Finding Calm

IN DIFFICULT PATIENT ENCOUNTERS

WITH DR. ANA BLAKE, MD,
CCFP, CERTIFIED LIFE COACH
ANASTASIA.BLAKE@MEDPORTAL.CA

Disclosures of Affiliations, Financial Support and Mitigating Bias:

Affiliations:

- Grants/research: Nil
- Speakers Bureau/Honoraria: nil
- Consulting Fees: nil
- Other: Owner of the Anti-Fragile Female MD private coaching business

Financial Support:

- The speaker has received honorarium from the Northern Ontario School of Medicine

Mitigating Potential Bias:

- No medications or therapeutic goods will be discussed. This presentation is for educational purposes and not marketing.

Finding Calm in Difficult Patient Encounters

- ·Differentiate difficult from unacceptable/abusive patient interactions
- ·Identify communication strategies for managing difficult patient interactions
- ·Describe how to manage abusive patient interactions

Why am I doing this talk?

Difficult vs Unacceptable Patient Interactions

Difficult Patient Encounters

- DIFFICULT PATIENT ENCOUNTERS: ONES THAT ELICIT NEGATIVE EMOTIONS FOR THE PHYSICIAN
  - EX: STRESS, ANXIETY, ANGER, HELPLESSNESS, FRUSTRATION
- TYPICALLY INVOLVE FOUR FACTORS:
  - PATIENT: UNCOOPERATIVE, HOSTILE
  - PHYSICIAN: "HALT", PEOPLE PLEASING
  - DISEASE: CHRONIC PAIN, MENTAL HEALTH
  - SYSTEM: LIMITED RESOURCES, WAIT TIMES

Difficult Patient Encounters

- DIFFICULT PATIENT ENCOUNTERS: ONES THAT ELICIT NEGATIVE EMOTIONS FOR THE PHYSICIAN
  - EX: STRESS, ANXIETY, ANGER, HELPLESSNESS, FRUSTRATION
- TYPICALLY INVOLVE FOUR FACTORS:
  - PATIENT: UNCOOPERATIVE, HOSTILE
  - PHYSICIAN: "HALT", PEOPLE PLEASING
  - DISEASE: CHRONIC PAIN, MENTAL HEALTH
  - SYSTEM: LIMITED RESOURCES, WAIT TIMES

Difficult Patient Encounters

- 15% of patient interactions are perceived as difficult by physicians

- Problem with difficult pt interactions:
  - Neg affect dr-pt relationship
  - Affect quality of care
  - Can lead to medical errors
  - Contribute to burnout and worsening mental health for physicians

Unacceptable Patient Encounters

- UNACCEPTABLE/ABUSIVE PATIENT ENCOUNTERS:
  - WHERE A PATIENT'S BEHAVIOUR CROSSES A BOUNDARY FOR THE PHYSICIAN
    - ex. emotional, psychological, physical, sexual
  - VERBALLY OR PHYSICALLY THREATENING BEHAVIOUR
  - PHYSICAL VIOLENCE
  - CYBER THREATS

Unacceptable Patient Encounters

- DUTY AS EMPLOYERS TO PROTECT OUR STAFF AND CREATE A SAFE WORKING ENVIRONMENT FOR THEM
- DIFFICULT PATIENT ENCOUNTERS TYPICALLY INVOLVE A COMMUNICATION ISSUE
- ABUSIVE PATIENT ENCOUNTERS TYPICALLY INVOLVE A SAFETY ISSUE

People Pleasing 101

Are you a People Pleaser?

- Do you struggle to say no, avoid conflict, accept poor treatment from others, and feel unsatisfied by your patient interactions and relationships (feel taken advantage of often?)

- Do you feel guilty if you say NO to something, but also experience resentment from always saying YES?

People Pleasing 101

Characteristics of People Pleasers....

