship, and that both parties have an obligation to respect the other. Yet, he remarks that the growing authority of patient autonomy poses a threat to the doctor's professional autonomy. When the two are in conflict, the patient's wish does not inevitably overrule the doctor's. Thus, a request from the patient should not always find a solution by means of SDM. Certain areas are indisputably regulated by law or medical guidelines and as such not negotiable. In Norway,

CONTACT Stein Nilsen nilsen.stein@gmail.com Research Unit for General Practice, Uni Research Health, Kalfarveien 31, N-5018 Bergen, Norway

The National Insurance Act and The Law Relating to Health Personnel are examples of such regulations [6,7]. Also, The Norwegian Medical Association has in its Ethical Guidelines for Doctors outlined the responsibility to avoid undue spending of common resources [8]. A doctor, sometimes as society's appointed expert, will have to make a number of decisions where such regulations may conflict with patients' wishes or views, posing a challenge to principles of SDM, leading to ethical dilemmas.

As general practitioners (GPs) we have both had painful personal experiences with these dilemmas. We recognise them as especially challenging in general practice, where long-standing and close relationships may add further strain to such encounters. We therefore decided to explore GPs' experiences from consultations when (s)he denies a patient's request, and outcomes of such incidents.

Materials and methods

We conducted a qualitative study where data were obtained through individual semi-structured interviews with GPs in Norway. Asking GPs for accounts about specific consultations where they, for good professional reasons, decided to deny their patients' requests, we wanted to explore how the GPs described their experiences of these disputes, and the subsequent consequences, especially in regard to the doctor–patient relationship.

Six participants were chosen by purposive sampling, seeking doctors with long-standing clinical experience and fluency in Norwegian language to obtain rich and concrete accounts. We included three of each gender, aged 40–63 (mean 58) years, with 10–34 (mean 24) years of general practice experience. Five were Norwegian born, one of foreign origin. Three of the participants worked in a rural setting, the remaining in a city. The interviews were conducted by SN, using a semi-structured interview guide inviting participants to recollect and describe specific consultations where they, for what they considered as professionally well substantiated reasons, had denied their patients' requests. Each participant gave 3–5 examples. The interviews were audiotaped and verbatim transcribed.

Analysis was carried out by SN and KM in collaboration using Systematic Text Condensation (STC), a method for thematic cross-case analysis [9]. The method consists of four steps: (i) reading all the material to get an overall impression and elicit preliminary themes, (ii) develop code groups from preliminary themes, identify meaning units describing GPs' experiences from consultations of conflicting views, and coding for these, (iii) establish subgroups exemplifying vital aspects of each code group, condense the contents of each of them and identify illustrating quotes, and finally (iv) synthesise the condensates from each code group, presenting a reconceptualised description of each category concerning perceived course, outcome and consequences of the consultations. We used a stepwise approach, conducting a preliminary analysis after the three first interviews, allowing for adjustment of the interview guide and aim of study. Analysis was supported by Pellegrino's perspectives, focusing on the GPs' experiences of the conflict between SDM and professional autonomy in regard to the patient–doctor relationship [5].

Results

Subjects of dispute when the patient's request was denied included clinical topics like investigation and treatment, certification regarding welfare benefits and medico-legal issues, and administrative matters. According to the GPs, the arguments took different paths, sometimes settled by reaching common ground but more often as unresolved disagreements with anger or irritation from the patient, sometimes with hostility and violence. The aftermath and outcomes of these disputes lead to strong emotional impact where the doctors reflected upon the incidents and sometimes regretted their handling of the consultation. Some long-standing and close patient–doctor relationships were injured or came to an end. Below, we elaborate these findings. Quotations are assigned pseudonyms.

Subjects of dispute included clinical topics like investigation and treatment, certification regarding welfare benefits and medico-legal issues, and administrative matters

Disagreement concerning investigation and treatment was mentioned by many of the participants and appeared to be a common area of conflicting views. Requests for antibiotics for viral infections or other self-limiting conditions was a typical issue that lead to denials, as were demands for tranquillisers from young patients known to have a misuse or addiction problem. Some also described how they had rejected requests for extensive investigations or screening tests that were obviously unwarranted. One participant recalled how a foreign patient had made a very forceful demand about referral to X-ray investigation for acute low back pain, and the doctor related the ensuing argument to a clash between different cultures.

