DIFFICULT PATIENTS

Objectives and Disclosures

Difficult patients are a challenge to physicians. A physician’s patience may be tested by patients who are noncompliant or demanding as well as by those who fail to pay their bills. Using case studies and a review of current literature, this article presents some techniques to better understand and deal with patients considered “difficult.”

**Learning Objectives:** At the completion of this activity, physicians will be able to:
- Use 10 different factors to determine possible reasons for a patient’s noncompliance.
- Incorporate into their practice’s risk management program eight suggestions for addressing a patient’s noncompliance.
- Take six specific steps when termination of the professional relationship with a patient.

**Accreditation:** Coverys designates this enduring material for a maximum of 1 AMA PRA Category 1 Credit(s)™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

This activity meets the criteria of the Massachusetts Board of Registration in Medicine for risk management study.

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**Target Audience:** Physicians, all specialties.
**Estimated Completion Time:** The estimated time to complete this activity is one hour.
**Date of Release & Term of Approval:** This activity was first released on April 1, 2004, revised on November 1, 2011, and is reviewed annually and will expire on January 1, 2014.

**Hardware/Software Requirements:** Minimum System Requirements: 486/66 MHz processor (Pentium processor recommended) Internet Browsers Supported: Microsoft Internet Explorer, version 6 and higher, Microsoft Internet Explorer 8 (recommended), Firefox 3.6 (includes Mac), Chrome 4, Safari 4 (Q1 2011) Browser Security Settings: must be set to the “default setting” to ensure the application runs smoothly. If the security settings are not set to the “default,” go to the browser security settings and enable the option for “active scripting” or “scripting of java applets.” Advanced Browser Settings (for Internet Explorer Users): Ensure that Java Virtual Machine is installed. Plug-ins: Users must have the following most current plug-ins installed: Macromedia Flash, Adobe Acrobat Reader and Microsoft Media Player.
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Difficult patients are the bane of many physicians’ professional existence, trying their patience, testing their limits, and challenging their ability to provide care.

Some people restrict their understanding of “difficult patients” to those who are non-compliant with their physician’s orders or advice. This is a surprisingly sizable group. According to one study, only one-third of patients are compliant with a prescribed treatment regimen. That is, they keep scheduled appointments with their physician, they have diagnostic tests performed, they seek out suggested referrals, they follow instructions for post-procedure care, and they take prescribed medications as directed.

Fully two-thirds of patients are non-compliant. Communication issues may be responsible for the behaviors of half that group, or one-third of all patients. They simply may not understand what to do, how to do it, or the importance of doing it. The other half of the non-compliant group, or the remaining one-third of patients, are non-compliant by choice.1

Who are these patients and why do they persist in misusing or even abusing the physician-patient relationship? They may be dealing with job loss, economic crisis, or crushing family responsibilities that make compliance with a treatment regimen only one more burden. Perhaps they are so hungry for attention that even the anger or frustration of the physician fills their emotional vacuum. Perhaps they doubt the efficacy of the treatment regimen because of stories they have been told by friends or relatives. Perhaps they have ethnic practices that conflict with the prescribed regimen. Perhaps they fear “bothering the doctor” with questions they need to ask and concerns they deem unimportant. Perhaps they are simply willful, demanding, and defiant. Or perhaps not.

Perhaps, instead, the problem is not the patient’s but the label attached to him/her. In the medical arena, compliance has traditionally indicated the extent to which a patient has cooperated with the physician’s treatment plan. But what if the treatment plan reflects the physician’s goals and omits the patient’s? And what if the patient is compliant with another, unspoken treatment plan about which the physician has asked no questions and has no knowledge?

This course looks at difficult patients, not only those deemed “non-compliant” but also those who make unrealistic demands, those who exhibit abusive behaviors, and those who fail to pay bills. It examines some of the reasons that may underlie the behaviors of these patients. And it proposes some risk management strategies to help physicians better work with those patients who seem but do not choose to be “difficult” while at the same time minimizing the risk of liability represented by those who persist in the behavior that earns them the label “difficult.”