- Say yes when you really want to say no
- Do things in an effort to make other people like you
- Depend on external validation to define your self-worth
- Prioritize the needs of others over your own
- Fear the displeasure of others so you say yes to avoid conflict or confrontation

Elements of a Boundary

DEFINING THE BOUNDARY THAT HAS BEEN VIOLATED

DEFINING THE CONSEQUENCE OF A BOUNDARY VIOLATION

FOLLOWING THROUGH ON WHAT WE SAY WE WILL DO

Elements of a Boundary

DEFINING THE BOUNDARY THAT HAS BEEN VIOLATED

DEFINING THE CONSEQUENCE OF A BOUNDARY VIOLATION

FOLLOWING THROUGH ON WHAT WE SAY WE WILL DO

Communication Strategies for Managing Difficult Patient Interactions

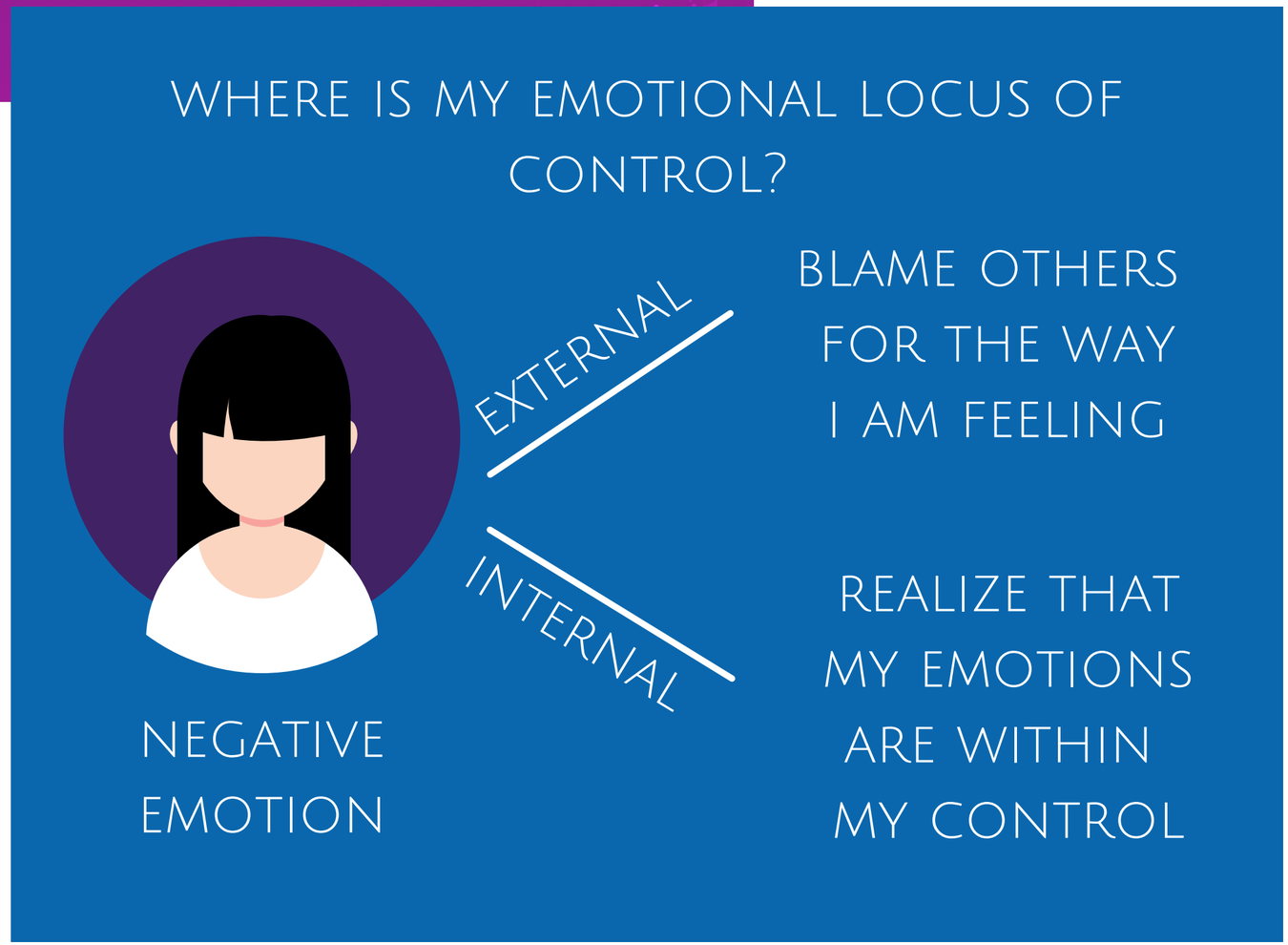
Two People Involved in Every Conflict

There's Only ONE Person We Can Control

Emotional Locus of Control

What is Within My Control in a Conflict?