Another GP, with 10 years of experience in a city practice, said:

> This was a man in a difficult life situation experiencing what I regarded as typical somatoform symptoms – very understandable in my judgement. I went along with a number of investigations – but finally… he could never be satisfied. (Paul)

Sickness certification was another controversial field where several participants sometimes had felt obliged to object to their patients' wishes. Disagreement had typically occurred when the patient returned for follow-up and wanted to extend the period of leave when the doctor no longer found a convincing reason why s/he was still unable to work. One doctor described how a young man demanded extended sick leave for months, when conflict in the workplace appeared to be the underlying problem. A female GP (59 years), working in a rural setting, related a consultation with a well-known patient:

> She complained of diffuse illness – being tired, not feeling in good shape, and 'having too much of everything'. I was thinking: 'This is a young woman in good health, and she should be able to handle her work.' (Ann)

Disagreement about whether to issue a health certificate for a driver's licence was also mentioned by some participants. They told of some elderly patients who had argued that they were entitled to sustain their driver's licence in spite of failing health incompatible with the legal requirements, and they had strongly opposed their doctor who pointed this out. A few of the participants also remembered incidents when the dispute concerned administrative matters, like the number of complaints allowed in one consultation, granting permission to free transportation back home after a consultation, or involuntarily admission to mental health care. A female GP, with 29 years of experience in a rural practice, recalled:

> Out here in my district we have quite a few retired bus-drivers, very experienced people, who have been driving a lifetime. I had to inform one of them that his medical condition no longer made him qualified for a driver's licence, as I had been warned by members of his family and others about his erratic driving. (Ruth)

Consultations where requests were denied were sometimes settled by reaching common ground, but more typically lead to unsolved dispute and even open hostility

The participants described how consultations had evolved in different directions when a patient was denied his or her request. Some of them described their perceptions of arguments where they eventually succeeded to reach common ground. Although the patient initially had argued for his or her request, s/he would after some discussion and reasoning back and forth agree to their doctor's decision, though sometimes grudgingly. Such consultations had ended on a reasonably good note, with no expressed dissatisfaction or display of disapproval. A GP, 63 years old, with 35 years of experience in primary care, gave this account of a consultation with a well-known female patient who requested a referral:

> When I turned down her wish for ultrasound screening, and argued that this was unwarranted without proper cause, she was sceptical and argued against me. But she has been my patient for many years and has trust in me, and after a while she more or less accepted my decision. (Alice)

More often, however, the GPs' accounts dealt with how the patient openly disagreed, seemed to ignore their doctor's arguments, or expressed anger, irritation or sadness. Some patients were portrayed as less verbal, displaying more of a silent discontent. Often, the consultation had ended without a resolution, sometimes abruptly, without agreement between doctor and patient of how to proceed. A male GP, 50 years old, refused a request for antibiotic treatment:

> After having turned her down, I tried to come up with some alternatives, but she just told me: 'This will not work for me'. I felt that the consultation sort of crashed. (Harry)

In quite a few instances, the argument had escalated to open aggression from the patient towards the doctor. Some participants related how they were yelled at, or received condescending or rude remarks and characterisations. These consultations sometimes ended with the patient slamming the door behind him or her. A few participants also told of being physically attacked, having to flee the office or fight back to prevent injury. These dramatic events typically had occurred with young patients with a drug problem who demanded medication. A male GP, 40, did not comply when his young female patient with a drug abuse issue demanded a prescription for strong opiates:

> When I realized that we weren't getting anywhere, I tried to terminate the consultation. That was when she got up and attacked me. I managed to throw her aside and get out of there. I was stronger than her, but couldn't know what she might be hiding in her pockets. This was a patient that I knew to be demanding and difficult, and I didn't feel safe with her. (Paul)

The aftermath carried strong emotions, reflections and regrets, and sometimes disrupted relationships

The participants talked extensively about the aftermath of the consultations. They all described vividly the emotional impact these confrontations had elicited in them. Some put a name on their strongly felt physical discomfort, such as stomach pain, others recalled feelings of strong irritation or feeling totally exhausted and worn out, one used the expression 'feeling like an empty battery'. A few recalled how they had become frightened or scared, not only for their own safety, but also for their families – one of them to the extent that he installed an alarm in his home for protection. He admitted that such feelings were something he would not be able to handle in large quantity. A couple of doctors also mentioned how they, after having refused a requested investigation, started to worry that their patient might have a serious condition after all. An experienced female GP turned down her elderly patient's wish to discuss a number of long-standing problems during an emergency consultation:

> She became very angry and disappointed with me. After she left abruptly, I felt this intense tummy ache, it was really unpleasant, and I felt bad about the whole situation. This was right before lunch, and I sat down with my secretary and confided in her. (Alice)

