Podcast Transcript

Challenging Patient Interactions: Conversations That Matter

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Transcript

Episode 1 – Examining Challenging Patient Interactions and the Healthcare Team

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LEANA MCGUIRE, HOST: Hello. And thank you for taking the time to join us. I am Leana McGuire, your host for this podcast by Colibri Healthcare. Today we will be discussing challenging patient interactions. We all know that conversations between people in general can have understandings and misunderstandings. Conversations can lead to peace or discord, a team approach or mistrust, understanding or confusion. In healthcare, many conversations take place in the presence of a health concern, scare, or crisis. This adds an additional layer of stress or the potential for a challenging or difficult time with communication. Today, we want to help healthcare professionals to thoughtfully consider the challenges that are part of the different types of patient interactions. Healthcare professionals often find certain patient interactions particularly stressful, anxiety-provoking, or upsetting.

We want to discuss how to recognize why certain interactions are stressful and help healthcare professionals break down their feelings and consider how to approach such interactions for the best possible outcomes. Our subject matter expert today is Dr. Heidi Moawad. Dr. Moawad is a neurologist and medical writer who has been writing educational materials for healthcare professionals and the public for over ten years. She also speaks at professional conferences and works with undergraduate and medical students at Case Western Reserve University. Welcome, Dr. Moawad.

DR. HEIDI MOAWAD, GUEST: Thank you so much for having me, Leana. It's nice to be here! (smiling)

MCGUIRE: Yes, we're, we’re really pleased to have you. So, let's get started. Now, the majority of us as nurses and physicians are familiar with challenging patient interactions. What would you like to cover today that will prove helpful to our listeners?

MOAWAD: Well, I think the main thing is that when I started reading and writing and learning about this, I was really so surprised that there's so much research on this subject. And so, I think the real key for healthcare professionals to keep in mind is that this is so common and it's really overwhelming for many people. And that's proven by the fact that there is so much research out there and so much written and so much concern about this subject.

So, a really important thing for any healthcare professional to keep in mind is that you are not alone, and you are not the only one who has found these things to be challenging. And you're definitely not the only one who's looking for solutions. Solutions are not obvious to anyone. So, trying to find a way to deal with these things really is, is a very important step. But it, um, you're not alone in that.

MCGUIRE: Um so, define challenging in this context.

MOAWAD: Well, challenging, one of the things I've learned, there are so many different definitions and so many different types of challenges. So, some of them come from patient stress. Some of them come from a patient sort of reaction towards the healthcare provider. And a lot of them come from our own inability to really

immediately know what is the right answer, and our own inability to be honest in saying everything is going to work out perfectly.

So, a lot of times we can't say that. And that can be challenging for any healthcare provider, because you always want to tell your patients everything is going to be perfect. We have a 100% guaranteed solution. And when you can't do that, it's hard for the healthcare provider, not just for the patient.

MCGUIRE: Correct. Okay, good. Well, we're going to dig into this a little bit deeper. But first, I'd like you to tell us some information about why this topic matters to you personally and how your experiences have prepared you to speak to us today about these challenging interactions.

MOAWAD: Yeah, sure. So, I'm a neurologist. I worked as a clinical neurologist for several years, and then I started to pivot to different areas of medicine, and I worked in utilization review for seven years. And then I started writing. And as I started writing for the public, one of the real benefits that I had was that I was able to look up and see, “What are people asking about?”

And that gave me a really interesting insight into what patients are concerned about, what they're scared about, what they want the answers to. And so, when you see what people Google on their computer, you see what they're really stressed out about when they go home after seeing the doctor, or you see what families are stressed out about.

And it just kind of um, I think it really builds a lot of empathy. But at the same time, I've been a clinical neurologist, so I've been on the side of trying to keep my own cool and trying to be reassuring. And in writing, of course, I have this advantage, which is that I have plenty of time to be reassuring.

I don't have to respond on the spot, so I'll, I'll admit right there that that is much easier than having to respond to someone in real time when they're very stressed out. But um, so that's why it's been so interesting to me.

MCGUIRE: So let's talk … dig in a little bit about the different kinds of encounters, starting with hostile patients. There's probably a myriad of reasons why a patient would become hostile. But let's talk about those interactions specifically.

MOAWAD: Sure. So, so as you, as you said, yes, there are so many different reasons. And, you know, the main one is that they're upset. So, they're upset about what is happening to them. They're upset potentially, because they don't have the answer that they want. And, you know, as healthcare providers, we also all wish we could give patients the answers that they want, which is really, “You are going to be better, and I know this for sure.”

But most of the time, we are unable to provide that answer. So, patients can just be going through those stages of grief that we often read about. And you know, where are you as the healthcare provider in their stage of grief? And so, they can often identify that provider, whether it's a nurse or a physical therapist or a physician or, you know, anybody on the whole team as being maybe the cause of that grief. Or, they can really associate that healthcare provider with sort of getting blocked in those stages of grief, because everybody has to go through them.

