Approaches to the Difficult Patient/Parent Encounter

AUTHORS: Cora Collette Breuner, MD, MPH, FAAP[a] and Megan A. Moreno, MD, MSEd, MPH, FAAP[b]

[a]*Division of Adolescent Medicine, Department of Pediatrics, Seattle Children's Hospital, Seattle, Washington; and* [b]*Department of Pediatrics, University of Wisconsin-Madison School of Medicine and Public Health, Madison, Wisconsin*

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Address correspondence to Cora Collette Breuner, MD, MPH, FAAP, Division of Adolescent Medicine, Department of Pediatrics, Seattle Children's Hospital, Seattle, WA 98105. E-mail: cora.breuner@seattlechildrens.org

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abstract

Most pediatricians have experienced uneasy interactions involving patients and/or their parents. The majority of literature on this topic reflects encounters in adult medicine, without providing much information for pediatricians who also face this challenge. Unique to the pediatric approach is the added quotient of the parent/family dynamic. Patients or their parents may have personality disorders or subclinical mental health issues, physicians may be overworked or have a lack of experience, and the health care system may be overburdened, fragmented, and inundated with poor communication. Recognizing the physical or emotional responses triggered by challenging patients/families may allow the provider to effectively partner with, instead of confront, the patient or the family. In this article we review existing literature on this subject and describe possible strategies for the pediatrician to use during a difficult encounter. *Pediatrics* 2011;127:163–169

CASE SCENARIOS

Case 1

Adam is a 7-year-old boy who was diagnosed with recurrent vomiting (rumination syndrome) after a long series of evaluations and consultations. His father, an attorney who specialized in medical negligence, was enraged with this diagnosis. The father's tirades about Adam's diagnosis led him from doctor to doctor while he refused to understand the nature of his son's illness; the threat of lawsuit was always imminent. He continuously demanded more and more tests and consultations. Eventually, his doctors did not return his calls and acknowledged fear, frustration, and even anger with the father.

Case 2

Anna is a 9-year-old girl who presented with fatigue and a rash. Her pediatrician, through a few referrals and many laboratory tests, was eventually able to make the diagnosis of lupus. Fortunately, her illness appeared mild. She and her mother responded to the diagnosis with thoughtful questions and eventually asked the pediatrician whether he would follow her long-term for this chronic illness. Flattered, he vowed to do so. Later that day the patient's mother telephoned briefly to thank him. In the following week, the mother e-mailed him twice, once professing great concern that her daughter would die and the second time to thank him again for taking care of her child. As weeks passed, the mother's calls and visits became more frequent, and the gratitude diminished. He began to dread communication from this mother. By the end of 2 months the mother was calling him daily, both at the office and at home.

Case 3

Delores is a 15-year-old girl referred for headaches. She walked confidently into the examination room and declared: "I have had a night-

mare headache since forever!" With further history, the patient said she has had a constant right-frontal headache since the age of 10. It varied in intensity between a 2 and a 10 on the pain scale. She missed between 5 and 15 days/month of school because of the headaches. The headache seemed worse at the time of her menses. As the doctor asked questions, Delores interrupted: "You know, this is getting really irritating. All you doctors do is ask questions and do nothing. I'm telling you, nothing works. My regular doctor is a total idiot, he has no idea what is going on. I saw another doctor, a 'nervologist,' and I thought she was smart, but she was also a total loser." While the doctor explained the treatment options to Delores, she summarily shot down each one, saying: "Tried that, didn't work."

Case 4

Joseph is an overweight 8-year-old boy brought in by his stepfather, who is also obese. Both the child and his stepfather were eating a big carton of french fries and sharing a large soda in the office. Joseph had "no-showed" the past 3 times for his nutrition and social work appointments, and he had not been regularly attending school, because it was "too hard for him to walk up and down the steps." His weight during this appointment was 135 lb. The stepfather laughed and said, "he still weighs less than me. I clock in at 320!" It had become common knowledge that the more the team tried to help this child, the more he and his family would resist. When the family moved to California, the team was relieved.