They also remembered in detail how these encounters with controversies about measures or outcome had left their mark on their professional identity in different formats – as reflections, afterthoughts and sometimes regrets. Most of them recalled making a retrospective self-evaluation of their decision to oppose the patient and their ability to carry out the difficult consultation. In some instances, they had comforted themselves with the notion that the decision was justifiable from a medical point of view, and that they did not need to have any regrets or remorse, even if the patient had expressed anger. Several of them remarked that they still – years later – pondered about how they could have conducted the consultation in a way as to reduce tension or hostility or achieved a shared understanding with the patient in spite of the dispute. Some of them also regretted their behaviour and reflected on how this specific encounter had been instrumental for them to change their consultation style. A 58-year-old GP with his practice in a suburban setting of a large town reflected upon what he had learnt from such an argument:

> I carried this incident with me for a long time. I had been much too stubborn and rigid, and this experience taught me to become more careful and understanding. (James)

Quite a few participants had experienced that the patient after such an encounter had left their list to choose another regular doctor. In one case, it was the doctor's suggestion that he should do so. But mostly, they expressed regrets that the relationship came to end, as they put great value in their often long-standing and close contact with the patient. One doctor related how she had checked on her patient list afterwards, and how she became remorseful when she discovered that the patient had left her. Some of the other participants expressed less concern. They had only carried out what they saw to be their duty, and the patient was free to do whatever suited him or her. This was the dominating sentiment when the patient was previously unknown to the doctor. In other cases, the patient stayed on the GP's list despite the incident, but some participants described how bitterness and lack of trust from the patient could sometimes disturb a previously well-functioning and valuable relationship. One mentioned that he really wished the patient had left, as he, after the incident, started to act more submissively towards the patient. A female participant had the following reflection after having rejected a request for prolonged sick leave:

> What is the use of giving it everything you've got to help your patients, only to receive a public denouncement on the internet, accusing you for being insensitive and lacking empathy, when you make something you believe is a proper medical judgement. I cannot see how this could have been handled differently, but still, a very close doctor-patient relationship was destroyed. (Ann)

Discussion

Subjects of dispute included clinical, medico-legal and administrative issues. According to the GPs, the arguments were sometimes settled by reaching common ground but more often ended in disagreement with anger and hostility. These incidents led to strong emotional impact, reflections and regrets by the GPs. Some long-standing patient–doctor relationships were injured or came to an end. Below, we discuss the strengths and limitations of the study design and the impact of these findings.

Methodological considerations

The participants described encounters that had taken place in the past, in some instances years ago. Exact recollection of these consultations might prove

difficult, putting the internal validity at risk. On the other hand, these instances of denial were rather uncommon, and seemed to have made a strong impression on the participants, who mostly provided vivid and detailed information. Although dramatic events will more easily remembered than disagreement that are solved without too much conflict, we argue that these experiences are valid for other GPs, as the dilemmas of disagreement about measures and outcome in general practice are frequently described and discussed [10,11]. Admittedly, there are a number of grey areas where the right solution is difficult to reach, but in this study the inclusion criteria included stories about events where the participating GPs and the authors considered the denials to be professionally correct, beyond doubt. Direct observation of such incidents, or interviews with patients who were denied their requests could have given more information about the interaction. However, we considered interviews with GPs to strengthen the validity of data intended to elucidate the perceived conflict between SDM and professional autonomy. Although the number of participants was limited, information power (IP) from the data was judged as sufficient [12]. Factors pertaining to high IP in this study included narrow study aim, purposive and specific sampling of participants, strong interview dialogue, and analysis being supported by established theory. SN, who conducted the interviews, is a GP with comparable experiences regarding consultations with disputes and the strong feelings that might ensue. This position made him familiar with the participants' experiences, making it easier to probe deep for detailed information. On the other hand, his experiences from similar situations were also significant elements of his preconceptions, certainly having an influence on dialogue and analysis. Using Pellegrino's ideas about professional autonomy as theoretical framework enabled us to narrow the scope of analysis, putting less emphasis on information that did not pertain to the dilemmas concerning patients' request conflicting with the GP's autonomy [5,13].

What is known from before – what does this study add?

Previous research has demonstrated that denying patients' requests is a particular challenge for doctors, making the gatekeeping role unpleasant and unpopular among doctors [14–16]. However, the nature and consequences of such disputes are to our knowledge not previously studied. Our analysis offers experience-based knowledge, demonstrating a variety of reasons for controversies, the anger and harsh remarks, the painful feelings, even violence and sometimes ruined relationships. Our findings indicate what is at stake when doctors consider turning down a patient. It adds weight to the impression that doctors, whenever possible, will opt for a compromise in order to avoid arguments, and why the gatekeeping role is often sacrificed [11,17,18].