MCGUIRE: (nodding)

MOAWAD: So, it would be very unusual for someone to hear something that they don't want to hear, that they have an illness … that or maybe that the illness, we don't know what it is. But, we don't for sure know what the treatment is. Or, the treatment's going to be hard or painful or take a long time. And the person who's relaying

that information or who is part of that negativity, it's easy to blame them. And um as human beings, all of us can imagine, you know, we're never happy with the person who tells us something we don't want to hear.

MCGUIRE: Right? Yes. Good point. And the unfairness of the disease or the outcomes can definitely, as I hear what you're saying, that that can raise that. They can be angry, and it can raise to hostility. Now, what about noncompliance? Sometimes I think, you know, patients will react with noncompliance, which can be which can be super frustrating for both sides, the health professional and the patient. Can you speak to that?

MOAWAD: Yeah. So noncompliance is really, really common when you start to look at studies about compliance and noncompliance. It's the numbers are kind of staggering a lot more than what most healthcare providers would imagine when they're sending their patient home with some instructions. You would never imagine! I mean, some studies will say things like 40%, 60% are noncompliant.

And you definitely don't expect that when you're explaining what people need to do. But compliance can be very difficult for so many reasons. One is that people often are in disbelief that the intervention is going to work, especially if they're asked to do something like give themselves an injection or take a medication every day or multiple times a day.

It can be kind of exhausting, and it can really interfere with your day-to-day life. So, it can just be hard to make yourself do it. And, and then sometimes people aren't really sure that the medication or any kind of treatment is going to help. So, if the condition is something that people are being told that they have, but the symptoms are not that terrible, then it's sort of, there's a lot of pieces of the puzzle that aren't super obvious.

You know, someone may have a mild symptom or a mild discomfort. And they're told, you know, your imaging tests tell us this big deal of a thing, and you have to take this medication three times a day. And so, it kind of seems like, well, well, the symptom wasn't really that bad. And it's hard to wrap your head around potential complications in three years down the road.

And, I'm going to prevent that complication by taking something every day. So, maybe I don't have to take it every day. Maybe I can skip once in a while, you know? So that's one of the reasons, it's just kind of that hard to dig your, your, you know, sink your teeth into really the pros and cons of taking the medication.

Another thing, of course, is side effects. So, side effects are unpleasant for anyone. And so, trying to stretch that out maybe or avoid the side effect is another reason.

And then another one is just kind of the idea that maybe the cost is a lot. So, trying to even stretch out a prescription before you have to go and get the next one. And this can be an issue for cost with co-pays.

It can be an issue if you, if it's kind of inconvenient to get the medication, if you have to jump through a bunch of hurdles like calling a few different places to get a renewal or a refill. Then, that can also make you want to hold off a little bit until you, you know, wait a little bit longer than usual or than what's recommended.

MCGUIRE: Right. Do you think that sometimes compliance is related or noncompliance, I should say, is related to some level of wanting to have control for these patients?

MOAWAD: It might be. Um, so, yeah, it might be. I mean, for a lot of people, you know, there's sort of this idea that the instructions that are given by a healthcare provider are a little bit cookie cutter. And, they tell everyone to do this. But maybe I'm a little bit different. And so, I'm not going to do it exactly that way, because I know

myself better than my doctor or nurse practitioner or therapist or whoever is giving this information. And so that can be part of it, too.

MCGUIRE: Great. Okay. Now, and, and we are, eventually we'll, we'll talk about some ways of coping with these interactions. But covering the different types, I think it's important before we get into that. But, can we also discuss the violence or burnout? Because sometimes it goes to a level that is, you know, beyond. I think a lot of, a lot of nurses sadly have experienced that … or health professionals, healthcare professionals.

MOAWAD: Yeah. Unfortunately, that is a real area of stress for healthcare providers. And I, I do think with some of the uh, some of the research that's been done, it can be directed towards anyone really in the healthcare system. But, it does tend to be a little bit more prevalent towards nurses, probably because of the more close and prolonged contact.

And also because nurses, there's still more females in the nursing profession than males, and they tend to be physically smaller. So, a little bit less intimidating there. And um, and so that can be, you know, overwhelming. I mean, it's not really possible for a nurse to always be accompanied by someone else. You just would never get your work done if you always had to work in teams or pairs or, you know, you can't have a bodyguard with you all the time. So. So it's, it's scary.

MCGUIRE: (nodding)

MOAWAD: And, and from what I understand, it's also unexpected. So it's not necessarily, and this is terrible really …

MCGUIRE: Mm Hmm!

MOAWAD: … is it's not necessarily the patient that you think is going to lash out. Because in that situation, a nurse may actually then take the time to ask for someone else to be in the room. And you know, maybe that's preventative. But, but a lot of times it's described as being unexpected. So, people didn't prepare. And so, from what I understand, I don't think it's always possible to predict or to prepare for that. And it's terrifying if that happens to someone, what do they do? Do they go back to work the next day?

I think a lot of nurses might want to just to kind of forget about it and remind themselves that most of the time this doesn't happen, but it can be really difficult. That patient may still be an inpatient, and physically it can be difficult. If someone is in pain or has a bruise or something, it's very difficult.

