



Dealing with

Difficult Patients

*By Susan Elliott-Smith based on interviews by
Christine A. Hovliaras-Delozier, RDH, BS, MBA*

Physical, mental and emotional factors all contribute to how at ease a patient is in the dentist's office. The knowledgeable hygienist may take charge of the situation by alleviating issues that concern the patient and increasing the patient's overall comfort and participation in each professional visit.

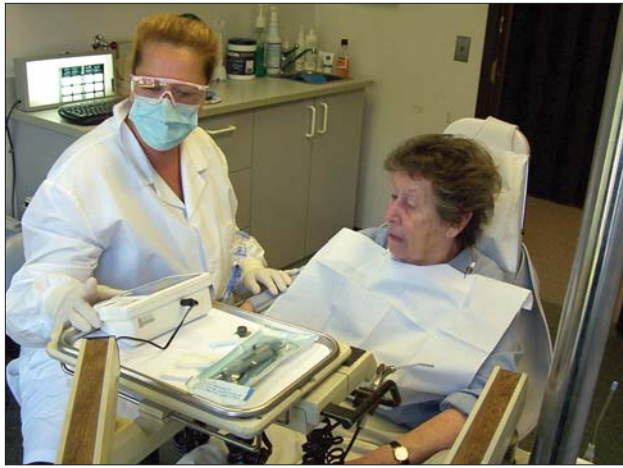
Some patients are all too familiar. Merely the sight of their name in the appointment book can create tension in the dental office.

Mary Calka, RDH, has treated more than a few of these patients in her 22-year career. One who comes to mind is not medically compromised, yet may have some medical issues, such as the adult form of Attention Deficit Disorder (ADD), which come out in her personality. In addition, she has a mouth full of sensitive, painful teeth. Each visit was excruciating for everyone involved.

Calka's solution? She stimulates self-interest and provides information needed to make well-informed choices about oral health care. With this particular patient, Calka shares information about pain management products. After agreeing that this course of the treatment is over and above her maintenance appointment, Calka and the patient discuss options such as local and topical anesthetics.

"Over the years, that has helped make her visits much more positive. She still has those underlying issues, but when she comes in for her appointment, she is much more at ease," explained Calka, who currently works in a two-dentist, general group practice in Darien, Conn.

Patricia Schonberger, RDH, BS, helps her patients face a different level of problems. For Schonberger, a hygienist with Mobile Oral Health, LLC, in Brush, Colo., those patients coping with Alzheimer's present the greatest majority of her challenges. On the whole, she has little trouble with patients in the early to mid-stage of the disease.



Mary Calka, RDH, verifies a patient's medical history and takes vital signs before beginning treatment.

"Sometimes you have to answer the same questions 15 times or ask them to open or move a certain way a lot more times than you would a normal patient," she commented. More problems arise in the later stages of the disease, when they "can't really open up [or] follow directions and are physically resisting you."

Schonberger meets these challenges by involving the patient's caregiver, who attends the appointment and helps control the situation by offering a reassuring hand to hold, freeing her to deliver care.

Cancer or chronic disease, mental health issues and developmental disabilities, time-schedule crunches and cranky kids—hygienists cope with a wide range of patient attitudes that impact the oral health care visit. While these physical, mental and emotional factors all contribute to the patient's behavior, the hygienist can influence the situation by diminishing issues and increasing patients' overall comfort and participation in each visit.

Defining a Difficult Patient

What are common characteristics of a difficult patient? It varies depending on the underlying problems that breed the difficulty.

Julie Bunn, RDH, a hygienist with more than 40 years' experience from Lakeland, Fla., puts patients into two categories: those who choose not to be cooperative and those who, because of physical and mental limitations, create a treatment challenge for the hygienist.

"Most of the people I have encountered—and I have encountered a ton—have had a bad experience, are uncomfortable or scared," explained Bunn.

"I define a difficult patient as one who has behaviors that make delivery of care challenging," said Lisa K. Shaw, RDH, MS, who sees elderly, long-term care patients on a daily basis in Utica, N.Y. In addition, she said that a difficult

patient might be one with an extensive medical history that impacts care.

Ginny Clark, RDH, BSDH, of Lawrence, Kan., tries to re-shape a difficult appointment by influencing her patients' behavior away from damaging habits such as smoking or poor at-home oral health practices.

"I really feel like with most of the people I would term difficult, both clinically and behaviorally, it is about developing that relationship," said Clark. "You learn how to not be so invasive into their space. You have to find what is important to them, and how oral health care may work into that."