The medical encounter usually constitutes a source of mutual satisfaction for both physician and patient. There are, however, patients/parents who evoke negative emotions in physicians such as anger, guilt, and depression. Pediatricians are not immune to this experience and may even be in a more unique position because of their relationship to the patient and the family. In adult practice, nearly 1 of 6 outpatient visits is considered difficult by physicians[1–3]; it is unknown what this frequency is in pediatric practice. Pediatricians may be at special risk for difficult encounters because of the complexity of dealing with a parent who may be both desperate and dedicated to his or her child with major needs.

Difficulties during patient encounters may be traced to patient/parent, physician, or health care system factors. Patient/parent issues can include psychiatric disorders, personality disorders, subclinical behavior traits, and information overload.[3] Physician features can include poor interaction or communication skills, inadequate experience with difficult patients, and/or general unease with diagnostic uncertainty. Factors within the health care system can include productivity and finance pressures. The purpose of this article is to review the current literature regarding difficult patient/parent encounters by using existing health information databases such as Medline, PubMed, ProQuest, PsycInfo and to discuss strategies for approaching these challenging situations in order for the pediatrician to provide the best care for patients and their families.

EXPLORING THE DIFFICULT ENCOUNTER

Patient Characteristics

Several previous studies have examined how physicians characterize a patient or patient encounter as difficult. In 1 study of 449 general internists and family practitioners, physicians noted several characteristics that they associated with difficult patients. These characteristics included patients with mental health problems or >5 somatic symptoms and patients with threatening or abrasive personalities. In addition, patients who brought a list of complaints to a visit or were frequent users of the health care system were also considered difficult.[4]

In another survey of neurologists, participants were presented with 30 patient behaviors. They were then asked how frequently patients had exhibited these behaviors in the preceding year and how "bothersome" the behaviors were to them. The most bothersome behaviors included not showing up for an appointment, being verbally abusive to staff, showing poor compliance with medications or treatment, arriving late, and not knowing the medications that they are taking. Other aggravating behaviors included answering cell phones during office visits, unnecessary after-hours calls, delaying copays, and the "add-on" symptom.[5] Frustrating patient personality characteristics included displaying a lack of respect and challenging recommendations on the basis of incorrect Internet information.[6] Encounters were also considered bothersome if multiple family members called and too many nonessential people (friends, other children) were in the examination room.

Even at subclinical levels, certain disordered personality traits in the patients or their parents cause problems in physician-patient interaction. Patients/family members with personality disorders may be excessively dependent, demanding, manipulative, or stubborn, or they may self-destructively refuse treatment (Table 1).[7]

Difficult Parents

In the pediatric population, it is often the parent who is the contributor to a difficult patient encounter rather than

TABLE 1 Classes of Difficult Patients/Parents

Patient/Parent	Physician Response	Suggested Response
I. Dependant clinger		
1. Initial mild/appropriate requests 2. Secondary escalation to repeated demands 3. Ultimate perception that physician is inexhaustible	1. Early feeling of being special 2. Progression to weary aversion 3. Final sense of exhaustion and depletion	1. Recogize that sense of "superman" is occurring 2. Begin to limit visits to regular office hours/ specific times 3. Continue to remind patient/parent their child's health will be monitored but less frequently as they improve
II. Entitled demander		
1. Early in visit patient/parent may use intimidation, devaluation and blame 2. Patient/Parent may act smug, self-important and superior 3. Unable to recognize that their hostility is a reflection of their "terror of abandonment" by physician 4. Does not acknowledge their fear and lack of control surrounding their child's illness	1. Preliminary desire to engage in conflict with patient/parent. 2. Secondary reaction may be rage and frustration 3. Final response is for physician to "second guess"/doubt the effectiveness of their care of the patient and then order more tests/ interventions than they normally would have done	1. Resist urge to enter into conflict; use personal radar/"early warning system" 2. Support efforts of patient/parent to assure that they are getting best care 3. Reassure patient/parent that they will not be "abandoned" 4. Discuss case/get feedback from previous physicians and current physician colleagues
III. Manipulative help rejecter		
1. Immediately reject the possibility that any treatment can help 2. Act self assured at return visits they were right and physician wrong i.e. symptoms persist 3. Continue to show up at appointments angry at everyone in the clinic	1. Initial response that physician may have overlooked something, that a diagnosis was missed 2. Secondary sense of trying to win over patient/parent-that they will be the only one that can "fix it" 3. Ultimate implication that physician is a failure	1. Stop and listen to patient/parent 2. Reflect back to patient/parent that previously they may not had an partnership with treatment team 3. Recognize that their won response may be a reflection of their own exhaustion/burnout 4. Take a break; suggest another colleague
IV. Self destructive denier		
1. Unconscious self destructive health behaviors 2. Helpless and hopeless endeavors to defeat physician attempts at improving health	1. Physican may feel loathing and even disgust 2. Ultimately come up with excuses to not see patient/parent; become unavailable and unconsciously provide substandard care	1. Recognise feelings/self monitor and disengage 2. Understand that these patients/parents may have significant mental health needs 3. Discuss case with colleagues 4. Elicit assistance from mental health professionals to help provide the care of these patents/parents