So, it's overwhelming, and it really makes people wonder, is this job worth it? Do I really want to expose myself to this? … especially when you think about why people become nurses in the first place.

They do it to help people, but not really to risk their lives in order to help people. So, so it's just absolutely horrible when it happens. And I don't know that there's um … I think the support that has to be given for a nurse or any healthcare professional who's been hurt by violence has to be just a huge amount of support physically and emotionally and practically, too, in terms of protection.

MCGUIRE: Yes. Yeah, absolutely. And, I think there probably are (I'll have you speak to this) some ways to prepare ourselves for potential violence.

I can say from a personal perspective, I've been a nurse for many years, that I stopped wearing my stethoscope around my neck. Thankfully, I had someone with me, but someone took advantage of that position to, you

know, try and strangle me with it, basically. And it was very overwhelming. So, stethoscope in the pocket is my advice.

But are there other ways to potentially prepare ourselves for these, like training, or what would be some ways for us to “just in case?”

MOAWAD: Well, and I don't necessarily think I have all the answers, but in what I've read about this, some things are really kind of um, potentially protective, are making ... having very clear team approach.

MCGUIRE: (nodding)

MOAWAD: So, showing that everyone gets along. ... so that anybody who does not like a nurse will understand that everybody else on that team is ... has her back or his back, you know? So, that's one thing, not really showing hostility or contradicting each other or talking in a way that sets up healthcare providers against each other. So that's kind of a big overarching thing. And it may not work for someone, for everyone. It may not work for every patient, but it can work for some.

MCGUIRE: (nodding)

MOAWAD: If some people feel that even subconsciously, that division among the team could potentially be an opportunity to attack someone either physically or verbally or accuse them in that way. So that's one thing, is to have good relations with the whole team as a policy. Okay?

And another thing is, you know, potentially doors open with patients. So, especially patients who may be a little bit larger than the healthcare provider. ... having doors open or having certain therapy sessions with a uh, with a window between provider and other providers, or, you know, curtains instead of complete doors.

Now, I know that doesn't work for everything and everybody, but it can help a little bit. Potentially, even just having students around. And, you know, a lot of times, it's not always possible to do what I'm going to suggest. But a lot of times there's, you know, five students with one provider. And in many situations, that's not necessary.

And really seeing that one-on-one care that a nurse provides to patients can be more beneficial than this kind of big team of lectures. And it doesn't always have to be the same way. But it's just one of those things that physicians in training, therapists in training, everybody can get this benefit by seeing what happens, you know, one-on-one and um, and observing that. So that can help protect people as well. But, but I also think another thing is, “Go with your gut.” So even you know if you're wrong, it's totally fine. But if something is even slightly concerning to you, maybe ask for help, ask for someone else to come in the room. And if you're wrong, that's great. It doesn't matter! You'll probably never know. But if, if there was any danger there, it could potentially be preventative.

MCGUIRE: I'm really glad that you mentioned the cohesiveness among the team and, you know, displaying that in front of the patients and working together. It really speaks to interprofessional or team approaches when it comes to that. But there's also the physician-nurse relationship and all of the pieces that go together to help as we work together to get the best outcomes.

MCGUIRE: Do you have any examples of interprofessional scenarios between, say, physician and nurses and the communication and how that's important in situations like this?

MOAWAD: Yeah, I think, um, you know, one thing is, is clear communication and consistent communication. If you, you know, patience is important, too. And so, I've been in this situation as sort of when I was a junior person where people would maybe say part of what they intended to say and expect you to read their minds with the rest.

And if you don't fill in the blank correctly, because potentially there's more than one way to fill in what they didn't say, then you're going to make a mistake. So, asking for clarification can be met with impatience or sort of like, “Why are you asking me over and over again?” But it's like, you know, details really do matter!

MCGUIRE: (nodding)

MOAWAD: And so, expecting people to read your mind is not usually a good idea! (laughter)

MCGUIRE: (nodding)

MOAWAD: And it's really important to be clear on the details. So, I think patience is one. ... not being afraid to ask for clarification. And those really do go hand in hand. If someone's constantly annoyed with you, because you ask for clarification, you're less likely to ask for clarification. And then you're gonna guess, and your guess might be right; your guess might be wrong.

So, communication, patience, um asking for clarification if you need it .... I think also not making, unfortunately, physicians and all healthcare providers, nurses and everybody, often make kind of sarcastic remarks about things, sometimes in front of the patient.

MCGUIRE: (nodding)

MOAWAD: And that can really set up other members of the team for, you know, just hostility from patients.

And it can even set up the whole healthcare system for hostility. So, we've, we've all unfortunately heard this where someone's looking at interns, “I can't believe they did this” or “I can't believe they didn't do this.” And, you know, you weren't there. You don't know what the circumstances were. Hindsight is always 20/20. That's just so obvious that looking back, of course, things should have been done differently many times.

But you don't know that until the outcome happens, and then you see where potentially gaps were made. So, so not making those kind of snarky sort of remarks, because it does make it challenging then for everybody else who's trying to do a good job.

