Patient Encounters of the Difficult Kind

While there are many theories about why these encounters occur, the consensus for a cure focuses on assessment, communication and empathy. This issue of infocus presents some strategies for recognizing, defusing and preventing difficult patient encounters. It also outlines some commonsense measures for physicians to protect their patients as well as insulate themselves from potential risk. Finally, when all else fails, there are some practical tips on how to sever a difficult patient-physician relationship.

In a clinical survey, physicians rated approximately 15 percent of their physician-patient encounters as difficult.1 How do you define a difficult patient? A difficult patient is someone who blocks the therapeutic relationship and deviates from expected patient behavior. This includes patients who are angry and antagonistic as well as those who seemingly want to stay sick, the so-called “worried well,” with thick medical records and no apparent improvement. Difficult can also characterize patients with multiple nonspecific medical conditions, chronic pain, addiction or psychiatric problems. And differences in patients’ belief systems, values and behaviors often put them in direct conflict with a physician’s sense of authority and control.2 Sometimes the causes for inappropriate behavior stem from situational factors, such as patients who are coping with serious medical decisions or those with cultural or language differences. Other times it can actually be the practice setting or a physician’s attitude or reaction that triggers a touchy situation.

Regardless of the causes, the fallout from these challenging encounters is ineffective care, dissatisfied patients, and physician and staff frustration.3 Further, studies show that patients labeled difficult require frequent health services, experience poor outcomes and do not hesitate to sue.4 (For more information, see “Studies Characterize Difficult Patients.”)

Difficult Patients in Action
What does a difficult patient look like in action? Here are some examples.

- **The Bully.** His abrasive attitude starts in the waiting room and continues during examination as he challenges your assessment, refuses to get a critical diagnostic test or take prescribed medicine, and even threatens to sue. How do you protect him from his own uncooperative, argumentative behavior?

- **The Internet Expert.** She has back pain and arrives armed with information from the Internet. After examination, you determine a reasonable course of treatment, but she counters by demanding an alternative course of costly diagnostics based on her research and a friend’s experiences. How do you get past the demands and proceed with treatment?

continued on page 2
Studies Characterize Difficult Patients

Do difficult patients share other common characteristics besides bad behavior? Several unrelated studies concluded that physicians consider certain types of patients to be more difficult than others. In one study, nearly 100 patients labeled as difficult by physicians were found to have more chronic problems with a greater number of tests and medications and close to two times more doctor’s visits.1

A series of studies involving more than 600 patients at four primary care clinics noted that about 15 percent of patients were considered difficult. Mental disorders, anxiety, depression, alcohol abuse and higher functional impairment topped the list of patients’ characteristics. These studies also found that difficult patients tended to use health care services more often, presented with a larger number of symptoms, and were less satisfied with the care they received. It was also noted that the physicians surveyed tended to dislike their difficult patients, and 50 percent of the time hoped they would not return. The studies concluded that this dislike and labeling of patients as difficult may result from physicians’ frustration and uncertainty in trying to diagnose and treat patients with complex, multi-symptom conditions, particularly somatization.2

In dealing with patients who are inappropriate, disruptive or rude, it is appropriate to set boundaries.3

Personality and Attitudes
For some physicians, personal attitudes, biases and emotions can clash with those of the patient. When that occurs, physicians need to be careful not to overemphasize their values at the patient’s expense.

Training and Experience
In clinical training, detached concern has been the long-standing model for physicians’ behavior. The idea is to avoid emotional attachments with patients that can lead to physician burnout. However, adopting this professional demeanor can make physician-patient relationships more challenging in situations where a different style is required by the patient.

Situational Factors Set the Scene
Various situational factors can also contribute to difficult patient encounters. The realities of today’s health care system require that practices see more patients in order to stay in business. This means there is less time for patients and physicians to interact and develop relationships.4 (See “Both Sides of the Story”). Many patients are also forced to choose providers based on their insurance plans. Additional stress may evolve from language barriers and cultural issues that inhibit clear doctor-patient communication. Sometimes the problem may be in dealing with someone other than the patient, such as a caregiver, spouse or parent who insists on being in the examining room. Finally, environmental factors such as chaotic or noisy waiting rooms, hurried staff and even a lack of patient privacy can set a detrimental atmosphere.5

Managing Difficult Patient Encounters
There are a number of techniques to help physicians manage difficult encounters. One study takes a clinical approach to management (see “Best Practices from Experienced Physicians”). Others focus on illustrative scenarios, role-playing solutions and a methodical series of steps (see “Step-by-Step Strategies for Difficult Encounters”). However, a common theme is the need for communication and empathy in dealing with difficult patients as well as setting appropriate boundaries.