Adapted with permission from Groves JE. *N Engl J Med.* 1978;298(16):883–887.

the patient. Educators who have written on this topic have offered suggestions of what to do when confronted with challenging parents in the school setting.[8,9] These authors have offered a repertoire of skills for working with parents who bully or are aggressive or apathetic. Occasionally a pediatrician may say something that triggers a negative response, yet a quick reflection such as "I see that what I said is upsetting to you. How can I help?" or "Let me try to say it another way" may turn it around. Parents of children with chronic illnesses may be considered challenging; these parents are vulnerable or even frantic because they are coping day after day with an ill child. Despite recent clinical advances, many chronic diseases cause great suffering and uncertainty. Pediatric mental disorders also bring the added stress of stigma and parental guilt when resources for treatment or respite are hard to access. In 1 article a parent's thoughts regarding acting as the child's advocate were described: "Maybe if the parents or patient are 'special' then the doctor will use all the resources available, including time, expertise and advocacy for the child. . . ."[10] If the parents can get that special level of treatment for their child, only then have they been good parents or the best parents.

Physician Factors

The source of these challenging encounters may be the interaction between the doctor and his or her patient and not just the patient. The difficulty may derive from the doctor's personality, from cultural gaps between the patient and physician, or from external circumstances that affect the encounter.[3,11–15]

Physicians with less experience may be more at risk for perceiving the encounter as difficult. The authors of 1 study found that younger physicians reported more challenging patient encounters than older colleagues.[11] In addition, physicians who are uncomfortable with diagnostic uncer-

tainty are more likely to regard patients as difficult if they are noncompliant or have vague complaints and/or diagnoses.[1,16]

Health Care System Factors

Health care system factors may also increase the likelihood or frequency of difficult patient/parent encounters. Having overbooked clinics and overworked physicians leads to greater numbers of patients seen in a day and greater numbers of patients who are considered difficult.[17] Within a busy clinic, patients/parents who feel rushed or ignored during a clinic visit may repeat themselves and prolong their visits.[18] If the process of receiving medical care results in unmet expectations, patients are more likely to be dissatisfied with their visits.[19–22] Dissatisfied patients/parents may become more demanding, and physicians may feel less able to respond to their needs, thus transforming the problems of the health care system into interpersonal frustration.

Risks to Physicians

Difficult patient scenarios are associated with negative long-term consequences for physicians. Physicians who experience more job stress and job burnout/dissatisfaction are more likely to report a higher number of difficult patient encounters.[23,24] It is not clear whether such encounters contribute to pediatrician exhaustion and subsequent negative health outcomes. More research is needed on the effect of possible negative interactions on medical career choice.

APPROACHES TO THE DIFFICULT PATIENT/PARENT ENCOUNTER

Patient Assessment and Referral: A Team Approach

In many challenging patient/parent situations, expanding the care team may be warranted. For patients in whom you suspect a mental health component contributing to difficult encounters, prompt assessment and referral is recommended. For patients with multiple somatic symptoms in which you may suspect a psychological component, introduce this possibility early in your encounters, even while ongoing medical evaluations are taking place. Avoid introducing a psychological component to the illness after all test results have come back negative, because that may lead to resistance from the patient and a desire for more medical tests. For some challenging situations, a referral to another general pediatrician, even one of your partners, may be of benefit to provide the patient and family another generalist's view on a complex situation.