- Think --> Feel --> Do
- Negative emotion is generated by the thoughts we have about a situation
- Good News: we can change our thoughts if we want to
- Two Core Skills:
  - Learning how to be the neutral observer of our thoughts
  - Learning how to regulate our emotions



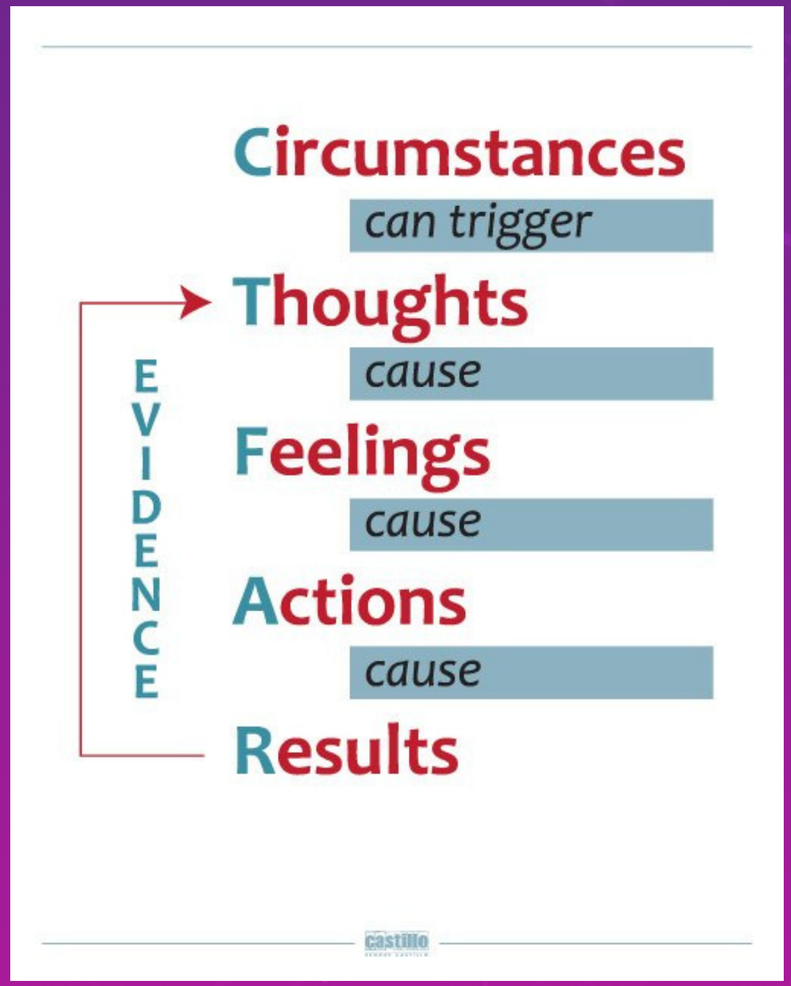
Understanding Your Thinking

TOOL #1: THOUGHT DOWNLOADS:

- TRY TO BE THE NEUTRAL OBSERVER OF YOUR THINKING
- SPEND 5-10 MINUTES WRITING OUT YOUR THOUGHTS
- CHOOSE 2- 3 THOUGHTS THAT INTRIGUE YOU OR ELICIT STRONG EMOTIONS
    - PLUG THESE THOUGHTS INTO TOOL #2

TOOL #2: THE SELF-COACHING MODEL

- CIRCUMSTANCES TRIGGER OUR THOUGHTS
- THOUGHTS CREATE OUR FEELINGS
- FEELINGS DRIVE OUR ACTIONS
- ACTIONS CREATE OUR RESULTS