In dealing with patients who are inappropriate, disruptive or rude, it is appropriate to set boundaries.
The physician may say, "I understand that you are upset, but I am here to help you. It is difficult for me to do that if you are using inappropriate language."

Communication is one of the most effective tools for physicians working with patients, especially those who are viewed as problematic. For example, in the case of a silent patient, asking open-ended questions often helps: "You seem quiet today. Can you tell me why?" By using communication techniques to pinpoint the cause—shyness, fear of authority, cultural or language barrier, medication, or a condition such as depression or even auditory loss—physicians can determine the right method of approach. If it seems like a fear of authority, the patient history could be taken by another staff member. If it is cultural, the patient may require a same-sex practitioner or even the presence of a trusted family member. Much as silence may be frustrating, especially for physicians who are used to being very direct, careful communication can go a long way in eliciting the desired responses from a patient (See "Communication Techniques for Physicians").

Empathy is the other key ingredient in combating abrasive situations. The idea is for physicians to focus on a patient’s emotions not behavior, to replace professional detached concern with emotional attunement. Physicians who are able to hone their clinical empathy skills to identify a patient’s specific feelings are more effective in working through difficult encounters (see “Developing the Art of Empathy”).

Regardless of the techniques used, it is essential for physicians to appropriately document all patient encounters to demonstrate proof of care. (see “Document, Document, Document!”). This is especially true with noncompliant and uncooperative patients who put themselves at risk by refusing a physician’s recommended treatment.

When It Is Time to Say Goodbye
Sometimes, in spite of all good intentions, the only recourse is to terminate the physician-patient relationship.

Best Practices from Experienced Physicians
At an annual meeting of the American College of Physicians, Dr. Michael F. Lubin wryly suggested that rather than get angry with difficult patients, frustrated physicians could always head to the supply closet and pound on a pile of sheets. Accompanying this tongue-in-cheek anecdote on keeping one’s cool, Dr. Lubin presented a more practical list of “Ten Commandments” for managing difficult patients. Among his suggestions to physicians, “Never lose your temper,” “Never be distressed by insistent patients,” and “Do not act as if your ego or well-being is adversely affected by the patient’s nonadherence.”

A 2006 study took another perspective, examining how respected family physicians view and manage difficult patient encounters. It reasoned that physicians follow evidence-based medicine and best practices for clinical conditions, so why not for patient encounters? Based on physicians’ input, researchers identified some best practices to help physicians better deal with difficult patients. These practices emphasize the appropriate use of power and control, collaboration and empathy. Let’s start with control. A physician expects to be in control. Thus, when a patient challenges that control by being noncompliant, the physician must be able to recognize this and not feel threatened by it. Physicians can turn to management strategies such as the clinical schedule or establishing limits and boundaries to restore balance in a difficult situation.

Collaboration calls for physicians and patients to work together to identify and investigate patients’ problems and find solutions and treatments. When collaboration breaks down, physicians must prioritize concerns, coach and encourage teamwork to restore the relationship.

Finally, physicians must be careful not to succumb to “compassion fatigue” or take a patient’s behavior personally, but must extend empathy, focusing on the patient’s emotions as well as their own. This can allow them to get past their indignation to help patients who may be manipulative or self-destructive. Despite these practices, the study concedes that sometimes it is necessary to terminate a physician-patient relationship, which it describes as either “put off,” that is, refusing a patient’s request so the patient leaves, or “hand off,” where a patient is referred someplace else.

relationship. This is especially true for situations that involve threatening and verbally abusive behavior, as well as noncompliance, including no-shows, treatment refusal and nonpayment (the most common cause for dismissal). Prior to termination, it is essential to ensure that all incidents of difficult behavior and attempts to correct the problem have been documented in the patient’s medical record. It is also advisable for physicians to check into the HMO/PPO contract terms for patient termination and to contact their professional liability insurer regarding any related risk management concerns. Before termination, you must also make an attempt to get the patient another health care provider and maintain care for an appropriate period of time. Above all, physicians must adhere to a consistent, established process to avoid any potential allegations of abandonment, discrimination or bias (see “The Process for Patient Dismissal”).

The challenges of dealing with difficult patients must be addressed head on. This holds true for new patients referred from other physicians. HMO/PPO contracts aside, physicians have the right to refuse a patient and return records to the referring physician so long as no physician-patient relationship has been established. If records indicate behavior problems, one article suggests arranging a free “get acquainted” meeting with the patient to discuss mutual expectations before determining whether to accept or decline the patient. (The patient would be required to sign a statement confirming that this initial discussion does not constitute a physician-patient relationship.)