Physician Communication

Many difficult patient/parent scenarios involve faulty physician-patient/parent interactions. It may be helpful for physicians to elicit feedback on their communication skills. Possible sources include staff, trusted patients/parents, or a review of audiotapes or videotapes of patient/parent visits.[25,26] Improving physician communication can lead to increased patient/parent satisfaction, increased job satisfaction, improved patient health outcomes,[27] and a decrease in complaints and lawsuits.[28,29] Key aspects of physician communication include ensuring that patients/parents understand that the physician comprehends their situation and cares about their health.[30,31] In addition, understanding the patients'/parents' agenda and expectations is associated with improved compliance and follow-through[7] and can reduce patients' reported fears of serious illness and patient/parent complaints at follow-up visits.[32] Specific communication techniques and greater patient involvement in the process of care may enhance the physician-patient/parent relationship.[5] Other recommendations include teaching strategies to help physicians manage difficult encounters. Coping techniques should also be supported, including learning more about empathy, nonjudgmental listening, and effective communication (Table 2).[33]

Practice Modifications

Physicians should consider modifying scheduling systems to allow more time for difficult patients. However, physicians should set firm and clear limits on what time is available to the patient both in and out of the office, especially for difficult patients/parents (Table 3).

Physicians' Self-care

Physicians who experience ongoing difficulties with difficult patients/parents or how they themselves deal with them may need additional support, particularly to avoid burnout. Options for support include a trusted colleague, a support group, or a psychotherapist. [34]

Physicians are encouraged to practice goal-oriented self-management, which includes acknowledging and accepting their own emotional responses to patients[35,36] and attempting to ensure personal well-being[37,38] (Table 4).

CONCLUSIONS

Pediatricians have unique challenges when providing care in difficult situations that involve challenging patients or parents. Previous work has outlined many common challenges and strategies for handling them. Future studies should investigate difficult clinical encounters in the pediatric setting. Strategies for improving difficult scenarios can include physician adaptation of approach toward difficult patients and parents, improved communication awareness and skills, and modifications in the practice structure. It is gratifying

TABLE 2 Helpful Communication Techniques[34–36]

Goal	Activity	Suggested Phrase
Improve listening and understanding	Summarize the patient's chief concerns	"What I hear from you is that. . . . Did I get that right?"
	Interrupt less	
	Offer regular, brief summaries of what you are hearing from the patient	
	Reconcile conflicting views of the diagnosis or the seriousness of the condition	
Improve partnership with the patient	Discuss the fact that the relationship is less than ideal; offer ways to improve care	"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."
Improve skills at expressing negative emotions	Decrease blaming statements	"It's difficult for me to listen to you when you use that kind of language."
	Increase "I" messages (eg, "I feel . . ." as opposed to "you make me feel . . ."	
Increase empathy; ensure understanding of patient's emotional responses to condition and care	Attempt to name the patient's emotional state; check for accuracy and express concern	"You seem quite upset. Could you help me understand what you are going through right now?"
Negotiate the process of care	Clarify the reason for the patient seeking care	"What's your understanding of what I am recommending, and how does that fit with your ideas about how to solve your problems?"
	Indicate what part the patient must play in caring for his or her health	"I wish that I (or a medical miracle) could solve this problem for you, but the power to make the important changes is really yours."
	Revise expectations if they are unrealistic	

TABLE 3 Suggestions for Better Practice Management

Suggestion	Activity
Access community resources	Develop on-site or community-based links to mental health and social work professionals.
Ensure adequate follow-up	Schedule regular follow-up visits at two- to three-week intervals, especially if high dependency needs are suspected. Educate the patient in appropriate use of telephone or e-mail contact as an alternative to more frequent visits.
Promote continuity of care	Educate patients that the involvement of multiple health care professionals may result in conflicting or confusing approaches; help the patient maintain a primary care provider.
Schedule appropriately	Length of visits should fit patients' perceived needs and expectations.
	Modify scheduling systems to allow more time for certain patients at the request of the physician.
Set firm limits	Discuss and enforce your policies regarding abuse of staff, insistence on immediate telephone access, or obstruction of the process of care. Terminating the relationship with the patient is a last resort and should be done with care.

Reproduced with permission from Haas LJ, Leiser JP, Magill MK, Sanyer AN. Haas LJ, Leiser JP, Magill MK, Sanyer ON. *Am Fam Physician.* 2005;72(10):2066.