Communicating at the patient's level of understanding is key in all oral health care situations, not merely the difficult ones. Sandra Magee, RDH, BS, RDHAP, has more than 30 years' experience and works in Bakersfield, Calif., with Alternative Dental Hygiene of California, a non-profit 501(c)(3) (charitable) organization. She advised hygienists to delay treatment time to make patients more comfortable in their environment and to establish a connection with them.

"Let them have ownership of the treatment," urged Magee. "Let them decide what they want to have done that day."

She realizes that this may not be practical in a traditional dental office, but encourages the hygienist in a stressful situation to "stay very positive, do small talk, watch their body language and give them a sense of control. That will help reduce the power struggle.... Use phrases that make them see that you are ... friendly, kind and caring."

For Calka, communication begins with careful listening.

"The first 10 to 15 minutes of any appointment I feel very strongly should be spent gathering information and using that information to establish the mood or the tone for the appointment," she said.

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Pat Schonberger, RDH, BS, is conducting an oral screening on a new nursing home resident.

General Tips for Dealing with Difficult Patients

- **Be a good listener.** Often, a difficult patient is just reaching out for someone to confide in, someone whom they can trust will listen to their concerns and find the best possible answers and approaches to their oral health care needs.
- **Watch the patient's body language.** "You are not going to get them to open up their mouth if they are gripping the chair," pointed out Sandra Magee, RDH, BS, RDHAP.
- **Communicate at the patient's level of understanding.** "You can tell when someone is working on a child because they get this sing-song thing going," asserted Julie Bunn, RDH. "They talk to them like they have an IQ of 2. I don't do that. I try very hard to never make any fast movements. With a patient who is apprehensive, I am very careful to explain what I am doing." Remind child patients of the noises they will hear during treatments and explain what is going on in a straightforward manner, she advised.
- **Keep up with cutting-edge techniques and technologies.** Mary Calka, RDH, recommends attending professional meetings, getting involved in study clubs, visiting trade shows and, of course, reading dental hygiene literature and following the research trends.
- **Communicate with your colleagues.** Get involved in ADHA and state organizations because the networking opportunities are unlimited. It is an opportunity to share strategies and stories that will help you through any challenge in dental hygiene.
- **Maintain a professional image.** Display those framed and mounted dental hygiene licenses, diplomas, professional awards and various certificates to reveal your accreditation. Calka does and finds that when she leaves the room and returns, the patient will comment on these accomplishments.
- **Take a page from the playbook of your local spa.** Use relaxation techniques or add aromatherapy or music to your treatment room. Even cooperative patients will appreciate the gentle atmosphere and become more relaxed.
- **Don't give up hope.** If a patient has a long history of being difficult, at least they are interested enough in their health to come regularly, points out Patricia Schonberger, RDH, BS. "I would emphasize that at each point. 'Great, you are back! You are doing great coming regularly.' Try to pick up something good that they have done," she encouraged.
- **Put yourself in the patient's place,** said Bunn, and try to understand where they are coming from. "I think that's the biggest thing—if you can understand a little bit of why they are acting [the way they are]," she explained. "And keep your sense of humor. This too shall pass in another hour."

Specific Approaches by Patient Category

While general approaches for patient treatment work well, hygienists know that there is not a one-size-fits-all method. Professionals who treat challenging populations on a daily basis recommend techniques that have proven effective for their patients in specific categories.

Combating Fears and Phobia

Sometimes the hygienist is challenged by a patient with a significant fear of treatment that has become a phobia over the course of several years. This may result in a state of disease requiring immediate attention, according to Calka.

"I find that education is an important tool to let them understand that the longer they stay away, the more of these conditions that can become apparent in their mouth," she explained.

Sometimes, the fear of the operatory can be reduced by simple, gentle explanations and adapting ordinary procedures. For example, Clark's mentally and physically disabled patients do not feel comfortable lying back, so Clark sits them up.

"Some people truly have psychosis problems, and you just work around it," she said. "I find that initially putting on a mask really freaks a lot of them out, so we might start with one glove and one finger sweep, and then I can put on my other glove, and then I can put on my mask. It is very, very individualized," she continued.

Taking on the Medical Challenge

In the case of a medical challenge, such as a heart condition, it is important to incorporate that health factor into the overall treatment plan.

"I have a patient who is on a long list of medications, and, believe it or not, in this day and age with information available everywhere, they are still not necessarily aware that there are side effects that are orally manifested from the medication," Calka shared. The medication sometimes results in situations such as dry mouth, which then leads to an increase in bleeding tissue and decay. She recommends artificial saliva in sprays or gels that can help the problem.

For cancer patients, Calka recommended immediate fluoride therapy in a tray form to minimize the risk of carious lesions caused by the patient's medications.