Countless resources are available, from cited studies and Internet links to practical training programs and podcasts, to guide physicians (and staff) through difficult patient encounters and to provide the skills for building healthy, effective relationships with their patients (see “Additional Resources”).

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**Additional Resources**

State medical associations, health care institutions and private companies across the country offer a wealth of training resources to assist physicians and their staff in dealing with difficult patients. Some of these qualify for Continuing Medical Education (CME) credits. To fit the needs of different practices, training options include instructor-led seminars, podcasts, packages including CDs and manuals, as well as online courses and webcasts. Examples include:*

*This small sampling illustrates some of the topical materials available and is not intended as an endorsement of specific products.

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Working with Noncompliant Caregivers

Sometimes the problem is not with the patient. Sometimes physicians have to deal with caregivers who don’t follow the plan. Take, for example, parents who don’t complete the full course of antibiotics for their children, but rather stop administering the medication as soon as their child seems better. Or consider the spouse of a patient with dementia who never bothers to get the patient’s prescriptions filled or lab work done. Physicians have a legal duty to ensure their patients’ health needs are met, yet it may be difficult to question caregivers about their actions. If a caregiver does not appear to be following the recommended treatment, it should be noted in the medical record. If that noncompliance is potentially harmful to the patient, the physician should also advise the caregiver and, where applicable, the patient of the fact. In situations where the caregiver’s lack of compliance constitutes abuse or neglect, the physician is obligated to report the case to the proper authorities according to applicable law.

These types of cases present extremely difficult issues of judgment under New York state law. Physicians are advised to consult an attorney if there is any possibility that a caregiver’s actions may be jeopardizing the patient’s well-being.

COMMUNICATION TECHNIQUES FOR PHYSICIANS

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<th>GOAL</th>
<th>ACTIVITY</th>
<th>SUGGESTED PHRASES</th>
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<tr>
<td>Improve listening and understanding.</td>
<td>Summarize the patient’s chief concerns.</td>
<td>“What I hear from you is that … Did I get that right?”</td>
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<td>Interrupt less.</td>
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<td>Offer regular, brief summaries of what you are hearing from the patient.</td>
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<td>Reconcile conflicting views of the diagnosis or the seriousness of the condition.</td>
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<td>Improve partnership with patient.</td>
<td>Discuss the fact that the relationship is less than ideal; offer ways to improve care.</td>
<td>“How do you feel about the care you are receiving from me? It seems to me that we sometimes don’t work together very well.”</td>
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<td>Improve skills at expressing negative emotions.</td>
<td>Decrease blaming statements. Increase “I” messages. Example: “I feel …” as opposed to “You make me feel …”</td>
<td>“It’s difficult for me to listen to you when you use that kind of language.”</td>
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<td>Increase empathy; ensure understanding of patient’s emotional responses to condition and care.</td>
<td>Attempt to name the patient’s emotional state; check for accuracy and express concern.</td>
<td>“You seem quite upset. Could you help me understand what you are going through right now?”</td>
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<td>Negotiate the process of care.</td>
<td>Clarify the reason for the patient seeking care.</td>
<td>“I wish I (or a medical miracle) could solve this problem for you, but the power to make the important changes is really yours.”</td>
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<td>Indicate what part the patient must play in caring for his or her health.</td>
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<td>Revise expectations if they are unrealistic.</td>
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Developing the Art of Empathy

According to a recent study, the potential to mitigate difficult patient-physician encounters resides in developing clinical empathy: the ability for physicians to emotionally engage during conflicts with patients. The study emphasizes the need to cultivate curiosity about patients’ particular perspectives. This asks physicians to:

- accurately recognize your feelings and negative emotions whenever they occur;
- reflect on your negative feelings—what they mean and how they may relate to your patients’ feelings;
- try to discern the emotional issues underlying your patients’ negative words and reactions;
- be attuned to your patients’ nonverbal cues and adjust your own nonverbal communications to coincide; and
- accept patients’ criticism and negative feedback without getting defensive.

When a patient refuses treatment, the issue may not be clinical, but emotional. The patient may have a concern about the outcome; he or she may have had a family member with a negative result. The study recounts the story of a young athlete who refused life-saving surgery for severe bowel disease, angering and frustrating his team of doctors. An empathetic resident realized the patient needed to talk with someone who had been through the same surgery, to address his concerns about life after a colostomy. With the emotional issues settled, the patient agreed to surgery.

This study concludes that empathy, accurately recognizing and relating to a patient’s feelings, is a valuable “trainable skill.” Some ideas for helping physicians develop the art of empathy call for rewriting negative encounters from the patient’s perspective and attending specialized training in communication skills and role-playing workshops. The study also suggests that empathy techniques be role-modeled as an integral part of medical training. Another article proposes that residents study selected literary works, short stories, poems, and patient narratives paired with creatively writing patient stories to help them learn empathy.