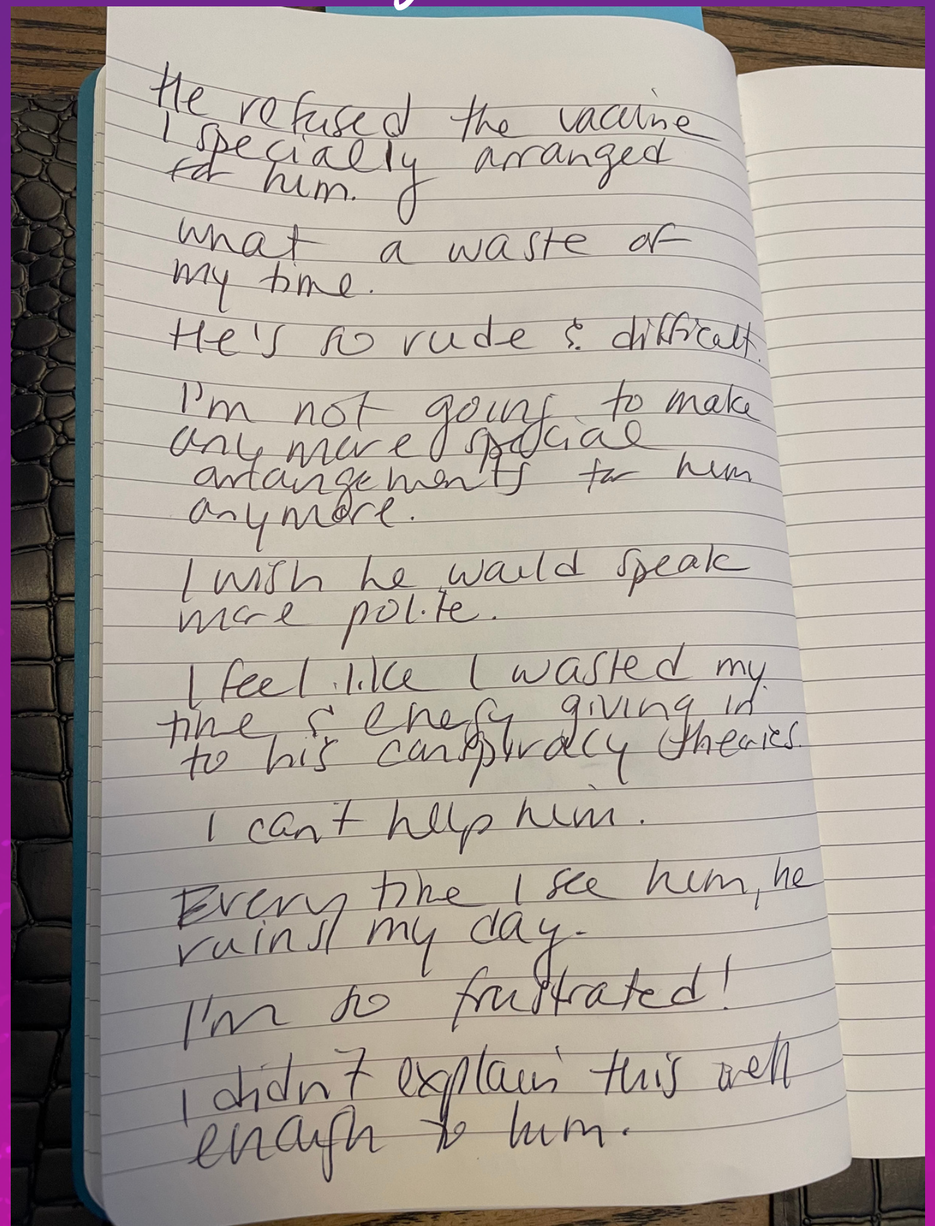


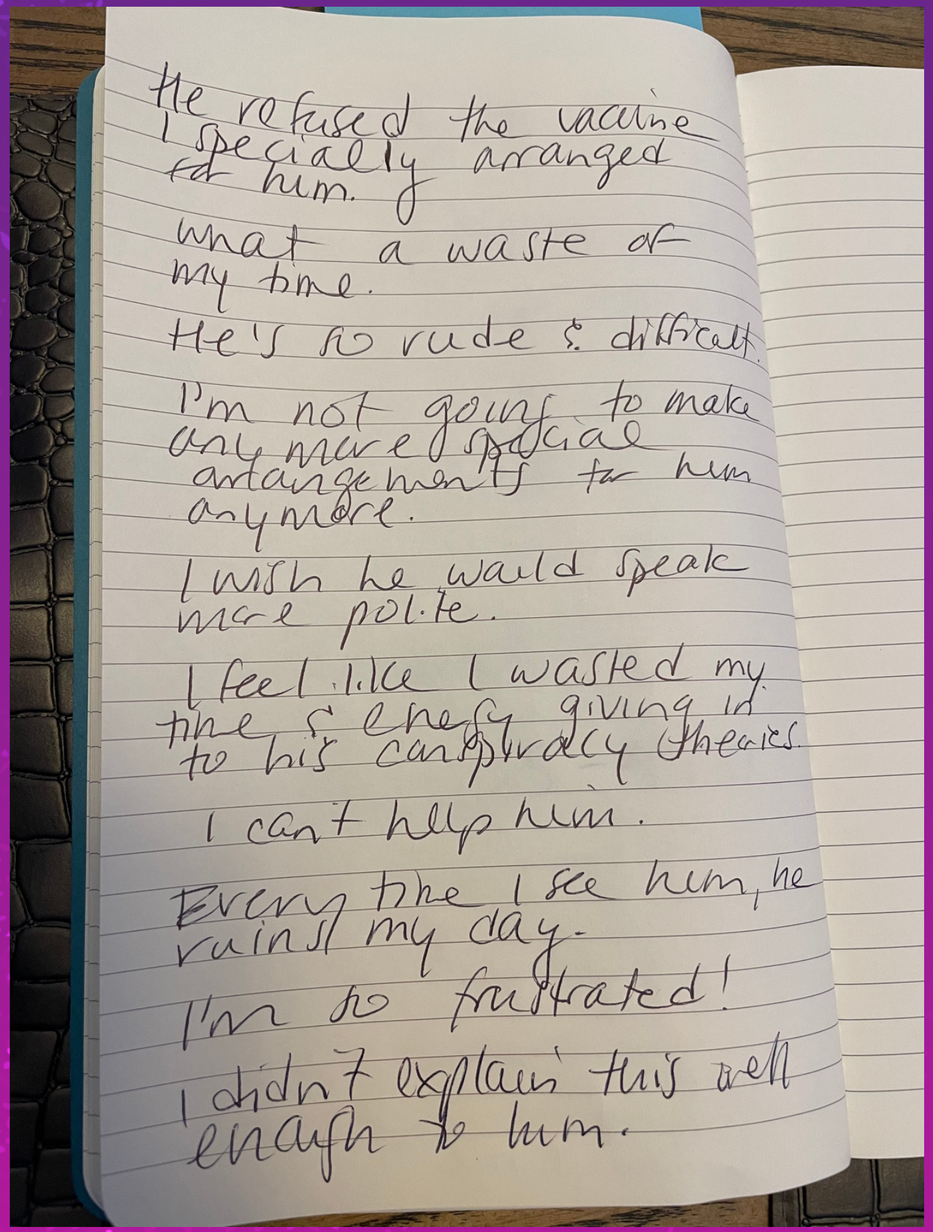
What is The Self-Coaching Model?

THE THOUGHT LINE:

- START WITH THE CIRCUMSTANCE, THEN ASK:
  - SO WHAT?
  - WHAT AM I MAKING THIS MEAN?
  - WHY IS THIS A PROBLEM FOR ME?
  - WHY DOES THIS MATTER?
  - WHEN I'M THINKING ABOUT THIS PATIENT, WHY DO I FEEL (INSERT PRESENT FEELING)?

