

Risk management perspective on the difficult patient and family

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The practice of medicine has become more difficult in many regards. Overhead has increased, while reimbursements have decreased. Patients experience similar stress from a financial position, and from the challenges related to access, as well. Patients may experience personal problems that certainly affect their doctor and office relationships. The patient may have a past negative experience—either with care or financial and insurance-related issues—that may influence their current relationships with the medical community. Society, sadly, has frequently encouraged unrealistic expectations that create patient demands and blame, if an inherent risk—even one that is fully explained in advance—occurs. It is also important to consider the fact that people are people, and



there are those patients and health care providers with personality disorders that can challenge these relationships.

This article focuses on what the physician and the practice can and should do to avoid conflict and to provide a continuous level of good medical care.

If permitted, patient selection—screening difficult patients before acceptance—is the best method to avoid unpleasant patients. The practice administrators should verify whether or not they have a contractual responsibility to treat the new patient. Emergency room call responsibilities usually create a contractual responsibility to see the patient, as does an exclusive managed care relationship, unless otherwise stated. Develop a plan with your office staff for recognizing difficult patients. Do not schedule appointments with challenging patients during busy hours; rather, schedule these patients at the end of the day, when the office staff has additional time available. Always have the staff person ready and available to see the patient, and be sure to avoid utilizing the patient’s family as chaperones. Document activity and discussions honestly, and utilize written care instructions for this documentation. These challenging patient scenarios often create added liability, as well as interfere with a successful patient outcome. When care is challenged, utilize second opinions, and consider firing the patient when you can no longer be responsible for their outcome. (This topic is addressed in greater detail later in this article.)

Patients with personality disorders further challenge care. These disorders can include the following behaviors: manipulative, seductive, confrontational, indecisive—all with unique complexities.

Generational differences

In addition to these behaviors, generational differences between the physician and the patient can add another layer of frustration to the situation. Generational differences include “Silents”—the generation before the “Boomers”—who usually are quieter, with a very strong work ethic and the mindset of simply doing what they believe is right. Sometimes patients describe a

lack of understanding for their condition. Practitioners should have a team member who can sit with the patient and openly discuss his or her care. Boomers usually have demonstrated a good discussion record, but may have less comfort in interacting with the noncompliant patient. The next younger generations, “X” and “Y,” have unique discussion patterns that impact care.

Basically, recognize that generational differences between the surgeon, the office staff, and the patient may interfere with care. Develop a team to interact with the difficult patient, combining methods to address the patient’s issues. Patients learn in many ways, but the leading three methods of learning and retention are visual, auditory, and kinesthetic. The team should develop visual aids to help instruct the patient, a written or discussion aid to address auditory learners, and lastly, develop a specific patient interaction that addresses kinesthetic learners. This last is the most difficult learning style, as these learners wish to know how care specifically affects them.

To avoid difficulty in dealing with challenging patients, it is also important to establish rules for care, for filling prescriptions, for behavior in the office, and to verify that all the team members are on the same page. The entire team should understand and accept these recommendations. These patients or their family will often “bait” one team member against another, by asking the same questions to multiple caregivers.

It is also important to arrange second opinions to confirm care, and to remember to see the patient as often as necessary, allowing adequate time for discussions and documentations, and always with a staff member present. It would be best to refuse to see the patient with their attorney, if the attorney accompanies the patient.

Financial challenges

Review billing statements with the patients, as there are patients who can become disruptive solely to avoid billing issues. Others who receive bills during a complication or after care have irate reactions, further escalating the situation. It is recommended to keep the charges reflective of care, but it may be wise to delay sending invoices to the patient until aftercare issues have

been resolved. It is important to have a financial information sheet available that outlines the patient and practice responsibilities. This sheet should cover the deductible and copay amounts, and the patient's insurance and fees, as well as any additional fees for facility, pathology, radiology, and laboratory, if applicable.

First visit (without contractual obligation)

Imagine that the staff tells you a first-visit patient was very difficult in scheduling the visit, and mildly abusive in the reception room while waiting to be seen, uttering negative comments overheard by others. It is recommended to see the patient if you feel you must, but be very cautious and careful about not giving advice or accepting the patient into your care. Avoid getting into an argument with the patient, but be sure to state that you could not provide the required care, possibly saying you believe you could not meet their expectations. The first visit is often the best, and when it starts that poorly, things can only go downhill. If permitted by your managed care contracts, stick to your guns and do not accept this patient for care. The big caveat here is to make sure there isn't a medical reason for the behavior. Our practices probably would be easier with all simple and pleasant patient problems, but, as we know, that is not often the case. We must take the bad with the good to help appropriate patients. The key is to determine whether there is a medical issue affecting the patient's behavior that can be reversed. Another approach would be to seek consultation with a psychiatrist who can help manage such a difficult patient. One final note: be cautious about referral patterns. It is wise to have your staff inquire about referring physicians, and difficult patients sent by very good referrals pose an additional burden to provide care or risk losing the referral line.

