Resolving Difficult Patient Interactions with Care

Reading time:
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Patient care is more than just healing, it's building a connection that encompasses mind, body and soul. If you could stand in someone else's shoes... hear what they hear. See what they see. Feel what they feel. Would you approach them differently?

Covid-19

- Stay calm and professional. Maintain good eye contact and maintain an appropriate body orientation.
- Consider your own safety (undertake a rapid risk assessment) but if possible (and if the person is not abusive or physically violent) speak with the patient in a quiet place (with a witness). Stay near the door.
- Hear the person out. This is often absent in highly stressed and busy environments. The stress of the busy environment and the stress on the difficult person can create a 'negative spiral' of 'failed communication'.
- Verbally acknowledge the person's frustration/anxiety/other matters.
- Actively listen to the other person and convey empathy. Aim to be in 'control' but not 'controlling'.
- Be mindful of your body language.
  - Use expressive but not over-expansive hand gesturing. Overuse of expansive gesturing is perceived as power and not effective for collaborative conversations / presentations.
  - Aim to maintain a relaxed face if the conversation is difficult. Smiles convey confidence and immediacy, but may not be appropriate in all difficult conversations.
- Use positive verbal language
  - For example, rather than 'I cannot/can't/not able to/refuse to,' try to use phrases such as 'this is what we can do'.
  - Use positive statement about the facts. 'It seems to me that we need to work together to do our best to resolve this matter'. In this case, 'We' and 'together' rather than 'I' or 'you'.
  - Speak in a positive way about rights and responsibilities.
- The **BATHE** technique may help you disclose issues in a sensitive manner[1].

		New or established patient with new presenting problem
B	Background	"What is going on in your life?"
A	Affect	"How do you feel about ... (the situation the patient described)? "Many people in that situation might feel ..." Name some emotional states, then ask, "Do any of these words fit with how you are feeling?"
T	Troubles	"What bothers you most about the situation?"
H	Handling	"How are you managing or coping with the situation?"
E	Empathy	"That sounds very frustrating."

Substance affected patients

- Order of priorities: patient safety → staff safety → community safety.
- Review immediate, medium and longer term actions as these will almost certainly apply in most scenarios.
- In violent situations and/or high-risk situations, be mindful that patient, staff and community safety must be managed concurrently
- Be mindful that drug affected patients may not listen but still have rights
- You must not put staff in high-risk situations. You have both a vicarious and non-delegable duty of care and work health and safety responsibility. Vicarious duty of care is in respect of employees and non-delegable duty in respect of contractors, visiting medical officers etc.

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- Often these are “no-win" situations. You can win the debate, but you will not win the ‘war’.
  - This particularly applies to querulous people. Querulousness is described as a disorder of behaviour demonstrating some mental health elements as well as a desire for vindication, retribution, and revenge.[2]
  - Similar characteristics of individuals have been described who are the subject of vexatious litigation and unusually persistent complaints[3]. ‘Unreasonable complainant conduct’, (UCC) includes unreasonable persistence, unreasonable demands, lack of co-operation, unreasonable arguments, and behaviour[4].
  - Unusually persistent complainants can also be more dissatisfied with the outcome of their case than average persons, resulting in additional complaints being filed.[5]
- Ensure some form of control and adopt an ‘agree to disagree’ position. This may be helpful but does not preclude the vexatious reporter from taking further actions.[6]

Delivering bad news

- Communicate the diagnosis clearly and how you reached your conclusions.
  - Give details of your prognosis and the reasons you believe this is most accurate
  - Do not mislead, be honest
  - Explain the purpose of care you propose and why this is the option most suitable above other alternatives.
  - Involve the patient in planning the treatment wherever possible.
- Give a warning that bad news will be conveyed.
  - Keep it simple, slow and summarise the information.
  - Avoid clichés and jargon
  - Allow time for questions
  - Check the patient’s understanding
  - Answer questions openly and truthfully
  - Avoid bluntness
  - Instill a sense of optimism but with realistic hope.

Non-compliant patients

- In case of a planned intervention, have a note taker.
- Ensure you provide enough information around risks versus benefits.
- Always ensure the patient is competent to make decisions.

Patient competency

- Adults are assumed competent, unless is demonstrated otherwise.
- The overarching principle is that at 18 years old an individual is considered an adult. However, this differs in different jurisdictions.[7]
- At common law, anyone even 10 or 12 years old can be competent to make decisions on a matter in front of them. May not have full understanding of all issues but the precise matter is understood. Risks, side effects and benefits need to be understood on the matter at hand.

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[1] Middleton, J. L. (2020). Why the Stress-Disease Connection Matters and How to Respond. American family physician, 101(10), 585-586.
[2] Mullen, P. E., & Lester, G. (2006). Vexatious litigants and unusually persistent complainants and petitioners: from querulous paranoia to querulous behaviour. Behavioral sciences & the law, 24(3), 333–349.
[3] Coffey, C. A., Brodsky, S. L., & Sams, D. M. (2017). I'll See You in Court...Again: Psychopathology and Hyperlitigious Litigants. The journal of the American Academy of Psychiatry and the Law, 45(1), 62–71.
[4] New South Wales Ombudsman Managing unreasonable complainant conduct practice manual (2nd ed) 2012 https://www.ombudsman.gov.au/__data/assets/pdf_file/0022/35617/GL_Unreasonable-Complainant-Conduct-Manual-2012_LR.pdf
[5] Lester, G., Wilson, F., Griffin, L., & Mullen, P. (2004). Unusually persistent complainants. British Journal of Psychiatry, 184(4), 352-356.
[6] David Mayhew Cooper (2020). ‘Vexatious reporting to health statutory bodies under qualified privilege.’ Sydney Law School. Master of Health Law, research capstone paper.
[7] Moritz, D., & Ebbs, P. (2021). Consent and refusal of treatment by older children in emergency settings. Emergency Medicine Australasia, 33(1), 168-171.

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