Caring for the Elderly

Elderly patients have limited flexibility. To work around this, Schonberger opts for exams and profes-



Julie Bunn, RDH, provides treatment to her patient, whose eyes are shielded from the operatory light.

sional cleanings where the patient lies on their bed or sits in a reclining chair.

“I have to accommodate them instead of them accommodating me,” said Schonberger. “Half the time, I end up kneeling on the floor and looking up sometimes, or just completely hunched over trying to look up into their mouth to get the view. We will just do what we can. I don’t end up seeing a lot of patients a day, many days, because it is pretty physically demanding, but it is okay.”

Shaw uses a similar approach in meeting the needs of elderly patients with limited mobility.

“Most of my patients cannot tolerate restraints of any kind, either physical or chemical,” she commented. “I tend to limit treatment times, and see them often. I approach them in a slow, careful and quiet manner. If transferring is difficult or upsetting for them, they remain in their wheel [or] Geri-chairs for treatment. In terms of medical history, I review their charts carefully initially and with each subsequent visit.

“One other thing that I tell people is magic in terms of gaining intra-oral access with difficult patients is the use of peri-oral lubrication,” Shaw concluded.

Helping the Mentally Disabled

Helping mentally disabled patients and their caregivers understand their care is the first major step in connecting with this patient population. A technique that works for Bunn is demonstrating tools.

“I show them what they can do . . . and how much they achieve using a 4 x 4, and what they can achieve just swabbing the mouth with a mouth rinse as opposed to trying to get them to cooperate with swish and swallow,” she said.

At Cottonwood Industries in Lawrence, Kan., a sheltered workshop for mentally disabled adults that also houses a dental operator in its clinic area, Clark treats patients with a variety of mental disabilities and also conducts on-site visits to group homes and private residences. She finds the greatest challenge with patients who are in pain.

To alleviate pain for Kirk, a patient with Downs Syndrome, Clark applied a topical anesthesia to his teeth 20 minutes before the cleaning, a technique that she says applies at home with brushing, as well. “Any OTC paste or gel of 20% benzocaine works,” she said. “That’s how Kirk started turning around his pattern of decay and pain. He became compliant with brushing when we realized why he wouldn’t brush. Now that he is more comfortable physically, it is really helping with everything else too.”

For more information on meeting the needs and coping with issues of mentally and physically disabled patients, see the January 2006 issue of *Access*, “Patients with Special Needs.”

Meeting the Needs of Medicaid Patients

Clark also works for the Douglas County Dental Clinic in Lawrence, Kan., a privately funded county clinic that serves people whose incomes are no more than twice those of those at poverty level.

“These patients do not have a lot of money, or they have other things in their life right now that are of a higher priority financially,” she commented.

“It might be shelter. It might be feeding their children. It might be making sure their car runs so they can get to work—if they even have a job,” said Clark, whose view is that even having these patients arrive for scheduled appointments is a victory.

Praising their efforts to get to the office and recognizing their other life struggles has helped Clark form a bond with her patients, which results in increased patient compliance.

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Lisa K. Shaw, RDH, MS, begins treating one of her favorite patients, Frank Degni, after discussing the procedures to be performed at that visit. Shaw sees elderly, long-term care patients on a daily basis.

“We have had a couple of patients completely turn their lives around,” she shared. “Their teeth were about ready to fall out, and they really pulled their lives together. One woman—you do not even recognize her as the same person physically. It gave her so much more confidence to have a healthier mouth that everything started changing.”

Dealing with Young Children and Their Parents

Obviously, children also are a part of the Medicaid category, yet in an area of their own. For the children she treats, Clark sees a difference in attitude based on what their home life is like. She finds the greatest test of her skills comes in treating children she suspects have suffered abuse. Gaining trust, and even a smile, can be challenging.

“It breaks your heart. Some of them are just really discomfited by the whole thing because they are not use to any kind of treatment,” Clark said, advising other hygienists to explain procedures and let the children play with the water and hold the instruments. She sometimes has more trouble with the parents of an apprehensive patient than she does with the patients themselves.

“I generally will ask the adults to leave the room if the child is getting really worked up, which of course is contradictory to their maternal or paternal instincts, but it usually works,” Clark related. In certain cases, when Clark has had the opportunity to observe negative parental interaction, either with their child or possibly the receptionist, she simply tells them, “We prefer that parents do not come back [to the operatory].”

“I just say it right off the bat because you can tell, kind of, what the situation will be,” she concluded.

Part of the challenge in treating difficult school-age patients is the combination of indifference, fear and worry over peer perception.