The Non-Compliant Patient

Few patients present more of a clinical challenge to a physician than those who fail to follow a treatment regimen. Some ignore orders for bedrest, cast care, dressing changes, or limiting activity. Others fail to make or keep follow-up appointments. Still others are a persistent “no-show” in the practice. And a fair number never appear for needed tests or consults with other
physicians. The largest number, however, are most likely those who fail to take their prescribed medication correctly. The prevalence of this problem is staggering. According to data from the National Council on Patient Information and Education, 75 percent of all patients currently fail to take the medications as directed. With the government, the news media, and the members of the medical community increasingly focused on patient safety, this statistic cries out for both explanation and attention. The explanation may include any or all of the following, which may be applied not only to situations involving medications but also to other situations in which “non-compliance” is an issue:

The patient does not understand the seriousness of his/her condition. The issue may be one of vocabulary, denial, or physician emphasis. The patient who believes a positive biopsy result is good because “positive is always better than negative” is unlikely to be able to process the need for a rigorous course of chemotherapy unless it is explained to him/her in the simplest possible lay vocabulary. On the other hand, the patient who wants or chooses to know nothing about his/her illness may be hard pressed to take medication for a condition he/she doesn’t admit having. And in another scenario, the physician, in an attempt not to overwhelm a frightened patient, may either go too far in downplaying the potentially serious consequences of not taking a prescribed medication as directed or fail to underscore the importance of an issue by never mentioning it after an initial question or statement.

The patient does not understand the instruction. Language or hearing difficulties

may be issues, the patient may be confused by directions that include two or more steps or that are different for two medications, or the patient may not understand the reason for taking a medication. How many patients, for example, stop taking an antibiotic when they “feel better” rather than completing the prescribed course?

The patient forgot verbal instructions. Patients who are tense in the physician office are likely to forget at least some of what is said. Others may feel intimidated by the physician and fail to ask the questions that arise in the course of a discussion. Written instructions, possibly pre-printed, presented in easy-to-follow steps, and written with minimal words and in easy English should always accompany oral instructions.

The patient has difficulty taking the medication. The patient who consistently chokes on a pill, gags on a liquid, or suffers nausea, dizziness, or another side effect is likely to believe the negatives of the medication outweigh the positives. Some will report the problems to the physicians; some will cut the dose of the medication to try and “make it work”; others will simply stop taking the medication.

The patient finds a drug (or treatment) regimen too complex. Multiple medications taken at different hours, some requiring an empty stomach, some needing to be accompanied by food, some requiring abstinence from certain foods, and some negatively interacting with other drugs may exact too much of a toll on the patience of a patient who is trying to live a life, not simply a drug regimen.

The patient cannot afford the medication. With many prescriptions now costing well over $100, some patients cannot afford the medications they need. Patients trying to stretch limited resources may skip doses, halve pills, dilute liquids, or even share medications with others. And in some financially stretched households where two people are taking medication, the patients may decide whose needs are the most critical and whose prescriptions get filled.

The patient is angry at or depressed about the chronic condition that necessitates the medication. Those with chronic illnesses often long to be “normal” and tire of the treatment or medication routines that continually remind them of what they may perceive as weakness, failing, stigma, or even mortality. The reason behind the failure to take a needed medication for such debilitating conditions as multiple sclerosis and amyotrophic lateral sclerosis (ALS) may be as simple as denial. It may also be as complex as a death wish.

The patient may have religious or cultural beliefs that prohibit a certain treatment or medication. Some groups refuse blood and blood products. Some reject immunizations. Others refuse antibiotics. Some may have taboos relating to medical treatment or medications during pregnancy and the menstrual cycle while others may eschew medications made from animal parts. The list goes on. These beliefs are not mere adjuncts to a person’s life; they often lie at its very core. If treatment is to be successful, they need to be explored, understood, and, to the extent possible, accommodated.
The patient may not have transportation to get to the physician's office or a pharmacy. For some people, particularly those in rural areas, this may be a major factor in "non-compliance."