What if there is a managed care or emergency room contractual obligation to see the patient? It is strongly recommended for practices to negotiate an "out" specifically for patients with a history with the practice. For example, say you were recently sued for malpractice and won a defense verdict by patient Mary Plaintiff. Mary now appears in the emergency room when you

are on call, and, to make matters worse, you have the exclusive contract for that group of patients in which she is a member. What should you do? It is important to remember when renewing these contracts to add language that allows you to refuse to see the patient under these and similar circumstances (for example, you recently fired the patient), or to work with the hospital call schedule, rules, and regulations to achieve the same goal. Make sure it has nothing to do with their financial circumstances. Be sure not to violate "dumping laws," and make specific objections, in writing, for caring for such patients with a pre-existing, altered, or negative doctor-patient relationship.

After the first visit

In this scenario, the patient may have had a complication, or any number of issues that interfere with care. You and the entire practice team have outlined what is expected, and the patient continues to violate rules, not follow directions and advice, and keeps coming back with complaints about your care and the outcome. Document your instructions and carefully explain to the patient that you can no longer be responsible for his or her outcome if they do not follow instructions. If he or she continues on this path, make the patient aware that you will release them as your patient. This situation is always difficult for everyone involved, yet continuing down this destructive path does not help the patient, and significantly exposes the physician to possible litigation.

At some point, when the patient repeatedly refuses to follow directions, the physician must give them a time frame—for example, 14 days—in which they must locate another physician. You have an obligation to direct them to a source of doctors—for example, the county medical society, the Yellow Pages, or managed care panel. It should be noted that the physician is required to care for this patient during that 14-day period. The physician should send this notification via both certified letter and through regular mail. It is a generally held belief that nothing good comes via a certified letter, and many patients will not accept such a letter. Therefore, there is a "mail presumption" that if a letter is mailed,

it is received—although the patient may argue this point as well. It is advisable, therefore, to send the patient a copy of the document in a plain envelope without your name or address listed on the outside.

It is important for the physician to strictly adhere to that 14-day deadline, and after the 14 days, to notify the managed care company, emergency room, and hospital, so all can be made aware of this situation. It is also important to continue to respect the Health Insurance Portability and Accountability Act, and to send the patient's name and release from care notice to those who are protected, or who have a business associate contract with you. It might also be a good idea for the physician to notify his or her liability carrier. Carriers like to hear about such issues, and such disclosures usually do not affect your record.

The most challenging patient of all

The difficult patient who does not reach the level of firing, or whose difficulty was missed during the patient's first appointment screening, poses a high risk to the practice.

The manipulative, flattering patient can be the most challenging of all. It is important to avoid the ego trap of falling for a patient's compliments, even as they are not following your medical advice and directions. Physicians should be nice to, but firm with, these patients, and avoid even the slightest perception of inappropriate behavior. I am aware of instances where a comforting hug, even in the presence of a chaperone, has led to state board formal complaints.

There are a plethora of personality disorders that will influence care. Be liberal about including the patient's family practice physician, clergy, and family support to achieve a positive treatment plan. No matter how nice these patients may be, always consider second opinions when difficult situations arise—this action shows you truly care about the patient, and it ensures that you do not miss anything. It may be suggested that you offer to pay for the visit, if insurance is a problem, although many colleagues will not charge a fee to you.

In summary, the difficult patient presents many varied characteristics. Rarely do they

wear a badge that announces, "I am a difficult patient." The physician should be sure to listen to their staff and to carefully document—but not excessively—assessment and care recommendations. (Excessive documentation can appear to be more "defensive," and may not reflect an unbiased account of the circumstances. It is possible to be concise and at the same time accurately document the situation.) Develop a communication team that is able to assist all types of learners and individuals from various generations. The difficult office experience affects everyone in the practice, so listen to the staff about their experiences with the patient and family. Devise an agreed-upon plan for the entire practice. When care is, or could be, compromised, seek second opinions, and consider ending the destructive relationship before harm is done to either the patient or you. □

Additional resources

- American Society of Plastic Surgeons Online Education Program. Patient safety can be profitable. Available at: <http://www.plasticsurgery.org>. Accessed December 12, 2009.
- Nora PF (ed). *Professional Liability/Risk Management: A Manual for Surgeons*. 2nd ed. Chicago, IL: American College of Surgeons, 1997.

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