Treating Students with Behavioral Issues

Part of the challenge in treating difficult school-age patients is the combination of indifference, fear and worry over peer perception. Magee works to establish a one-on-one connection with the students she treats to combat this. Her service targets second- and sixth-graders, providing preventive dental hygiene services such as screening, prophylaxes, sealants, fluoride and varnish treatments.

“We help with dental case management and can implement tobacco cessation programs,” she said, describing the portable service that travels to schools. The service regularly

visits a middle school that focuses on children with behavioral problems and a local summer school comprised predominantly of migrant workers’ children. She regularly treats children with multiple behavioral problems—from anger to ADD and Attention Deficit Hyperactivity Disorder (ADHD).

“I always want to see them as an individual,” Magee commented. “I just try to get them to be comfortable with me as a person and I try to win their respect. I let them know that I am caring and friendly ... to reduce their power struggle. A lot of them come in with the [deep sigh] and say, ‘Well why am I here?’ and I will have to say, ‘Well, your Mom signed a consent form for you to be here. How do you feel about that?’” she said, explaining that using this type of interaction helps her win trust and shape the child’s behavior.

“I create an environment where the child becomes less resistant to the recommended treatment, and I help him to become willing to cooperate,”

Magee continued. “He is willing to cooperate because he feels that he has ownership.” Once in the chair, she continues the process of letting the child be a part of the appointment. She uses her hands and lets the students practice proper flossing techniques by using the product on her gloved fingers (see photo, page 23).

She sends each student home with a letter for their parents explaining what was done. “I put in something positive for the parents to read: great teeth or nice young person. I do try to build their confidence and self-esteem,” Magee explained. She follows up with the parents to find out if a dental appointment has been made and offers phone numbers for finding dentists and insurance. Because of the trust she has established, the student has a greater comfort level in sharing news of appointments and asking for more oral health care products.

Magee meets challenges such as the temporary nature of the students’ term at the school and disorders such as ADHD by accomplishing as much as she can in one visit, even though she typically has two opportunities to visit with the children—once during the screening and again in a one-on-one oral health care education visit.

“Remember, we see children with many issues, so I use those skills that will get their attention right then and there. I have learned to do everything that needs to be done—and



Ginny Clark, RDH, BSDH, and her patient, Kirk Douglass, whose brushing compliance improved with the addition of a topical anesthetic.

that they allow to be done—while I have them in that one appointment,” said Magee.

Lassoing the Patient with the Impossible Schedule

Last, but not least, are the grown-up patients who vent frustration and anxiety in the dental chair. For these patients, Bunn advises hygienists to address the attitude head-on. Name the emotion you think you are hearing and confront it as diplomatically as possible.

“I address the patient immediately and say, ‘You seem to be very angry today.’ If I am wrong, they will correct me. If I tell [them]... ‘You sound like you really want to get this over with,’ they are going to tell me, ‘Yes, I really do. I have something to do after I am done here.’ Or they are going to say, ‘No, not really. I just want to make sure I get all this correct,’” Bunn said.

Schonberger takes a similar approach in that she attempts to match her attitude with that of her irascible patient—but turns up the “positive” volume.

“I really try to take it slow with them and be fairly quiet and kind of gain their trust,” she commented. “I think just being patient and flexible are probably the two biggest keys to dealing with any patient to get the best outcome.”

For patients with an impossible schedule, Calka maintains a strict schedule and is respectful of the time that they are willing to devote to treatment. She said it is important to establish early in the appointment that the patient has a busy lifestyle. She asks the patient, “What is going on in your life right now?” She moves on by acknowledging these things and saying that the practice will do its best to maintain the timeframe and develop ways the patient can complete preventive therapies or treatments at home to improve general and oral health.

Conclusions: Improving the Process

Bunn observed that problematic adult attitudes stem from what she termed the growing number of people who don’t want to bother with regular oral health care visits and come in only at the urging of a loved one.

Patients, she asserted, kept regular oral health care appointments 30 years ago because they could afford to come. “They appreciated the work that they were getting far more,” she said.



Sandy Magee, RDH, BS, RDHAP, uses a couple of different approaches in teaching students proper flossing methods. In one, student Bob Davis learns how to floss using Sandy's fingers as teeth. This is a very relaxed way to show proper flossing. In another method he tries out the method under Magee's supervision.



Sandy Magee, RDH, BS, RDHAP, teaches Bob Davis proper brushing technique during an in-school visit.

Last, but not least, are the grown-up patients who vent frustration and anxiety in the dental chair.

“Now I encounter people who say, ‘My mother made me come in’ who are in their 30s,” Bunn continued. “I actually had one the other night. She wasn’t noncompliant, but she was miserable. I get men who are there because their wives have said [they had to] go. I have had people who were there because they were a transplant patient and had to have it done,” Bunn explained.