The patient may not feel comfortable with the physician or the medication. A patient whose family or friends strongly discourage the use of a prescribed treatment or medication because of their own negative experience is unlikely to share his or her concerns with a physician who explains little, exhibits no interest or empathy, and belittles complaints.5

The patient wants attention. For some lonely people, their physician may be the only person listening to them and treating them with dignity and respect. Non-compliance ensures repeated visits.

The patient and physician may have different goals. Non-compliance is occasionally about defiance. It is sometimes about ignorance. In the case of skipped invasive tests, for example, colonoscopies, it may be about fear. Often, it is about misunderstanding. Most frequently, however, it is about miscommunication. The physician and the patient may have differing expectations of or goals for a prescribed treatment.5, 1 The physician, for example, may simply want improvement whereas the patient expects cure. The physician may want to rule out a medical possibility; the patient may expect an exact diagnosis. When these goals are not communicated, actions that may lead to the patient’s being labeled “non-compliant” may result.

Risk Management Suggestions

The physician’s first response to a patient’s disregarding medical advice is likely to be anger and frustration.5 However, if the physician is able to convert at least some of that emotion into a search for the issues underlying the patient’s behavior,6 an answer, or, at the very least, a compromise solution may be found. Some of the steps physicians may want to take, first in an attempt to avoid, and then in an attempt to manage these situations include the following:

Before Non-Compliance Begins

- Determine the patient’s understanding of his/her problem or disease. any cultural factors that influence his/her beliefs about the medical problem and its potential treatment, and his/her interest and ability to participate in his/her own care.

- Educate the patient and, whenever possible, his/her family about the patient’s health, his/her medical condition or disease, and the importance of his/her role in maintaining health and co-managing illness with the physician.

- Include the patient in planning the treatment regimen. The largest single determinant of the success of a treatment regimen may be patient’s ability and willingness to carry it out. The patient who participates in creating his/her treatment regimen and understands the rationale behind it is far more likely to adhere to it than the one who is merely told what to do.

- Consider a patient's support system when planning a treatment regimen. The elderly patient who lives alone should not be expected to apply Lidocaine patches to his/her upper back.

- Consider the behavior changes the treatment regimen will require and ask the patient, “Do you think this will work for you?” If the answer is no, an alternative may be required.

- Try to agree on common goals with the patient. In the absence of common goals, the physician and patient may be working at cross purposes.

- Give clear instructions. It is not adequate to tell a patient to “lose weight,” to “take it easy,” or to restrict work to “light duty.” Specify what each of those directions mean. The failure to do so may result in a medical malpractice suit if a patient subsequently experiences injury or harm and can show the directions given by the physician were unclear.3

- Make sure verbal instructions are accompanied by written ones. The instructions may be pre-printed, standardized, or individualized.

- Follow up with the patient to determine how he/she is doing once the treatment plan has been implemented. Are there problems? Is a minor adjustment indicated? Does the plan need to be completely reformulated? Attention to issues early in the process may obviate the need for a label of “non-compliance” at a later time.

- Establish guidelines for telephone calls regarding prescription refills and lab results.

- Obtain an informed refusal from the patient who admits he either cannot or will not follow all or part of a proposed treatment plan.

- Document thoroughly and completely all instructions given the patient and all discussions.
about the treatment regimen. Good documentation may be the most persuasive argument for the defense in a malpractice suit involving a non-compliant patient. Consider the following case from Coverys’ closed files.

Case 1: A 52-year-old female was the patient of the same internist for 24 years. She was on record as stating she “did not want to look for trouble” and wanted to know nothing about a medical condition until she was symptomatic. For years, she declined pelvic examinations and consultations with gynecologists and other physicians. The PCP documented talking with her and giving her brochures about the importance of routine Pap smears. The patient refused until she developed vaginal spotting and cramps. Diagnosed with metastatic cervical cancer, she died two months later. The family sued the PCP.

This case closed with no indemnity payment. Experts opined, “This case is entirely defensible because of the patient’s intractability and repeated documented refusals to accept care.” and “There is serial documentation that the physician [informed the patient of the risks of refusing to seek care].”