Patient autonomy and SDM are considered the prevailing moral guidelines for patient–doctor interaction. Pellegrino asserts that the doctor's autonomy must also be taken into account. He argues that the doctor's autonomy may involve him or her respectively as a person, as a doctor, or as a member of the medical profession. The doctor's autonomy as a person is related to personal moral views pertaining to issues like abortion or euthanasia, which is not relevant for our discussion here. Considering the disputes described above, SDM may oppose the doctor's autonomy as a doctor and as a member of a profession. This professional autonomy is, to quote Pellegrino, 'grounded in the possession of expert knowledge needed by sick people and society' [5]. The doctor is, just like his patient, entitled to respect for his professional judgments and choices. Also, Pellegrino remarks that patients, in order to obtain sufficient knowledge to execute their autonomy, are dependent on the doctor's cooperation and beneficence. Consequently, it is not necessarily a contradiction between patient and doctor autonomy, but rather coherence.

For matters related to clinical practice, like diagnosis and treatment, principles of patient autonomy and SDM are usually important and applicable. When medico-legal issues arise, as was the case in many of the disputes related by our participants, the principle of patient autonomy might however no longer be indisputably valid. Examples in this category included eligibility for driver's license or sickness benefit. In such cases, the doctor is obliged by law to give an objective evaluation of the patient's condition to establish whether s/he is entitled to specific benefits or rights. The patient's own view of his or her ability to fulfill the requirements for such a benefit is not necessarily valid for this purpose, although it has a pivotal impact on the dialogue, because (s)he might not possess the specific knowledge of the requirements. Furthermore, (s)he craves a personal gain that might be unjust or even illegal. Accordingly, patient autonomy was not a valid argument for the participants in this study when they recalled the arguments and described their thoughts and feelings.

Rather, the GPs were more concerned about their personal experience of the incidents, and of the

negative consequences that might ensue. Agledahl et al. argued that patient autonomy as overriding general principle in every consultation is simply a misunderstanding, and an inadequate notion in a number of medical encounters [19]. Others have pointed out that doctors also have an obligation to balance the wishes of patients with the needs of society [11]. Still, the principles of patient autonomy and SDM have become so prominent that some authors have speculated that it may be put forward as a convenient excuse when the doctor wish to avoid the burdensome role as gatekeeper [15].

Many of the reported arguments presented by our participants escalated beyond the doctor's control, and breakdown of communication was not realised before it was too late. Often, the participants seemed to be taken by surprise and seemed ill prepared for such disputes. Several authors recommend how such incidents can be resolved if the doctor is prepared and has sufficient skills regarding arguments with patients. Patient satisfaction improves for example significantly when the GP's approach to denial included a discussion of the patient's perspective [11]. Aggressive behaviour seems to be triggered when patients experience unmet needs, when they are subjected to involuntary assessment or when they face unsolicited touch from caretakers [20]. Similar situations were recognisable in this study, and increased awareness from the doctor of how and why certain encounters carry such a risk might have prevented escalating aggression.

To avoid unintended humiliation of the patient, Malterud and Hollnagel advocate that doctors should pay more attention to their own emotions in the consultation [21]. Other strategies found to reduce risk of dispute related to requests for unwarranted investigations include taking time to discuss the patient's worries, and communicating empathetically and expanding patient involvement in the plan for care [17,22]. Clinical communication has for many years been regarded as a core curriculum in medical education. Still, our analysis reveals that the particular field of resolving disagreement may be underestimated, explaining why denying patients their requests sometimes carries dire consequences [23].

Implications

All doctors will, on occasion, face the challenge of denying patients' requests. Our findings indicate that the price for this act may be high, and that GPs find themselves uncomfortable and bewildered in such situations. In order to better prepare them to handle such disputes, skills pertaining to this particular challenge could be improved though specific education and training, drawing attention to negotiation of potential conflicts. Also, the notion that doctors have a professionally commitment to his or her own autonomy and to society should be restored, through engaging doctors in medical education at all levels in a renewed awareness of core professional ethics.

Acknowledgements

The authors thank the GPs who participated in the study.

Ethical approval

The study was approved by the Norwegian Data Inspectorate (Project # 47007), and the Regional Committee for Medical Ethics (Ref. # 2016/123).

Disclosure statement

The authors declare that they have no competing interests.