Sample Thought Download





Sample Model:

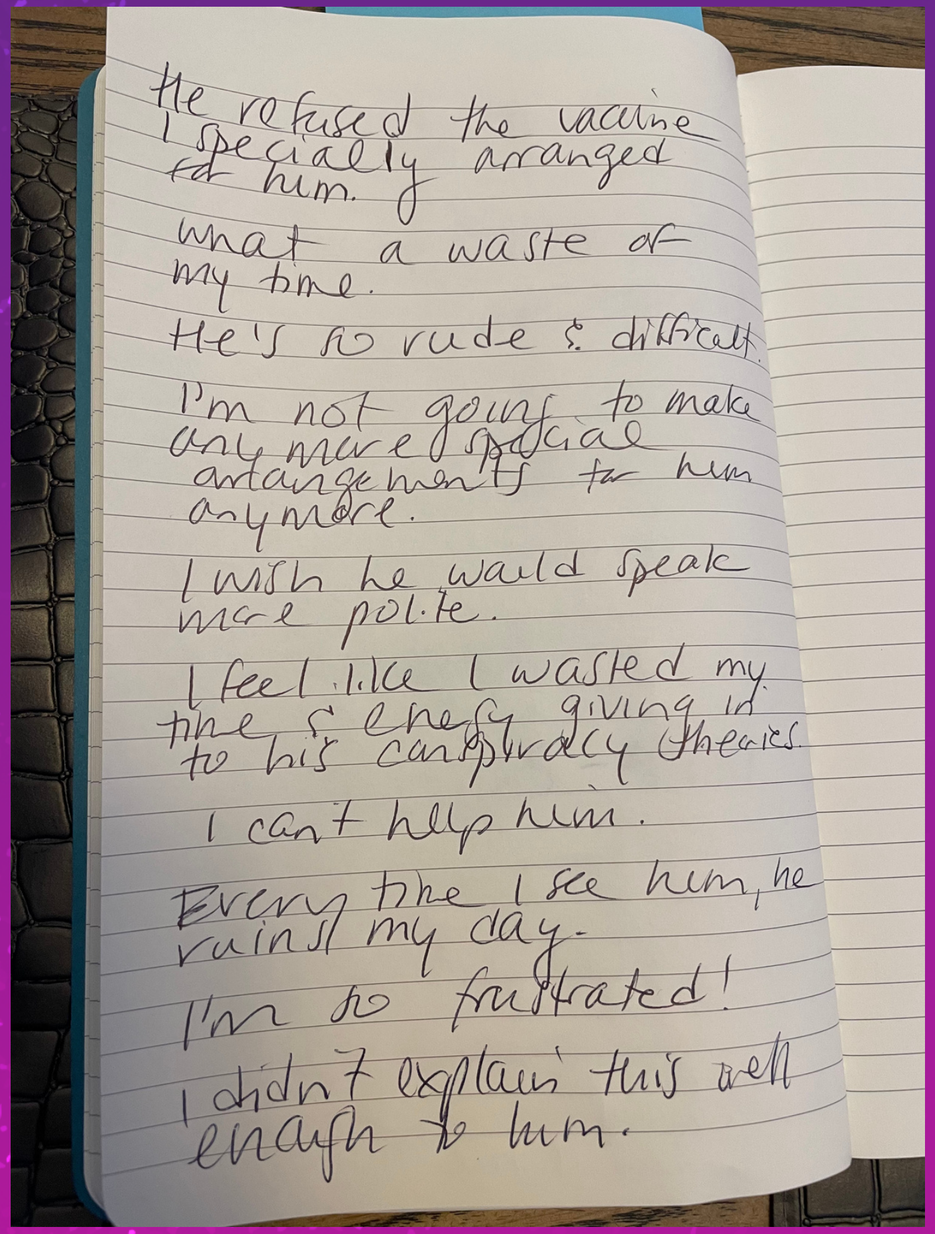
Circumstance: Patient refuses COVID vaccine that he asked for, uses lots of swear words

Thought: He's so rude and difficult

Feeling: angry

Actions: tell myself I shouldn't have bothered, argue with him, speak in a harsh tone, judge him

Result: I am so rude back to him



Sample Model:

Circumstance: Patient refuses COVID vaccine that he asked for, uses lots of swear words