When Non-Compliance is a Factor

- **Treat the patient’s non-compliance as a symptom** and develop a differential diagnosis.\(^5\) The real problem may be, but is probably not, the non-compliance.

- **Without judging the patient, discuss with him or her the non-compliant behavior.** The physician who begins such an interchange asking, “You seem to be having some difficulty taking the medicine we discussed. How can I help you?” is likely to learn far more than the physician who threatens a worsening of illness if the patient persists in not doing what he/she was told.

- **Name the specific problem and ask the patient why he/she is engaging in it.** Some patients may not believe they have a problem. Naming the behavior that is at issue may shed light on the issue. The patient of one physician was taking only half the dose of a medication that had been prescribed. When the physician asked why she was not taking a whole pill, the patient replied, “I only had to take half when the pill was green.”\(^7\)

- **Take into account circumstances that may make compliance difficult.** Some patients may want to do exactly as the physician says but cannot because of some of the reasons cited earlier. The physician may need to make concessions or compromises. He or she might begin by asking, “How can we work together to make this work for you in your life as it is structured right now?”

- **Try to limit the problem.** Some patients may be overwhelmed by a multi-task treatment regimen. Asking the patient to name his or her greatest health concern and what part of the treatment regimen is proving most difficult to carry out may help the physician first determine the patient’s health priorities and then work with the patient to structure a workable treatment plan. That plan might begin with the patient naming one step he/she will take before the next office visit.\(^4\)

- **Help the patient solve the problem.** Its tempting, but not helpful, for the physician to offer an immediate solution to the problem identified by the patient. In general, however, patients who assume an active role in their healthcare planning are more invested in the plan and have better outcomes than those who are simply told what to do.\(^4\)

- **Document all indications of non-compliance on the part of the patient.** Establishing a pattern of “contributory negligence” is extremely important in a malpractice case.

- **Consider terminating the professional relationship** with the patient who, despite all efforts on the part of the physician, willfully, flagrantly, or repeatedly disregards the physician’s advice and/or otherwise abuses the professional relationship. In the case below, which reflects a telephone call made to Coverys’ Risk Management Department, termination was advised before repeated disregard could be established:

Case 2: A 38-year-old woman made an appointment with a surgeon for biopsy of a breast mass. At the first meeting, the patient told the physician she was a “privacy specialist” and was in his office under an assumed name because she “did not want to leave a paper trail.” She refused to name her primary care provider or gynecologist and refused to have a mammogram forwarded to the current physician. She said she wanted this physician to perform the biopsy but noted that she would be going to another physician if surgery was indicated.

This patient presented a challenge that was more than difficult; it was impossible. She admitted lying
about her name and her history, and acknowledged that this physician was just one in a series she planned to see during her pregnancy. The physician was advised to follow the standard risk management protocol for terminating a professional relationship, that is:

- explain to the patient, both in person and in writing, why he could not care for her,
- give her 30 days to find a new obstetrician,
- provide her with the resources for finding a new physician, for example, the telephone number of the local medical society,
- offer to send her record to the new provider,
- meet any emergency needs she might develop during that time,
- suggest she go to an emergency department if, after one month, she had not yet found a new physician.

Termination should be reserved for patients who are not in physical or emotional crisis and, if pregnant, are not at more than 20 weeks gestation.

**Demanding Patients and Families**

If some difficult patients are non-compliant; others are demanding. They may tell the physician what medication to prescribe, what test to order, and often what narcotic will prove most effective. Others demand frequent and immediate access to the physician. They expect the office staff to bend schedules, to break rules, and to abandon established office protocol to accommodate them. When their wishes are denied, some may threaten to “go to the papers” or to sue; others may become verbally or physically abusive. A few may even begin stalking the physician.

Some physicians accede to the often unrealistic demands of demanding patients and their families because they don’t know how to say no.

These physicians are among those most likely to be named in a malpractice suit. In trying to achieve the superhuman goal of being everything to everyone, they drive themselves to exhaustion. That, in turn, leads to mistakes or oversights and patients who are either disappointed or angry to discover the fallibility of the physician they once thought infallible.