Funding

This work was supported by a research scholarship from the Norwegian College of General Practice.

Notes on contributors

Stein Nilsen, MD, is a Ph.D.-student at Uni Research Health (Bergen/Norway) and Department of Global Public Health and Primary Care, University of Bergen/Norway, and also a General Practitioner in Florvåg/Norway.

Kirsti Malterud, MD, PhD, is a senior researcher and professor of general practice at Uni Research Health (Bergen/Norway), Department of Global Public Health and Primary Care, University of Bergen/Norway and Research Unit for General Practice (Copenhagen/Denmark).

References

[1] McWhinney IR. An introduction to family medicine. New York: Oxford University Press, 1981.
[2] Sandman L, Munthe C. Shared decision making, paternalism and patient choice. Health Care Anal. 2010;18:60–84.
[3] Elwyn G, Frosch D, Thomson R, et al. Shared decision making: a model for clinical practice. J Gen Intern Med. 2012;27:1361–1367.
[4] Pilnick A, Dingwall R. On the remarkable persistence of asymmetry in doctor/patient interaction: a critical review. Soc Sci Med. 2011;72:1374–1382.
[5] Pellegrino ED. Patient and physician autonomy: conflicting rights and obligations in the physician-patient relationship. J Contemp Health Law Policy. 1994;10:47–68.

[6] Lov om folketrygd (National Insurance Act); [cited 2017 Jan 23]. Available from: https://lovdata.no/dokument/NL/lov/1997-02-28-19
[7] Lov om helsepersonell (Act relating to health personnel), Krav til helsepersonells yrkesutøvelse (Requirements for health personnel profession); [cited 2017 Jan 23]. Available from: https://lovdata.no/lov/1999-07-02-64
[8] The Norwegian Medical Association. Etiske regler for leger (Ethical guidelines for physicians); [cited 2017 Jan 23]. Available from: http://www.legeforeningen.no/index.gan?id =485
[9] Malterud K. Systematic text condensation: a strategy for qualitative analysis. Scand J Public Health. 2012;40:795–805.
[10] An PG, Rabatin JS, Manwell LB, et al. Burden of difficult encounters in primary care: data from the minimizing error, maximizing outcomes study. Arch Intern Med. 2009;169:410–414.
[11] Paterniti DA, Fancher TL, Cipri CS, et al. Getting to "no" strategies primary care physicians use to deny patient requests. Arch Intern Med. 2010;170:381–388.
[12] Malterud K, Siersma VD, Guassora AD. Sample size in qualitative interview studies: guided by information power. Qual Health Res. 2016;26:1753–1760.
[13] Malterud K. Theory and interpretation in qualitative studies from general practice: why and how? Scand J Public Health.2016;44:120–129.
[14] Wynia MK, Cummins DS, Van Geest JB, et al. Physician manipulation of reimbursement rules for patients: between a rock and a hard place. JAMA. 2000;283:1858–1865.
[15] Gulbrandsen P, Forde R, Aasland OG. [What does it feel like for a physician to be a gatekeeper?]. Tidsskr nor Laegeforen 2002;122:1874–1879.
[16] Carlsen B, Norheim OF. "Saying no is no easy matter": a qualitative study of competing concerns in rationing decisions in general practice. BMC Health Serv Res. 2005;5:70.
[17] Gallagher TH, Lo B, Chesney M, et al. How do physicians respond to patient's requests for costly, unindicated services? J Gen Intern Med. 1997;12:663–668.
[18] Nilsen S, Malterud K, Werner EL, et al. GPs' negotiation strategies regarding sick leave for subjective health complaints. Scand J Prim Health Care. 2015;33:40–46.
[19] Agledahl KM, Forde R, Wifstad A. Choice is not the issue. The misrepresentation of healthcare in bioethical discourse. J Med Ethics. 2011;37:212–215.
[20] Morken T, Alsaker K, Johansen IH. Emergency primary care personnel's perception of professional-patient interaction in aggressive incidents – a qualitative study. BMC Fam Pract. 2016;17:54.
[21] Malterud K, Hollnagel H. Avoiding humiliations in the clinical encounter. Scand J Prim Health Care. 2007;25:69–74.
[22] van Bokhoven MA, Koch H, van der Weijden T, et al. Influence of watchful waiting on satisfaction and anxiety among patients seeking care for unexplained complaints. Ann Fam Med. 2009;7:112–120.
[23] Deveugele M, Derese A, De Maesschalck S, et al. Teaching communication skills to medical students, a challenge in the curriculum? Patient Educ Couns. 2005;58:265–270.