MCGUIRE: (nodding) Right, right. Well, this is, I mean, all of this information is so important. And I'm curious about statistics. Are there specific types of patients who are more prone to have these reactions or challenging interactions?

MOAWAD: Well, so this has been hard for me to nail down, to be honest with you.

MCGUIRE: (nodding)

MOAWAD: So, um there are some type of patients who have, you know, certain personality disorders like antisocial kind of personality, where there is just an overall tendency to do things that are harmful to others.

But in addition to that, there are people who are otherwise trying to live a healthy and happy and peaceful life, who might become overwhelmed and react out of character and unexpectedly to their own healthcare crisis or the healthcare crisis of a family member.

So, you know, certainly, certainly people who are otherwise, you know, having violent or hostile tendencies, will probably have that across the board in many aspects of their life. And, others can as well, unexpectedly.

MCGUIRE: Right. And we're talking specifically in this conversation about those people who are aware of what they're doing and what's going on. I mean, the confused patient is a completely other different category in itself in that they're not aware of what they're doing. And I think all of us listeners, all of our listeners and ourselves are well aware of those situations.

And it is kind of a sad and scary fact that all of us have experienced or witnessed some kind of, you know, difficult interaction with patients, um even to the point of seeing those that do get violent. So, it is something that happens on a fairly frequent basis. And as you said, it can be heartbreaking for the caregiver. So I'm, I'm really glad that we're having this conversation.

I think it's really important that that we go down this road and discuss these interactions. So people who suffer from depression can be prone to these reactions, too. Is that correct?

MOAWAD: Well, you know, I haven't seen that specifically prone to kind of violent outbursts necessarily, but maybe more, you know, hostility or blaming. But I don't know that that particular, that people who have been diagnosed with depression are more likely to be violent.

But I actually do want to go back to something you said, which is that you mentioned that we've seen this. So one thing I also wanted to mention is that for sure, the person who is personally impacted by violence has a huge trauma to deal with.

But other people who maybe were on the same shift or who frequently work with that person are also very likely to be traumatized in emotional ways.

MCGUIRE: Mm Hmm.

MOAWAD: So maybe not as much as the person who was physically attacked, but it really does affect everyone. And then it can often cause people to sort of pull back all of them. Everybody can pull back in the aftermath of a violent attack and really um just hesitate to spend too much time with anybody who they perceive as potentially being violent.

So, it does have consequences that really are much more widespread than just one individual who was attacked. Even though, of course, that person has the biggest emotional fallout to deal with.

MCGUIRE: Sure. Absolutely. It's like a, a secondary post-traumatic stress, correct?

MOAWAD: Yeah, right.

MCGUIRE: ... if you've witnessed it? Yeah.

MOAWAD: Absolutely.

MCGUIRE: No, that's a really good point. I'm glad you brought that up as well. So, is there anything else that you'd like to add about these particular challenging interactions?

I know that we'll get into um kind of looking at different aspects of it when we do our second episode in this series, which will be super interesting as well. And, you'll be returning for that.

Anything that you'd like to add on these interactions before we close out the first episode?

MOAWAD: Well, I think just you know, one thing about it that I do want to add is that, you know, a lot of times we all have really extreme reactions of trying to avoid another event. And sometimes we don't understand why. So, I think just self-awareness about, you know, why something affected you, maybe um not being so hard on yourself if you are very traumatized and accepting the fact that it really bothered you if you or someone else was harmed in some way is a really important thing to be aware of.

MCGUIRE: Thank you, Dr. Moawad, for your expertise during this first episode in our series on Challenging Patient Interactions: Conversations that Matter.

So far, we've discussed why challenging patient interactions occur and the different types we may encounter.

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In our second episode, also, like I said, featuring Dr. Moawad, we'll dig further into this complex dynamic covering how to potentially avoid these scenarios, whose fault they may be (if anyone's?), problems that occur as a result, our own feelings toward these interactions, and possible solutions. It'll be another informative half hour, and we look forward to seeing you there.

This is Leana McGuire for Elite Learning by Colibri Healthcare.

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Episode 2 – Letting Go of the Blame Game

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MCGUIRE: Welcome back to part two of our two-part series on Challenging Patient Interactions: Conversations that Matter. I am Leana McGuire, your host for this podcast. And, I'm pleased to again welcome Dr. Heidi Moawad as our subject matter expert. Dr. Moawad is a neurologist and medical writer who has been writing educational materials for healthcare professionals and the public for over ten years. She also speaks at professional conferences and works with undergraduate and medical students at Case Western Reserve University. Welcome back, Dr. Moawad.

MOAWAD: Thank you so much for having me, Leana!

MCGUIRE: In the last episode, we covered why challenging patient interactions occur and the different types we may encounter. Now let's discuss other aspects of these interactions. For example, I know we touched a little bit on this in the first episode, but is it possible to maybe not avoid but at least limit challenging patient interactions? And if so, how?