Step-by-Step Strategies for Difficult Encounters

Following are two examples of strategies that physicians can use in an effort to improve their relationships with patients.

Testing the BATHE Technique

The BATHE Technique is a tool to help physicians deal with difficult patient encounters. The idea is for physicians to try to appreciate their patients’ particular situations so they can more sensitively respond when patients become problematic. How does this work? For example, a male patient suffering from persistent stomach pain is belligerent when forced to wait while an emergency case is treated. To defuse the situation, allow the patient to vent. Often the problem turns out to be more deep-seated, such as fear and concern with a medical condition. Put yourself in the patient’s place; acknowledge that fear and ask the patient questions about his concerns. This not only helps you determine how the patient is handling the situation, it also conveys empathy. These steps can go a long way toward calming a volatile situation with an angry patient.
The Process for Patient Dismissal

Physicians should establish and follow a process for patient dismissal that includes a series of increasingly serious warnings (verbal then written) indicating that the patient’s behavior or noncompliance is unacceptable. It is critical to document every patient notification in the medical record. If the patient does not respond with behavioral changes, proceed with these termination steps.1

1 GENERATE A DISMISSAL LETTER. Objectively outline your reasons for terminating the physician-patient relationship, e.g., failure to keep appointments, inappropriate behavior.

2 ENABLE A REFERRAL PROCESS. Provide a medical records transfer request form and indicate that you will transfer the patient’s records to the new provider upon this written authorization. Where possible, offer general recommendations for finding another physician in your specialty area, such as a medical society, hospital referral center, or PPO/HMO provider listings.

3 EXPLAIN SERVICE CONTINUANCE. Explain in the letter that you will be available to provide services for a reasonable time period (usually 30 days) to enable the patient to find another provider.

4 SPECIFY LEVEL OF CARE. Outline in the letter the level of interim care to be provided until the patient locates another provider. This is typically limited to acute care needs.

5 SEND THE LETTER. Mail a certified letter, return receipt requested. As patients may refuse an official letter, you might also consider sending a letter via regular mail. Retain the return receipt (or refusal) with a copy of the letter in the medical record.

As a follow-up, be sure to notify your staff about the patient’s dismissal and ensure that any existing appointments for the patient are cancelled. Also keep in mind that the 30-day timeframe for finding a new provider can be delayed by the particular services required, the geographic location, and the patient’s condition. For example, a patient who is in the hospital or mid-way through a pregnancy may face difficulties finding a new doctor. As a final caveat, under certain circumstances, you may still be obligated to treat a dismissed patient. For example, if you are on call and the patient is admitted to the Emergency Department (ED), you must see that patient if requested by the ED physician. Any refusal would violate the Emergency Medical Treatment and Active Labor Act.2

A CALMER Approach

The CALMER Approach encompasses six steps to help reduce physician distress in dealing with difficult patient exchanges.2

When facing challenging patient behavior, concentrate on the things you can control, such as your emotions and behavior. Actively listen and try to understand the patient’s concerns so you can address them. Then make a pact with the patient confirming your understandings and expectations. Ensure that the patient has all necessary information to alleviate concerns. Reach out for help; discuss with peers your feelings regarding a difficult situation. Above all, keep communication open, for that can often be the source of patient angst. By observing this approach, physicians can be better equipped to manage a challenging patient.


Patient Noncompliance Hinders Cancer Diagnosis

Documentation Critical to Reducing Risk, Confirming Proper Care

This patient’s behavior thwarted care and ultimately contributed to a delay in diagnosing her cervical cancer.

Irene Kassel, RN

Case Details
A 34-year-old nulliparous female had a history of recurrent abnormal Pap smears, which she self-managed with herbal remedies. She was concerned any therapeutic interventions would jeopardize a future pregnancy, and she sought care with multiple gynecologists. In January 2002 a colposcopy revealed a condyloma. In June 2002, at the request of the patient, two Pap smears were done and sent to different laboratories. One reported moderate to severe dysplasia CIN II-III, and the other reported degenerating atypical cells. A non-party gynecologist recommended a colposcopy and biopsy. In July 2002, the patient presented to the defendant gynecologist.

Initial examination by the gynecologist was normal except for a finding of cervicitis, and a Pap smear was deferred until the infection cleared. The patient completed a course of prescribed antibiotics and self-medicating with vinegar, yogurt and herbs. In October 2002 the gynecologist repeated the Pap smear and the result was atypical squamous cells present, suggestive of CIN I or condyloma. The gynecologist documented that the patient was recalled for a colposcopy. In December 2002, the office secretary documented that the patient was reminded of the need for a colposcopy. However, the patient did not return for the recommended colposcopy, and there were no further follow-up efforts by the gynecologist.