Physicians should not allow themselves to be manipulated by their patients or their patients’ families. Neither should they succumb to their threats. The best way to avoid both situations is to establish and adhere to practice guidelines. They should be detailed in the philosophy statement shared with every patient at the initial visit and should be repeatedly underscored for those who ignore them.

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**Risk Management Suggestions**

The following suggestions are offered to help physicians deal with patients who repeatedly present with unrealistic demands.

- **Acknowledge personal and professional limits.** It is better to do some things well than to fail at trying to do everything.
- **Set limits with patients and strictly adhere to them.** If someone abuses the telephone, for example, be available to him or her during set times only. If he/she is verbally abusive to staff, talk with the patient and let him/her know that the professional relationship will be terminated if the behavior persists. If he or she demands antibiotics for a virus, try to educate him or her. If he or she is drug seeking, confront the patient and offer help, perhaps in the form of a contract with the patient, perhaps by suggesting referral to a therapist or enrollment in a detoxification program. In all instances, follow established protocol exactly so that a one-time exception doesn’t become the expected rule.

- **Have the patient or family name one person in the group as the “point person” for all professional conversations about a sick relative.** Trying to answer one question multiple times wastes time that might better be spent with patients.

- **Make sure a patient’s informed consent/refusal and advance directive are in order.** Initially, it can save time and argument. If the patient becomes incompetent, it can save the physician from litigation or protect him/her if a suit alleging negligence is filed.

- **Do not enter into an argument with the patient or family.** Determine what the patient/family envisions the needs to be and why. Then, to the extent possible, empathize with the situation and explain to, educate, and try to reason with the patient/family about the need to approach the matter from a medically optimal perspective.

- **Do not be intimidated by the threat of a lawsuit.** Doing — and documenting — what is medically justified can be argued far more successfully in a malpractice case than giving in to a patient whose demands may be based on nothing more than television advertisements or information gleaned from questionable websites.
• Summon police help if a patient becomes physically violent. Try to isolate him/her to prevent injury to staff or other patients, try to calm him/her and, if possible, try to reason with him/her.

• Notify the police if a patient continues stalking — either out of anger or perceived “love” — after being confronted about his/her behavior. A restraining order may be the necessary next step.

• Terminate the professional relationship with patients whose demanding behavior persists despite all efforts to change it.

Non-Payment of Bills

Patients who expect free care may be terminated from the practice. Before taking that step, however, physicians would be well advised to consider some of the issues discussed under “non-compliance” and determine if there are extenuating circumstances that are making it difficult, if not impossible, for a patient to meet his/her financial responsibilities. A job layoff, the termination of unemployment benefits, the illness or death of a family member, and acute depression are only some of the factors that may weigh into a patient’s inability to pay a medical bill.

Risk Management Suggestions

From a risk management perspective, the physician would be wise to:

• Post billing practices in a visible place and let patients know at the time of the first visit how they are expected to handle bills, including co-payments.

• Address payment issues with the patient and determine if there are any extenuating circumstances.

• Set up a payment schedule that is workable for the patient and that ensures the payment of a certain amount on a regular basis, to be determined by physician and patient.

• Continue to see the patient who is making good faith efforts to pay a bill or who has a reasonable excuse for not doing so, at least temporarily.

• Consider referring to a collection agency the patient who makes no effort to pay a bill.

• Consider terminating the professional relationship with the patient who is a chronic or persistent non-payer. Termination should follow the steps noted under “non-compliance.”

• Do not refuse to see a patient because of non-payment of a bill. The medicine must take precedence over the finances until the patient has been terminated from the practice.

Conclusion

Difficult patients are often both a frustration and a challenge. A few will push beyond the bounds of acceptable conduct and need to be terminated from the practice. Many more, however, will be found to be fearful, angry, anxious, or unaware. The physician who approaches this latter group with frustration is likely to hasten the deterioration of an already strained relationship. On the other hand, the practitioner who takes the time to look behind the behavior that earns one a label of “difficult” may be rewarded with the gratitude of a patient who is not only not difficult, but a willing and agreeable participant in his/her own healthcare.

References


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