MOAWAD: Um, I don't think it's possible to completely eliminate them. So …

MCGUIRE: (nodding)

MOAWAD: I think that given the situation that patients are dealing with their own illness or the illness of a family member, it's going to be impossible for patients and healthcare providers not to have challenging interactions, because neither patients nor healthcare providers are robots. So, everybody has their own emotions, their own way of dealing with things, and it's not always going to be pleasant.

So, I don't think it's possible to completely avoid them. But I think acknowledging that it's almost inevitable that they're going to happen sometimes is a really big step in potentially managing them and having the best outcome. So, there are a couple things to consider.

And one of those is that, you know, unpleasant interactions, hostility, potentially blaming, crying, disbelief, noncompliance, all of those kinds of things are possible. And really, any patient can have these kinds of reactions. Any patient might not like their healthcare provider. There's all kinds of reasons. They might not like you, because you remind them of someone that, that was really mean to them in the past.

MCGUIRE: Right!

MOAWAD: That has absolutely nothing to do with their healthcare at all. So, there's all these different kinds of things that, that people bring into this interaction that's not personal.

But I think knowing that is really helpful, because when you're dealing with a challenging situation and already you know that it's not about you. You are just, as a healthcare provider, you are just a blip in the patient's whole entire life. So, the fact that it's a challenging interaction and that it's not about you, but that you have to do your job, and your job is to try to get the best outcome for the patient.

That's why you became, you know, a nurse or a physical therapist or any kind of technologist or a physician or any healthcare provider. It's because you wanted to help patients, right? Or else, you wouldn't be doing this.

MCGUIRE: (nodding)

MOAWAD: So, knowing that challenging interactions and them not liking you or what you have to say is just part of, part of the whole story is a really good way to go into it with a sense of being realistic and a sense of understanding that that's a challenge you're also going to have to learn to deal with so that you don't get shocked or disappointed or surprised or blame yourself *every single time*.

MCGUIRE: (nodding). Really good point! I'm so glad that you said that, because I really do think that, that acknowledging does create preparedness just in the fact that you know it's going to happen. Because we get our feelings hurt when, when patients aren't nice to us or we have bad interactions or, you know, God forbid, it becomes … it escalates. So, I love that you brought that up.

MOAWAD: Right.

MCGUIRE: That's a really, really good point!

MOAWAD: Right. Thank you. Yeah, everybody will get their, can get their feelings hurt. But if you already, it's a lot about expectations. If you already know that this is likely to happen, you won't get your feelings hurt. Yet at the same time, that doesn't mean, “Oh, who cares about this patient? They're just rude. It's not about me. I don't have to address that rudeness.” I mean, it's not to that extent.

You still have to then try to, you know, help them cope with their feelings, because, you know, as a healthcare provider, again, we're not robots. So, if it was, if it was a video game, you could just press a couple buttons and make them better. But it's not that way. So, so helping them requires really addressing a lot of the issues that are going on, not just the diagnosis, the prescription, and you're on your way. You know?

MCGUIRE: Right. And that, that kind of opens up another series of questions in a way, because you were saying, you know, you don't just, we don't necessarily just have to accept that we are going to be treated badly in a sense. There are some things that we have to think about. So, a couple of things that you said I'd like to pull on.

Number one, you talked about patients crying or being noncompliant and those different reactions. Can those things sometimes be cues that interactions could get more complicated or challenging with that individual?

MOAWAD: You know, it's possible. And, and I, but I have to say not always. So, so I have taken it that way myself when I was practicing. And someone was, you know, very unpleasant. I would often assume that the next visit was going to be unpleasant … but not necessarily. Because … and especially if you're dealing with an outpatient, but even with an inpatient kind of situation, the next time you see that patient, they may have had time to think about what's going on, to think about their diagnosis and even to potentially ask questions that are a little more proactive. You know, "What does this mean?" "What do I have to do?" "Is there anything I can do to make this get better faster?" Or, "Is there anything I can do to really minimize the impact this has on my life?" I mean, they, they might not use those words, but that's really what they're asking.

And so, they're not always gonna act the same way, because you're potentially telling them something, or they've just gotten news that they're not happy about. By the next time you see them, even if it's just an hour later, you know, like an inpatient, you know, floor nurse interaction, where you're seeing them really frequently, already their attitude about the situation may have changed. And, they may be ready to deal with things a little bit differently. And so, I don't think they always are going to behave in the same exact way.

MCGUIRE: Wow, that's important too, because I think as healthcare professionals coming in for a second shift after a bad one with a patient, we can be a little defensive. And, you know, have our guard up.

MOAWAD: Yeah.

MCGUIRE: So, I'm glad that you brought that up as well. If you do have someone that it's just, you know, the conversation or interactions don't … aren't going well, and there is some indication that they aren't crazy about you or, you know, fond of a particular healthcare individual ….

MOAWAD: Right.

MCGUIRE: Is it recommended to change assignments in that situation?

MOAWAD: It might be. So, sometimes it can be, and sometimes that can actually be really helpful. And, you know, a lot of times patients (and I've seen this so many times and sometimes it just didn't even make sense to me where someone) would like me but wouldn't like someone else (who I actually thought was probably better than me). Or the other way around, you know, where they definitely didn't like me, and they like someone else.