Thought: I didn't explain this well enough to him

Feeling: self-doubt

Actions: think about how I could have done things differently, fumble through trying to convince him

Result: I prove to myself I didn't explain it well enough

What Else Could We Have Thought?:

Circumstance: Patient refuses COVID vaccine that he asked for, uses lots of swear words

Thought: I may not agree, but I respect his choice for his body

Feeling: calm

Actions: feel glad that I went out of my way to help him, explain risks/benefits without attachment to outcome, relax and focus on his issue today

Result: I maintain respect for him and me in the encounter

Changing Dynamics with Difficult Patients

- What's different in my 'good' pt encounters?
- How would I approach this problem with my 'favourite' patient?
- What do I want to believe about myself in all patient interactions?
- What if there were no 'difficult' patients?

Changing Dynamics with Difficult Patients

- I'M LETTING GO OF THE ROPE IN THIS TUG OF WAR
- I'M OK WITH LETTING THIS PERSON BE WRONG ABOUT ME
- OPPOSITES CAN BE TRUE AT THE SAME TIME
- THERE MUST BE SOMETHING I'M NOT UNDERSTANDING HERE
-

Other Communication Strategies

- ACTIVE LISTENING
  - Restate what the patient told you in their own words
  - Ask them to explain things you say back to you
- DOCUMENT DIFFICULT CONVERSATIONS IN A FACTUAL WAY IN THE MEDICAL RECORD
- SET BOUNDARIES AND FOLLOW THROUGH ON THEM
- ENGAGE THE PATIENT IN SOLUTION FINDING

Other Communication Strategies

- EXPRESS EMPATHY
  - But just the right dose!
  - Use simple empathic statements that move the conversation forward
- ACKNOWLEDGING THAT THEY ARE GOING THROUGH SOMETHING DIFFICULT OFTEN CHANGES THE DYNAMICS OF THE ENCOUNTER
- ASSUME THEY ARE DECENT HUMAN BEINGS HAVING A BAD DAY VS BAD HUMAN BEINGS

Being the Thermostat not the Thermometer

- Two skills for finding calm in DPE's:
  - Becoming the neutral observer of our thoughts and changing the ones that don't serve us
  - Learning how to regulate our emotions

- Tools to diffuse emotions:
  - Wiggle your toes, check in with baby toe
  - Self-compassionate touch (ex. hand on cheek, chest)
  - breathing - longer exhale than inhale
  - excuse yourself from the room

How To Manage Abusive Patient Interactions

Unacceptable Patient Encounters

- SOME SITUATIONS MAY ESCALATE INTO THREATENING BEHAVIOURS AND VIOLENCE
  - First priority should be establishing safety for yourself, your staff and your other patients

- TELL PATIENT THE BEHAVIOUR IS UNACCEPTABLE AND OUTLINE THE CONSEQUENCES
  - Call 911 if behaviour continues
  - Give police only info needed to manage the threat (do not breach confidentiality)
  - Have workplace policies and document factually in the medical record

Unacceptable Patient Encounters

- CONSIDER IF THERE HAS BEEN A BREAKDOWN IN THE DOCTOR-PATIENT RELATIONSHIP
  - Contact the CMPA and CPSO for direction
  - CPSO: abusive behaviour is grounds to consider terminating patient
    - Physician must make effort to resolve situation
    - Physician communicated expectations for patient conduct
    - If behaviour is part of repetitive pattern
    - Discussion has been held with patient explaining reasons physician can no longer provide care (tip: send in writing by registered mail)

CASES

Mrs. Mary Complainalot

- 75 YO FEMALE
  - Always presents with multiple vague complaints
  - Can't tolerate any medications
  - Believes she has lots of medical conditions you have no evidence for on her record
- YOU SPEND EVERY VISIT EXPLAINING THAT SHE'S HEALTHY AND HER CONCERNS ARE UNFOUNDED
- YOU FIND YOURSELF ANNOYED AND DISMISSING HER CONCERNS AT EVERY VISIT