In September 2003, the patient returned with a complaint of bleeding between periods, back pain, flatus and abdominal distension. A physical exam revealed left cervical displacement and thickening in the left sidewall. A colposcopy was attempted but was inadequate due to bleeding from a vaginal tear. A sonogram was negative and a repeat Pap smear was planned. The patient was referred to a non-party gastroenterologist who found no suspicious findings and attributed the gastrointestinal complaints to irritable bowel syndrome. In November 2003, a Pap smear was attempted, but there was too much blood for an adequate specimen. The cervix was deviated to the left, misshapen and friable. The case was discussed with a gynecological-oncologist and the plan included an exam by him at the next visit.

In December 2003, the gynecologist performed a colposcopy and biopsies, which revealed mild dysplasia (CIN I), condylomatous changes, squamous metaplasia and dysplastic changes. There is no documentation that the patient was informed of these results or of the need for further intervention, or that the gynecologist made any follow-up efforts. There is no documentation of an exam by the gynecological-oncologist, nor any indication why it was not done.

In June 2004, the patient returned. The gynecologist noted the patient had refused to treat the CIN I as recommended and refused yearly colposcopy with biopsy, instead wanting Pap smears every six months. If abnormal, she would consent to biopsy. The patient reported she saw other gynecologists in the interval period and a recent Pap smear was negative. Exam by the gynecologist revealed further advanced cervical abnormalities and a Pap smear revealed CIN II or III.

Immediate surgical staging revealed cervical cancer stage IIIB. Treatment included radiation and chemotherapy. The patient sustained radiation complications including burns to the rectum and vagina, as well as intestinal and urinary blockage. She also required a permanent colostomy and ileoconduit. She had intractable pain and was unable to work. Uterine scarring precluded pregnancy.

Allegations
The failure to timely diagnose cervical cancer resulted in the need for extensive radiation therapy that caused severe permanent radiation injuries.

As the consequences for noncompliant behavior escalate, the physician should increase his or her efforts to ascertain the patient is notified of the serious condition, required interventions and the consequences of noncompliance.

Irene Kassel, RN

Closed Claim Review
Investigation and Case Development

The experts all concluded this was a liability case. The care in 2003 could not be defended. The patient had blatant signs of cervical cancer including abnormal biopsy findings, significant cervical changes and new abdominal symptoms. However, there was no documentation about diagnoses considered, recommended interventions or discussion with the patient. The gynecologist testified that she informed the patient about the biopsy findings and informed her that a cone biopsy and gynecological-oncology consultation were necessary. However, the patient refused and dictated treatment to be a repeat Pap smear in six months. In contrast, the patient testified she was told everything was alright and to return for a repeat Pap smear in the future. Without documentation, there was no way to substantiate the defendant’s recall of the events. Nonetheless, even if the gynecologist had recommended the appropriate interventions of a cone biopsy and gynecological-oncology consultation, she failed to address the issue of the patient’s noncompliance. This patient was difficult. The gynecologist perceived her noncompliance as one more instance of a controlling and bizarre behavior pattern and left it at that. The experts agreed that the physician had a duty to take further actions, including providing written documentation to the patient about the serious nature of her condition and consequences of noncompliance.

The experts held the gynecologist responsible for the delay in diagnosis between 2003 and 2004. Whether this delay affected the outcome is unknown. The experts could not state with certainty if the cancer would have been less advanced in 2003 and therefore required less radiation to treat. The defense attorneys did not want to put this uncertainty before a jury. The patient sustained severe radiation complications that would engender tremendous jury sympathy. The plaintiff’s attorney could have easily swayed the jury to believe that every single day of the delay mattered and contributed to further injury. Settlement was the only reasonable defense option.

Resolution

This was an indefensible case and settled for $1,500,000.

Conclusion

A patient’s controlling and irrational behavior may present roadblocks to the provision of care as well as serious challenges to the physician. The physician’s responsibility is to ensure the patient is provided with the necessary information in a timely manner in order to make an informed decision about the course of treatment. As the consequences for noncompliant behavior escalate, the physician should increase his or her efforts to ascertain the patient is notified of the serious condition, required interventions and the consequences of noncompliance. Timely and thorough documentation of discussions with the patient and follow-up actions is critical to help confirm the physician provided the appropriate care, even if the patient’s behavior was obstructive.

Risk Reduction Strategies

Patients react differently to upsetting news about their clinical condition, and their behavior may appear as noncompliance. Sometimes they need to hear the information a second time or need to talk through their feelings. When a patient’s behavior puts her health in serious jeopardy, the physician needs to ask her why. Opening this dialogue allows a patient to express concerns that can then be addressed and many times resolved. The discussion and any resolution should always be documented.