TABLE 4 A Pediatrician's Guide to the Difficult Patient/Parent Encounter

Consider the parents' perspectives: ask parents about how the child's illness has affected the family. What were their hopes before the illness occurred? How much of a loss did they experience when it became clear that the illness would have a major impact on the child or on the family's future? Have there been other recent or past losses in the family or in their childhood that were similar or as momentous as what they are facing now? Empathize with their worries and concerns.
Remember the child as the patient and your role as a pediatrician. Do not try to manipulate or control the child. Provide the child empathy, even during a difficult visit.
Learn about the family's/patient's existing strengths and preferences: what in their past relationships with the health care system did they find helpful or not helpful?
Be aware of changes in your pattern of treating a child or his or her family. Listen to internal feelings of frustration, anger, or resentment, and address them.
During a difficult visit, approach the visit in a way that is process-oriented rather than outcome-oriented.
View these challenging visits as something you can do, something you have trained for, and are ready to handle.
Promise yourself a reward for getting through an encounter without losing your cool.

when an encounter can be changed from one that is extremely challenging to one for which there is a positive outcome for everyone. The pediatricians' sense of pride in their work when they can steer a difficult encounter toward health is rewarding and may even help prevent cancer burnouts.

CASE CONCLUSIONS: WHAT HAVE WE LEARNED, AND WHAT DID WE DO?

Case 1

In the case of Adam, the 7-year-old male patient with the father who may be called an "entitled demander," the doctor asked the parents about what effect the illness has had on the family, empathized with their worries and concerns, and elicited help in the treatment of their child. After a few brief conversations with the family, the parent/doctor team became more cohesive and less conflicted. The child improved with biofeedback.

Case 2

Anna is the 9-year-old female with a diagnosis of lupus whose mother may loosely be called a "dependant clinger." The doctor, after recognizing his response to this parent, became more clear with the limits on telephoning after hours, reassured the mother that he would see her daughter regularly, and asked for support from his fellow providers when he was not in the office.

Case 3

Delores had headaches and may, at her young age, be considered a "manipulative help-rejecter." Delores needed to be angry, and her doctor just needed to listen for awhile, reflecting on the frustrations she was experiencing, and then ask what Delores wanted. Her desire was merely to have her headaches "go away." They worked as partners, acknowledging it may take awhile for the headaches to decrease intensity and have less of an impact on her life. Together, they sought consultations, including for mental health, biofeedback, and acupuncture. Delores helped make her headaches "go away."

Case 4

Joseph and his stepfather had weight issues and for all appearances were "self-destructive deniers." This situation was difficult for the doctor, and when the family moved, she recognized her mixed feelings. She called the family and asked permission to talk with their new doctors. The stepfather was actually glad to hear from her and happy to help with the new information. Joseph and his stepfather went to the new pediatrician and were actually successfully enrolled in the clinic's weight-management program.

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COLLEGE STUDY ABROAD: *A few weeks ago, my eldest son announced that he planned to spend next fall studying in Japan. While of course I was excited for him, part of me thought "Could you have picked a more expensive place to study?" The expense of college study abroad may be on the minds of lots of parents these days. As reported on* USAToday.com *(November 15, 2010:1–2), the number of U.S. students earning college credit abroad dipped in the 2008–2009 academic year. While not much of a dip, this is the first recorded decline in 25 years. Based on a survey of 3000 colleges, approximately 260,000 students earned college credit abroad during the same academic year. That is more than twice as many students who studied abroad 10 years ago, but still down from 262,000 the previous year. The U.S. recession played a large role in the decline. Families had fewer resources to pay for overseas study. Furthermore, the recession increased interest in new and oftentimes more affordable programs in developing countries. Although Europe is by far and away the most popular study destination, the number of students going to Europe dropped 4%. Enrollments in African and South American programs increased 16% and 13% respectively. According to the Institute of International Education press release, 15 of the top 25 destinations for study were outside of Western Europe. Money was not the only reason for deferring overseas study. The H1N1 epidemic and increasing drug violence both contributed to a 26% decline in U.S. students studying in Mexico. As for my son, he will be one of a small number of Americans in Japan, as Japan was not one of the top 25 destinations for college study abroad.*

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