So, sometimes patients may even feel a little bit empowered if they have someone different that they can talk to. Maybe they can even complain about you, get it off their chest, and then move on. And, and again, it may be because you're associated with something really unpleasant that's happening in their care. Or, it could be that you remind them of some someone or something.

Sometimes it is even our fault. I mean, maybe you were really busy, and you had to get, you know, maybe you were looking at the clock, because you had to do something else at a certain time at 3:00. You've got to be out of that room and go do something else. You know, that's, that has to be done at that time for another patient.

And so, they can perceive that and get offended that way too. So, sometimes it is kind of our fault in the way we come across. Sometimes maybe you got paged and walked out of the room, and they really didn't like that. So, so there's so many different reasons why the interaction might not be great, and potentially the interaction with someone else might be better for them.

MCGUIRE: That's a really good point too, is the perception. And I think, you know, sometimes with technology, they could be looking up medical information on their cell phone. And an elderly patient can be very offended by that, because they don't know what they're doing. And it just feels like, yeah, so, you know, you're bringing up some really, really important points.

You also mentioned fault there for a second when we were talking about looking at the clock. But are these, are these challenging interactions .... Is there blame? Is their fault, or should we let go of that, that whole scenario of blame?

MOAWAD: I think we should really let go of the whole scenario of blame. I mean, I think if a person is having repeatedly negative interactions more so than other people, then maybe it's time to see if you can get some help. And this can be very difficult for healthcare providers to reach out to .... I've heard just minimally about some physicians getting personalized coaching for this kind of thing, but it's really not common.

And if there would be any way to get help from, you know, outside your institution or just somewhere where it wouldn't be perceived that you are to blame or that there's something wrong with you, maybe you could talk to someone, a therapist or a coach or something to get an idea if you're repeatedly doing something wrong. So, you gave a really obvious kind of example that could potentially, you know, it's, it's a nice example.

But, you know, if you look at your phone or if you look at a tablet on patient information, and it annoys people. You know, it would help to just say, “I'm looking at your results.” Or, just something like that every time you do it and to make it a habit. So, you know, if that was potentially a reason that people constantly get mad at you, then you could do that and you could make it obvious to them that you're not just checking your emails or something that doesn't have to do with them.

And so, you know, “I'm ordering your medication to come up as soon as possible.” Or, “I'm looking at this.” Just something to show them what you're doing and that you are actually engaged even though you're not looking at their face.

MCGUIRE: Nice, excellent. Communication, right?, is the key. Absolutely.

MOAWAD: Yes.

MCGUIRE: So, are there potential problems? We talked, we touched just briefly on some of them in the first episode, but ... potential problems that can occur due to stressful or negative patient interactions? And if so, can you give, give some examples.

MOAWAD: Um, potential problems for healthcare providers, you mean, or?

MCGUIRE: Yeah, in the aftermath of ...?

MOAWAD: Yeah I mean, um, in the aftermath, yeah, definitely. There are. And a lot of times we're not necessarily aware of how we are responding. So sometimes a healthcare provider ... because, you know, we all have these reactions ... and sometimes we maybe try to bury them or deny that they're happening. ... is you

may try to avoid too much interaction with other patients who remind you of someone who is extremely hostile to you.

And that could be unfair to those patients, because we know that not everybody who looks the same or has the same diagnosis is going to act the same way. But of course, you know, we all can sort of get that sort of just a reflex reaction that could be a little bit unfair. But if we don't think about what happened and sort of explore why it happened, we can try to ... we can end up inadvertently or on purpose avoiding certain kind of patients. And that, that's one thing.

Some people may get so burned out that work becomes very stressful. I mean, you can get headaches before you go to work, you can get neck pain, you can get all these different kind of things, because you're tensing up and you're so worried about what's going to happen next. Potentially blaming is another thing that can happen, blaming other healthcare providers.

So, if you start to feel attacked and you start to feel like everybody's blaming you or even just one person has blamed you very aggressively, you can start, you know, lashing out at others to try to not make it all about you. And so, there's a lot of really negative consequences that can come and sort of like side effects almost, that can spread that aren't necessarily even directly related to that challenging interaction. But it takes its toll.

MCGUIRE: Sure. I know you mentioned counseling or seeing a therapist when you're talking about the, when we were talking about the blame issue. But would you recommend that as a post-, you know, (I don't want to diagnose) but I was going to say post-traumatic? But if you've had one of these interactions that you really feel has affected you, would you recommend that as having, you know, speaking to someone?

MOAWAD: Well so, so, you know, based on what I've read, and what I've read is mainly research about this. So, it may be a little biased. It seems that people do. But of course, you know, when you're looking at research articles, there's going to be more of the type of participants or study subjects who have sought out some kind of therapy. So, from what I understand, it seems to be common enough that, that if it does happen, you certainly should consider it. I haven't seen that there's any adverse effects of getting therapy.

MCGUIRE: Sure.