It is reasonable to assume that a patient’s bizarre or unpleasant behavior may frustrate the physician and engender negative reactions. Physicians need to be aware of their own emotional makeup and triggers. They should not form preconceived judgments about a patient that desensitizes them when changes in the clinical picture occur. In this case, the physician simply expected the patient to act as she had in the past and, though the 2003 clinical urgency was more evident, the physician continued with the same approach for dealing with the patient’s behavior. This case illustrates that each patient encounter is unique. Physicians need to constantly reassess the impact of the patient’s behavior relative to the findings and need for intervention.

Physicians must consider the consequences of a patient’s noncompliance. As the consequences for the patient increase, the physician’s efforts must increase and these efforts must be documented. It is a physician’s responsibility to ensure the patient is aware of pertinent information and able to understand the ramifications of her behavior on her clinical condition. Actions may include phone calls, regular letters and certified letters. If the physician believes the behavior is due to alcohol or illicit drug use, the physician should consider a referral to a mental health clinician. The physician should document all steps taken to ensure the patient was fully informed.

When physicians request consultations to resolve abnormal or questionable findings, they should follow up to make certain that the consultation was done, that the consultant’s report was received and reviewed, and that recommended interventions were initiated. If the referring physician elects not to follow the recommendation, the clinical rationale should be documented. In this case, the gynecologist consulted with a gynecological-oncologist and expected him to examine the patient. However, the planned exam never occurred, and the record failed to explain why it was not done. The gynecologist’s decision to get this consultation indicates a heightened level of concern about the diagnosis, but she did not follow through. This loose end was one of the factors that unraveled the argument that quality care was provided.

Inadequate or absent documentation is almost always a stumbling block in the defense of a malpractice lawsuit. In this case, the defendant did not document her assessment or interventions in response to the 2003 biopsy findings. Although her planned interventions were appropriate, without corresponding documentation, there was no way to show that. Further, the lack of documentation about the pivotal 2003 discussion regarding follow-up testing opened the door to a credibility issue between the defendant and the patient. Accurate, thorough and timely documentation moderates the effect of imperfect recall in the defense of a lawsuit.
More Patients Opt for Alternative Therapies

From herbal remedies and dietary supplements to chiropractic techniques and acupuncture, the use of alternative therapies continues to rise among all patient populations. The comprehensive 2007 National Health Interview Survey (NHIS), which questioned more than 33,000 Americans, found that 38 percent of adults and nearly 12 percent of children use some form of complementary and alternative medicine (CAM). That number jumps to 62 percent (adults) when vitamin therapy and prayer are added to the list.2

“Alternative therapies,” “unconventional medicine,” and “CAM” all refer to health care products and practices that fall outside the realm of conventional medicine. Non-vitamin, non-mineral natural products and deep breathing techniques are the most commonly used products. The problem is that these therapies are largely unregulated and untested, with little scientific evidence of their effectiveness. And while many alternatives may be harmless, a number of herbal products and supplements have proven toxic and even triggered drug interactions with conventional medications. The misuse of Ephedra is an example. Mega doses of this preparation may have resulted in at least 150 deaths and it is still under a ban by the Food and Drug Administration.3

What is even more disturbing is the large number of patients using CAM without consulting or informing their physician. In a national survey of adults age 50 or older, conducted by the National Center for Complementary and Alternative Medicine (NCCAM) and AARP, nearly two-thirds of respondents use some form of CAM, but 77 percent have never discussed it with their doctors. When asked about the nondisclosure, about 42 percent of the patients responded that the doctor never asked, 30 percent did not know they should discuss CAM use and 19 percent cited not enough time during the office visit. Others indicated that their physician would not understand or would disapprove.4

Given this quiet noncompliance, it is good practice for physicians or medical staff to simply ask patients, “Are you using any alternative therapies?” In an effort to help, NCCAM has launched “Time to Talk,” a program offering resources to encourage physician-patient discussions about CAM. Tips for physicians include adding a question on CAM use to patient medical history forms and asking patients to bring a list of CAM therapies to their appointment. (For free tools, tip sheets, wallet cards and other resources, see nccam.nih.gov/timetotalk.)