Mrs. Mary Complainalot

- How can we apply these tools?
  - Identify our cognitive biases using the model:
    - We're believing her concerns are unfounded
    - Feel annoyed when we see her on our day sheet - primed to dismiss her concerns
  - Identify the unhelpful actions we're taking:
    - Dismissing her concerns
  - Ask ourselves how we would approach this concern if our 'favourite' patient brought it?
  - Ask ourselves how we want to feel and act when we see this patient?
  - Practice being the thermostat

Mr. Y. Wontu

- You see Timmy with his dad, Mr Y Wontu, in after hours clinic
  - Timmy has had a cough for a few days
  - His father is concerned he needs a chest xray and antibiotics, you disagree
  - He becomes angry and yells "I'm just going to have to take him to emerge if you won't help us" and "I know a kid that got pneumonia this way"
- You leave the encounter feeling really uncomfortable and doubting your management

Mr. Y. Wontu

- HOW CAN WE APPLY THESE TOOLS?
  - Identify our cognitive biases using the model:
    - We're making his anger mean that we've done something wrong
    - We are uncomfortable with the conflict
    - Recognize if we have the temptation to people please and give in to his demands
  - Opportunity to set boundaries:
    - "If you keep speaking to me in that tone of voice, then I will have to end the appointment"
  - Practice self-compassion and allowing emotions
  - Cultivate belief that we are good clinicians even when the patient doesn't agree with our plan

Mrs. Gimme Moremeds

- 65 YO FEMALE WITH CHRONIC BACK PAIN AND COMPLEX MEDICAL HISTORY
  - Every time she comes in she complains she needs more medication to manage her pain despite high doses of opioids and other analgesics
  - You spend long amounts of time listening to her complaints
  - She has no transportation to get to a specialist and declines physiotherapy and other suggestions

- YOU FEEL FRUSTRATED AND BELIEVE THAT NOTHING YOU DO WILL EVER HELP HER

Mrs. Gimme Moremeds

- HOW CAN WE APPLY THESE TOOLS?
  - Identify our cognitive biases using the model:
    - We believe that we can't help this patient
    - Caught up in her story that nothing helps
  - Identify the unhelpful actions we're taking:
    - Escalating doses of opioids with no improvement
    - Taking all the responsibility for her pain management on ourselves rather than involving her in her care
    - Over-empathizing (iatrogenic)
  - Opportunity to engage her in problem solving
  - Ask ourselves what we would do differently if we believed that we could help her?

Mr. B. Igot

- 73 YEAR OLD MALE WITH HYPERTENSION AND CAD, COMES TO YOUR OFFICE DEMANDING A SAME DAY APPOINTMENT WITH YOU
  - Uses racial slurs to describe his cardiologist
  - Refuses to leave the waiting room unless he sees you
  - Raises his voice and rips up the code of conduct when your office staff point it out to him
  - Makes threats that he is going to sue you and the cardiologist

- YOU ARE ASKED TO GO TO THE WAITING ROOM TO MANAGE THE SITUATION

Mr. B. Igot

- HOW CAN WE APPLY THESE TOOLS?
  - First priority is establishing the safety
  - Ask him to de-escalate his behaviour and offer him an appointment at another time
  - If his behaviour continues, establish boundary that you will call the police
  - Consider whether the therapeutic relationship has been broken
  - Address with him in writing what behaviour will not be tolerated at the clinic going forward
  - Assume he is a good human having a bad day unless he shows you otherwise - then grounds for dismissal

References

- ENDING THE PHYSICIAN-PATIENT RELATIONSHIP:
  - https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Ending-the-Physician-Patient-Relationship
- MANAGING CHALLENGING INTERACTIONS WITH PATIENTS
  - https://www.bmj.com/content/347/bmj.f4673
- HOW TO MANAGE DIFFICULT PATIENT ENCOUNTERS
  - https://www.aafp.org/pubs/fpm/issues/2007/0600/p30.html
- CHALLENGING PATIENT ENCOUNTERS: HOW TO SAFELY MANAGE AND DE-ESCALATE
  - https://www.cmpa-acpm.ca/en/advice-publications/browse-articles/2021/challenging-patient-encounters-how-to-safely-manage-and-de-escalate