Managing Challenging Patient Interactions

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Regardless of your training or your clinical specialty, you are bound to experience interactions with patients that can prove challenging. These interactions, if not addressed appropriately, may leave practitioners feeling anxious, vexed and with a sense of lost equanimity and professional identity.

If this resonates with your clinical experience, you are not alone. Studies show that over 70% of Australian doctors have experienced verbal or written aggression and almost a third suffered physical aggression, especially those in hospital non-specialist positions[1] .This is further heightened with the cultural and societal changes resulting from the stress imposed by the COVID-19 pandemic.[2,3]

So, how do you navigate these challenging scenarios, providing care, empathy and respect, while adhering to your legal obligations and protecting your mental and physical wellbeing?

Consider the following scenario:

Dr K is a Sydney-based GP who works in private practice. In her 20 years as a healthcare professional, she has seen a wide range of patients and presentations and feels proud of the long standing, caring and therapeutic relationships she has fostered with families and individuals over her medical career.

Megan is one of them. She is a 52-year-old mother of two sons, married to Tristan, a 60-year-old schoolteacher. Megan's mother, Anita, 75 also lives with them.

Dr K has been their family doctor for the last 10 years.

In June 2019, Megan presented with Anita to Dr K's clinic, as Anita had complained of severe headaches, difficulty breathing and had been experiencing insomnia for the past three days.

After examining Anita, Dr K finalised the appointment by prescribing painkillers for the headaches and recommending a set of laboratory tests. Unexpectedly, as the appointment concluded, Megan was quick to anger and accused Dr K of not spending enough time examining her mother, and not giving her enough time to answer her questions. Dr K expressed that the 15-minute consultation included all the examination that was required, and nothing further could be addressed until the lab tests were returned.

This outburst shocked Dr K, who remained silent allowing Megan to vent her displeasure at the appointment including a threat to take her complaint to AHPRA. Never in ten years had she seen Megan react this way. Dr K remarked to Megan "I have done all I can

today. What do you want me to do?"

Megan was angry that the appointment had ended so quickly expecting a longer appointment from Dr K, her family physician. Megan had recommended Dr K to many friends and believed that Dr K should have spent more time discussing the condition with her elderly mother.

Dr K left the clinic that evening feeling abused, harassed and in fear of receiving a notification from AHPRA.

What would you have done differently in Dr K's position? What do you think is the best course of action to take when involved in a situation where there seems to be no possibility of a win-win outcome?

MIPS recommends you consider the following strategies.[4]

Examine the situation from various angles. Identify the interactional difficulty and the factors (patient characteristics, doctor characteristics and/or systems issues) influencing the behaviour. This should precede the diagnosis and management of the patient. Practitioners are encouraged to self-reflect on their contribution through their own attitude or actions and what environmental factors may come into play. Were there other external issues or stressors influencing Megan's reaction? Had Dr K inadvertently displayed dismissive characteristics when stating there was nothing further she could do?

Keep your cool. In any challenging interaction, your first obligation as a healthcare practitioner is to remain calm and professional, while modelling appropriate behaviour. If a patient appears emotionally charged, interrupting or talking over them will only escalate the situation. Your aim in these cases is to diffuse any conflict by maintaining a collected attitude in your tone, words and actions, while trying to reach common ground as soon as possible.

Aim to find common ground (where possible). Often difficulties arise when there appears to be little common ground or unmet expectations from both the patient and clinician's perspectives. You may reframe what the patient is saying to find some overlap quickly. For example, "Let me make sure I hear you correctly", "Let's agree on what we need to do to resolve this situation amicably" As soon as there is some overlap and common ground, tensions tend to rapidly decrease.

Collaborate and empathise. Anger directed towards a clinician could stem from anxiety or stress of an unrelated matter. Actively listen and offer empathetic signals which will allow the patient to feel supported and less reactive. For example, you may use the following framework.[5]

- Validate concerns: "I understand where you are coming from".
- Offer empathy: "I can see how difficult this must be for you".
- Reframe: "Let me check my understanding".
- Refocus: "Let's agree on the most important issues that need addressing in this visit".

Set clear boundaries and limits. You are advised to set the limits on what patient behaviours might "cross the line' [6] and establish appropriate ways to respond in case of breaches.

When all of the above fails

When there is a severe breakdown in rapport that makes it impossible to continue providing care, you should consider terminating the therapeutic relationship. Where possible, this should be done in person. If you are concerned the patient will return and be rude or violent, you can further protect yourself by putting this in writing following your conversation. If the patient does not respond, you need to exhaust your follow up procedure. You have the legal and ethical obligation to ensure and facilitate the continuity of care as you transition the patient's care. You must also comply with the Medical Board of Australia's Good Medical Practice: A Code of Conduct for Doctors in Australia when ending a doctor-patient relationship.

In conclusion, it is important for MIPS members to acknowledge the different contributing elements which may be at play in a challenging patient interaction – including their own role. When being involved in such situations, you are encouraged to remain collected and to model calm and professional behaviour. Validating the patient's feelings and concerns, offering empathy while trying to reach common ground as soon as possible, can minimise tensions and prevent issues from escalating any further. If all efforts to mend a broken doctor-patient relationship fail, you may consider terminating it, in compliance with your ethical and legal obligations.

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[1] Hills Danny J., Joyce Catherine M., Humphreys John S. (2011) Prevalence and prevention of workplace aggression in Australian clinical medical practice. Australian Health Review 35, 253-261.

[2] Violence towards GPs and staff a growing problem

[3] Chataway, M. (2021). Occupational Violence Against Healthcare Professionals: Applying a Criminological Lens. QUT Centre for

Justice Briefing Paper, (15).

[4] Black, D. W. (2021). Managing 'difficult' patient encounters. Current Psychiatry, 20(7), 12-19.

[5] Ibid

[6] Ibid