Patients with chronic or recurrent musculo-skeletal pain tend to be the most frequent users of CAM. Other triggering conditions include colds, anxiety, depression, sleep issues and gastrointestinal problems.1 In addition to knowing the reasons someone may choose a particular remedy, it is important to be informed about the various types of CAM therapies. Recognizing the increasing popularity of these therapies, physicians should find out as much as they can about them through current scientific and medical literature. One valuable resource is the National Institutes of Health’s NCCAM site (www.nccam.nih.gov). The American Family Physician journal (www.aafp.org/afp) also has created a series of separate reviews on the most popular, researched alternative therapies and herbal treatments for traditional medical conditions.3

As with other noncompliance situations, when patients insist on using CAM therapies, communication is key. In cases where the alternative therapy is innocuous, doctors can simply note in the medical record that this treatment is being implemented at the patient’s request. Challenges arise with more controversial therapies or those that directly conflict with a prescribed course of treatment. In these cases, particularly if the doctor believes the alternative treatment could be harmful, the best approach is to counsel the patient, clearly documenting the conversation and possible effects.

It’s clear that adverse reactions do occur with alternative therapies. Due to the lack of product regulatory standards, it is not uncommon for herbal remedies to vary in strength and contain dangerous contaminants. Sometimes the inherent ingredient can cause difficulties. A recent study examining interactions between CAM products and conventional medicine found that a significant risk of adverse interactions (bleeding) occurred when patients combined ginkgo, garlic or gingseng with aspirin, ticlopidine or pentoxifylline.6 A study of emergency department admissions found a relationship between medication noncompliance and patients using CAM. The results found that 33 percent of emergency admissions were attributed to noncompliance, more than 40 percent of those patients were CAM users, and in nearly half of those cases, CAM use was strongly related to admissions.7

Certainly, patients have the right to choose CAM and refuse recommended conventional treatments. In cases where a patient is gravely ill and grasping at alternative remedies in lieu of conventional medicine, it can be a source of conflict. But from the outset, doctors must make it very clear, through communication and meticulous documentation, where they stand on the issue. And once that conversation takes place, physicians should continue talking and reiterate their position as often as possible, since silence could be construed as tacit approval. This provides backup when patients testify, “I told my doctor what I was doing and assumed everything would be okay.”

Finally, when a patient’s alternative choice is deemed potentially harmful, physicians must be careful to instruct patients that it is not in their best health interest and goes against medical advice. If a patient remains adamant about pursuing this course, physicians may find it necessary to state clearly that they can no longer treat the patient and must terminate the relationship (see “The Process for Patient Dismissal” for steps in this process).8

Document, Document, Document!

Even the best of patients can forget instructions. With difficult patients, the rule should be: Never assume that they have done what they were instructed to do. The best recourse is to document everything in the medical record. This is especially true for noncompliant patients, such as those who fail to make or show up for necessary appointments and those who regularly ignore or refuse to follow medical advice. Contributory negligence aside, physicians can be held responsible if a patient’s lack of cooperation results in injury (see “Closed Claim Review”). Moreover, cancelled or no-show appointments and AWOL patients can signal that a potential problem, such as legal action, may be brewing. The medical record is the best safeguard for documenting a physician’s reasonable and repeated attempts to secure a patient’s compliance. Here are some suggestions for medical record documentation.

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<td>Document date, time, and essential content of telephone conversations in which you urge the patient to comply and warn about potential ramifications of noncompliance.</td>
<td>Document the missed appointment by drawing a line with “no-show” in the appointment book by the patient’s name. Never erase or write over an entry, as it could be viewed as a cover-up in court.</td>
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<td>Document missed and cancelled appointments, patient reminders and attempts to clarify the reason for missed appointments.</td>
<td>Call the no-show patient to find out why the appointment was missed and document the call. (This also demonstrates your concern for the patient and can help defuse potential legal action.)</td>
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<td>Document the patient’s failure to show up for diagnostic tests or incidents of improper patient preparation that delay testing.</td>
<td>Document all no-shows and subsequent follow-up calls, postcards and letters in the patient’s medical record. (This shows your efforts to encourage the patient to make and keep appointments.)</td>
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<td>Document the patient’s failure to arrange recommended tests or specialist visits that must be performed outside the office (and your attempts to aid the patient in arranging any tests or appointments).</td>
<td>Set up a recall system using one of the numerous scheduling programs available to help your office personnel track appointment scheduling and rescheduling as well as follow up on laboratory reports and specialist consultations.</td>
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<td>Document the patient’s refusal of recommended treatment, reflecting your reasonable efforts to ensure the patient understands the potential impact of refusal.</td>
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<td>Send the patient a letter affirming dates and your instructions for needed treatment, appointments and testing with an urgent reminder to contact the office immediately. If the patient fails to respond to the letter, document the failure in the medical record.</td>
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<td>If termination is pending, resend the letter with a statement about terminating your relationship with the patient.</td>
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Even the best of patients can forget instructions. With difficult patients, the rule should be: Never assume that they have done what they were instructed to do. The best recourse is to document everything in the medical record. This is especially true for noncompliant patients, such as those who fail to make or show up for necessary appointments and those who regularly ignore or refuse to follow medical advice. Contributory negligence aside, physicians can be held responsible if a patient’s lack of cooperation results in injury (see “Closed Claim Review”). Moreover, cancelled or no-show appointments and AWOL patients can signal that a potential problem, such as legal action, may be brewing. The medical record is the best safeguard for documenting a physician’s reasonable and repeated attempts to secure a patient’s compliance. Here are some suggestions for medical record documentation.