She believes that improvement in managing difficult patients comes from having an office policy that is consistently followed by everyone in the practice.

“You need to know that your employer is going to back you up 100 percent,” she asserted. “If you feel you need to say something to someone, you can without fear. The patient may leave the practice, but do we need this patient?”

While having a plan in place is a good idea, Schonberger stressed that it should be flexible to meet the individual patient’s needs.

“You need to be able to modify it at the time and move on,” she explained. “I think the key really is flexibility and patience and let[ting] the patient be your guide.”

Magee agrees that knowing your patient is important. She recommended that hygienists try to gain understanding of the patient’s behavior problems before the initial visit.

“Do diligent research if you are not aware of what is going on in the child’s life. Explain what you are going to be doing and demonstrate it,” she continued. “And always, always enjoy what you are doing because the patient will pick up on whether you are being real or not.”

Avoiding judgment is key for Clark: “We do not know anything about these people’s personal lives generally. We do not know where they are coming from. We must be accepting, and help where we can.”

Calka believes that the process should begin with education; that people need to learn that their oral health care needs to be optimal before engaging in bleaching or cosmetic procedures.

“It’s like building a house on a weak foundation,” Calka said. “Patients just need to have a clearer understand-

ing of the connection between total health and oral health.”

“I think the key is patience, patience, and patience,” concluded Shaw. “In addition, a sense of humor is mandatory, as well. Always remember that [the patient’s] inability to tolerate care is not about you; anything that they do is not personal.”



Julie Bickart Bunn, RDH, has practiced dental hygiene in Central Florida since graduation in 1967. From 1992 to 2005, she was employed with the Polk County, Fla., Health Department. She credits her training for the six years she worked as a Catholic youth minister and leadership facilitator for her ability to deal with difficult situations and people. For the next five years, she will devote time to her grandchildren, clinical dental hygiene, classes, and R&R.



Mary Calka, RDH, has 22 years of clinical dental hygiene experience. She is a former dental hygiene advisory board member for Ora-B Laboratories and hygiene educator for Ora Pharma, Inc. She is president-elect of the American Academy of Dental Hygiene, past chair of the American Dental Hygienists' Association Council on Annual Session Association Policy & Bylaws, past president of the Connecticut Dental Hygienists' Association (CDHA), Sigma Phi Alpha member and a recipient of CDHA's Mabel C. McCarthy Award.



Ginny Clark, RDH, BSDH, has more than nine years' practical experience in private practice, public clinic, and sheltered workshop environments. She is a proponent of the Kansas Extended Care Permit, which she uses in her work each week. She has developed and delivers various in-service presentations to allied health care professionals regarding oral care of special needs populations (children, elders, developmentally disabled). She is an active member of ADHA and serves on the Kansas Dental Hygienists' Association Executive Council. She is a graduate

of the University of Missouri-Kansas City Dental Hygiene program.



Sandra G. Magee, RDH, BS, RDHAP, graduated from the University of Southern California with a bachelor's degree in dental hygiene in 1975. A clinical hygienist/periodontal therapist, she owns and operates "All About Smiles" as a registered dental hygienist in alternative practice. She is founder/president of Alternative Dental Hygiene of California, Inc. (ADHC), a 501 (c) (3) public benefit charitable organization that pro-

motives and provides preventive dental hygiene services to children and seniors. Her passion and ministry is to serve those with limited or no access to dental hygiene care.



Patricia Schonberger, RDH, BS, graduated from the University of Colorado in 1982. Currently, she owns and operates Mobile Oral Health, L.L.C., a portable dental hygiene practice that serves residents of long-term care and assisted living facilities. She also works in a private general practice and a correctional facility. She is a member of DMORT-8, a federal mass disaster response team.



Lisa K. Shaw, RDH, MS, is a 1970 graduate of Erie County Community College, Buffalo, N.Y. In 2004, she received a master's degree in health psychology from Capella University and is currently working to obtain a graduate health education certificate. She has practiced dental hygiene for 29 years, the last 21 in a hospital-based dental residency program. Her patients over the years have included individuals with all types

of physical and behavioral concerns, and they have been from all age groups.

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We have also begun planning our 2007 editorial calendar and welcome your participation. Whether you would like to write a feature, suggest a topic, or identify an expert who would be willing to write an exclusive article for the fastest-growing dental hygiene publication on the market, please contact Christine at the email above.

Everyone's input is welcome, but students in particular are encouraged to respond. If you don't want to write a whole article, consider submitting a letter to the editor.