Approaches to the Difficult Patient/Parent Encounter

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.

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-
mature 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 physicians1–3; 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
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 an 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.5,11-15 Physicians with less experience may be more at risk for perceiving the encounter as difficult. The authors of a 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 non-compliant or have vague complaints and/or diagnoses.\textsuperscript{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.\textsuperscript{17} Within a busy clinic, patients/parents who feel rushed or ignored during a clinic visit may repeat themselves and prolong their visits.\textsuperscript{18} If the process of receiving medical care results in unmet expectations, patients are more likely to be dissatisfied with their visits.\textsuperscript{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 difficulties with difficult patients/parents.\textsuperscript{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.\textsuperscript{25,26} Improving physician communication can lead to increased patient/parent satisfaction, increased job satisfaction, improved patient health outcomes,\textsuperscript{27} and a decrease in complaints and lawsuits.\textsuperscript{28,29} Key aspects of physician communication include ensuring that patients/parents understand that the physician comprehends their situation and cares about their health.\textsuperscript{30,31} In addition, understanding the patients/parents’ agenda and expectations is associated with improved compliance and follow-through\textsuperscript{7} and can reduce patients’ reported fears of serious illness and patient/parent complaints at follow-up visits.\textsuperscript{32} Specific communication techniques and greater patient involvement in the process of care may enhance the physician-patient/parent relationship.\textsuperscript{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).\textsuperscript{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.\textsuperscript{34} Physicians are encouraged to practice goal-oriented self-management, which includes acknowledging and accepting their own emotional responses to patients\textsuperscript{35,36} and attempting to ensure personal well-being\textsuperscript{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.
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.”

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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.

Noted by WVR, MD
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