**FOR NONCOMPLIANT PATIENTS**

- Document date, time, and essential content of telephone conversations in which you urge the patient to comply and warn about potential ramifications of noncompliance.
- Document missed and cancelled appointments, patient reminders and attempts to clarify the reason for missed appointments.
- Document the patient’s failure to show up for diagnostic tests or incidents of improper patient preparation that delay testing.
- Document the patient’s failure to arrange recommended tests or specialist visits that must be performed outside the office (and your attempts to aid the patient in arranging any tests or appointments).
- Document the patient’s refusal of recommended treatment, reflecting your reasonable efforts to ensure the patient understands the potential impact of refusal.
- Send the patient a letter affirming dates and your instructions for needed treatment, appointments and testing with an urgent reminder to contact the office immediately. If the patient fails to respond to the letter, document the failure in the medical record.
- If termination is pending, resend the letter with a statement about terminating your relationship with the patient.

**FOR NO-SHOW PATIENTS**

- Document the missed appointment by drawing a line with “no-show” in the appointment book by the patient’s name. Never erase or write over an entry, as it could be viewed as a cover-up in court.
- Call the no-show patient to find out why the appointment was missed and document the call. (This also demonstrates your concern for the patient and can help defuse potential legal action.)
- Document all no-shows and subsequent follow-up calls, postcards and letters in the patient’s medical record. (This shows your efforts to encourage the patient to make and keep appointments.)
- Set up a recall system using one of the numerous scheduling programs available to help your office personnel track appointment scheduling and rescheduling as well as follow up on laboratory reports and specialist consultations.
Both Sides of the Story
A patient and physician share their perspectives on the difficult patient issue

Shedding some light on the difficult patient issue, *Health Affairs* recently featured two insightful essays written from the perspective of a patient and a physician. In the first, the patient, a research professor with a Ph.D. in public health, traces her evolution from acquiescent to empowered as she seeks medical advice and treatment in her ongoing battle with scleroderma, an autoimmune disease. Despite her “feisty personality,” the patient admits that being “difficult” was not her first choice. Rather, it was her “natural response” to become a self-advocate after she encountered physicians who were not willing to collaborate with her on treatment decisions. Her narrative offers a meaningful, informed look at how and why patients may feel compelled to become “difficult.”

In the second essay, a family physician from a small town in Illinois recounts his frustration in trying to effectively treat three “difficult” patients: one who insists on “calling the shots;” another who demands needless testing; and the third who has lost hope for a cure for his chronic injury. Sharing his side of the story, the physician relates his coping strategies and rue his inability to actually remedy some of his patients’ challenges.

Despite various areas of disagreement, both writers conclude that the current state of health care, with brief office visits, only exacerbates the difficult patient situation. As the physician quips, “No one would make a major decision … after only fifteen minutes of deliberation. Why then do we cram important decisions about personal health matters into fifteen- or twenty-minute appointments?” They concur that extending appointments would give physicians and patients more time to discuss health histories and treatment options, improve communication and develop more collaborative relationships. Time will tell whether this approach becomes a viable tool in addressing these physician-patient challenges. (Access these narratives and other pertinent articles at www.healthaffairs.org.)

Medication and Noncompliance Do Not Mix

Patients who abuse or misuse prescribed medication by not following dosage instructions or by taking too much or too little may find their noncompliant behavior leads to serious medical and legal repercussions. Physicians should make every effort to ensure that patients thoroughly understand the medication instructions for optimum therapeutic results and document it in the medical record. This documentation becomes critical in the event that the patient is injured because of medication misuse, such as driving while taking medicine that warns of impaired responses.

Likewise, physicians must act if they suspect patients are using controlled substances illicitly, obtaining drugs from multiple prescribers or are otherwise abusing prescribed medication. In such cases, it is wise for a physician to initiate a discussion with the patient about medical care for the abusive behavior as well as for the underlying condition. This discussion must also be documented in the medical record. Also, in these circumstances of drug abuse, the physician must notify the New York State Department of Health’s Bureau of Controlled Substances to comply with New York Public Health Law Section 3372.