MOAWAD: It seems that probably the most negative effect is maybe denying that there was a problem. And, I think that's one of the things I've seen in some of the research I've read too, is that a lot of people try to just kind of bury it, go back to work the next day, move on, and say that was a fluky weird thing, which it probably was, and it probably won't happen again.

But, not dealing with it or not dealing with the feelings can, can result in behaviors that are not helpful professionally or physically or, you know, with other people and with other patients.

MCGUIRE: Sure. And, you know, when we talk about professional therapy, but there's also, there are a myriad of EAP in most, most positions, hospital anyway, maybe not community, but some/most employers have some form of EAP that would be worth investigating.

MOAWAD: I think so.

MCGUIRE: Yeah, so that would be something that probably could be helpful. Okay. Now how do we as healthcare professionals reframe our own feelings about these interactions? We've talked about a few things.

MOAWAD: Yeah, well, I think one thing is to incorporate it into the education of healthcare professionals, both the initial education as well as the continuing education. Because I think the more healthcare professionals of all/every type acknowledge that this is real, the less it will be a surprise. And, the more people will not feel personally attacked or have their feelings hurt if they're dealt with um with hostility. So that's really another, that's an important feature.

And then also supporting each other. I think, you know, we talked in the last episode a little bit about the violence that can occur against healthcare providers from patients. And I think, you know, um if you have a bad feeling, to ask for help. And if someone's asking you for help, (it can be really hard, I know everybody's super, super busy but to) accompany them with that patient. Or, maybe to divide your students and have a few go in there. Sometimes it's not, you know, just having numbers of people can be preventative.

And another thing is if you have a bad feeling about someone and you see someone else could potentially be exposed, you know, warn them or, or see if there's anything you can do to help protect them. So, I think really looking out for each other and not being afraid to ask for help can be really beneficial.

MCGUIRE: (nodding) Yes. And, being supportive of each other eliminates being afraid to ask someone for help. So ….

MOAWAD: Yes!

MCGUIRE: It's huge that we, it’s huge that we do that. Yeah, huge that we do that. I'm glad you brought that up as well.

MOAWAD: Right.

MCGUIRE: So, let's talk solutions. Are there any?

MOAWAD: Well, so a lot of the things that I have been able to find lately is that there are continuing education training that occurs in services and, and CMEs and lectures and training and all kinds of things and groups. And, I think that, that taking the time to do that kind of training once in a while can be really helpful.

So you had mentioned kind of something that I would have never intuitively thought of, which is that having your stethoscope around your neck was um actually harmful to you at one point, and you were very fortunate …

MCGUIRE: Yeah. (nodding)

MOAWAD: … that it didn't end up with anything bad. But, you know, that's not something that is intuitive for anybody who is not thinking about perpetuating violence themselves.

MCGUIRE: Right.

MOAWAD: I wouldn’t think of that. So, most people wouldn't think of that. But so going to continuing education about wellness, about wellness for the healthcare provider is really important. And sometimes it can be um continuing education that's directed towards your *specific* area. So, for instance, people who work in the emergency room may have different concerns than people, than, you know, people who work in a pediatrics’ ward, because, you know, you're dealing with a different type of population.

So, in a pediatric situation, it could be … the parents could get very hostile.

MCGUIRE: Hmm hmm.

MOAWAD: Whereas in in the emergency room, it's, you know, whoever happens to come in. But there's also some benefit there that there's a crowd of many people and, you know, not as closed off. And it could also be very different in a, you know, a, a presurgical room or someplace where people have anesthesia. So, I think specialty specific can also be good once in a while. It doesn't have to be the only thing you do but sometimes.

MCGUIRE: Right. Good. Excellent. Um so, I know that there was a time I worked with a couple of individuals who all got together and took self-defense classes. But is that something that actually is beneficial, or do we set ourselves up for some version of liability at some point with that, with that approach?

MOAWAD: Um so, so from what I've seen, this doesn't seem to be a common approach. That's not to say that it's not beneficial, but I don't think there's evidence to prove that this is over-, overarching the right solution.

Now, do you set yourself up for liability? I don't know that I can speak to that. (laughter) That's a great question. I think for a nurse or any other healthcare provider to actually employ physical self-defense, I imagine the situation would have to be so significant that I, I don't know.

It could potentially be a setup for liability, but I, I imagine the back story would be pretty, pretty significant. It's probably not a bad idea to have some basic concepts of how to protect yourself, doesn't necessarily mean you have to be a martial arts expert …

MCGUIRE: Right! (laughter)

MOAWAD: … but some ideas of, you know, how to protect yourself. And this could be more in terms of, you know, an emergency call button or some other way to potentially get help or lock a door, or unlock a door, or just something to protect yourself within the environment that you're in.

And that could be potentially part of an onboarding or an education for healthcare providers in a particular location. And again, that may also be specific to the type of patients that are being taken care of and what their physical abilities are.

MCGUIRE: Sure. Right? And we are talking defense and not offense. So, we are, you know, that's important to, to clarify.

And, the other piece is that, you know, not all interactions go to that level. You know, we mention them, we talk about them, but a lot of these challenging interactions are verbal, and it doesn't escalate to that point just to, just to clarify where we're going with that. So that's really helpful. And, we talked about counseling. We mentioned communication and the importance of it. Communication is the key.

And we've also talked about how it's not just nurses who are vulnerable to these interactions. It's every discipline across the board. We have, like you said, physical therapists, respiratory therapists, physicians. It could be just about anyone that has, that is in that arena, so to speak, and ends up having that challenging interaction. Can we talk a little bit more? I know in the first episode we talked about the importance of that interdisciplinary communication or interprofessional communication and the importance of it.

What kinds of things should a nurse be informing a physician of if they have, are having these interactions? Is it helpful to, to make the whole team aware? What's the best-case scenario for that communication piece?

MOAWAD: You know, I think it's, it's a good idea for everyone to be on board and understanding, you know, that the patient is having a hard time dealing with their diagnosis or the patient is not happy with this hospital care or the patient hates the food or just … it doesn't have to be a big central part of it. But I think it's, it helps everybody, and it helps people to acknowledge that even if it was something as upsetting to the patient as hating the food.

But of course, that's not, you know, fatal. But it would be something that anybody, you know, who's taking care of them might benefit from knowing, because they might say, you know, I know this diet that you have to follow is really tough. And we're, you know, these are maybe some of the ways that people have dealt with it.

So, it doesn't have to be the most central part of the conversation if it's not the biggest aspect of their care. But some acknowledgment, I think, can make patients feel a lot better. And even if they've expressed it to one person and then another person knows about it, that can actually make the patient feel really cared for, because they know you care enough that you remembered what they said.

And you're not only thinking about the absolute most important, critical things, you know, putting that IV in and getting that medication in and, you know, measuring their oxygen level. You're also thinking about their comfort and expressing it to someone else. And then that other person is talking about it. And so, it just shows them that you care enough to listen, that you were listening, that you talked about it. The other person is talking about it. And it just, you know, they might not say, “Oh, wow, I'm so happy that you guys are all so nice.” But, they, they won't be as mad probably.

MCGUIRE: (nodding) Right! Right.

MOAWAD: You know, I think we would all feel a little bit happier knowing that someone is acknowledging our concerns.

MCGUIRE: Wow. The power of empathy, right?

MOAWAD: Yeah.

MCGUIRE: It can be disarming.

MOAWAD: It can.

MCGUIRE: And I think that that's, that's a really huge takeaway from this conversation. So, I appreciate that. What about involving family? If a patient, if there's a difficult interaction, is that helpful?

MOAWAD: It can be. So sometimes it can be worse. Sometimes family like to kind of stick together and feel like they're a team. And some family members, particularly if they, if they actually don't get along very well, this is their way of showing their family member that they care … is, you know, I also don't like it. So, it's all of us against them.

So, it might be helpful. But you know, there might be other situations or other kind of um complications behind the scenes that you don't know about. And so, some people feel like they have to show that they're being protective as a way to show their family member that they care. And, sometimes it can be helpful. So, sometimes a family member can understand what you're saying in a way that's a little bit more objective or just see it from a different angle and can help. So, it’s always a good idea to try.

MCGUIRE: Yeah, no that’s … it’s … okay. Good. Yeah, it's, no, that's a really excellent point. You're absolutely right! We've certainly seen that with family members. Maybe, maybe for the purposes of deciding or figuring out whether this person's behavior is their normal baseline or there may be cues, as we spoke about earlier, that they're um … that they're having, struggling with other things, and it's coming across in a different way.

So that's really, really helpful. This conversation is so important, and I'm glad that you brought it up. We all deal with it. It's important that we go over all of these details. You've given us some great takeaways. The conversation has been fantastic! Anything, any concluding thoughts that you want to leave us with or anything that you want to emphasize before we conclude the series, podcast series?

MOAWAD: Yeah, sure. I think just for healthcare providers, it's important to recognize that you're gonna have challenging patient interactions, and that it's a constant learning process. I think we can all learn, even the day before you retire, some new things about how to manage all of this. And so just to never blame yourself for not doing it perfect the first time.

MCGUIRE: Fantastic. Yeah. That acknowledging piece was, that's a, boy am I glad you brought that up! That was fantastic! All right! Thank you so much!

Now, during this second and final episode of our series, Challenging Patient Interactions and Conversations That Matter, we've talked about why challenging patient interactions occur, along with different types, how to potentially avoid them. We talked about the blame game, problems that can occur from these discussions, our own feelings, and again, possible solutions. So extremely valuable information that we can all take into our practice to make us better clinicians.

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Thank you so much, again, Dr. Moawad, for joining us and sharing your expertise. We really appreciate your time.

MOAWAD: Thank you so much for having me. It's been delightful talking to you. (smiling)

MCGUIRE: Great. Thank you. Likewise. And thank you for listening. And be sure to check out our list of other informative podcasts and courses on EliteLearning.com as you grow in your career. This is Leana McGuire for Elite Learning by Colibri Healthcare.

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