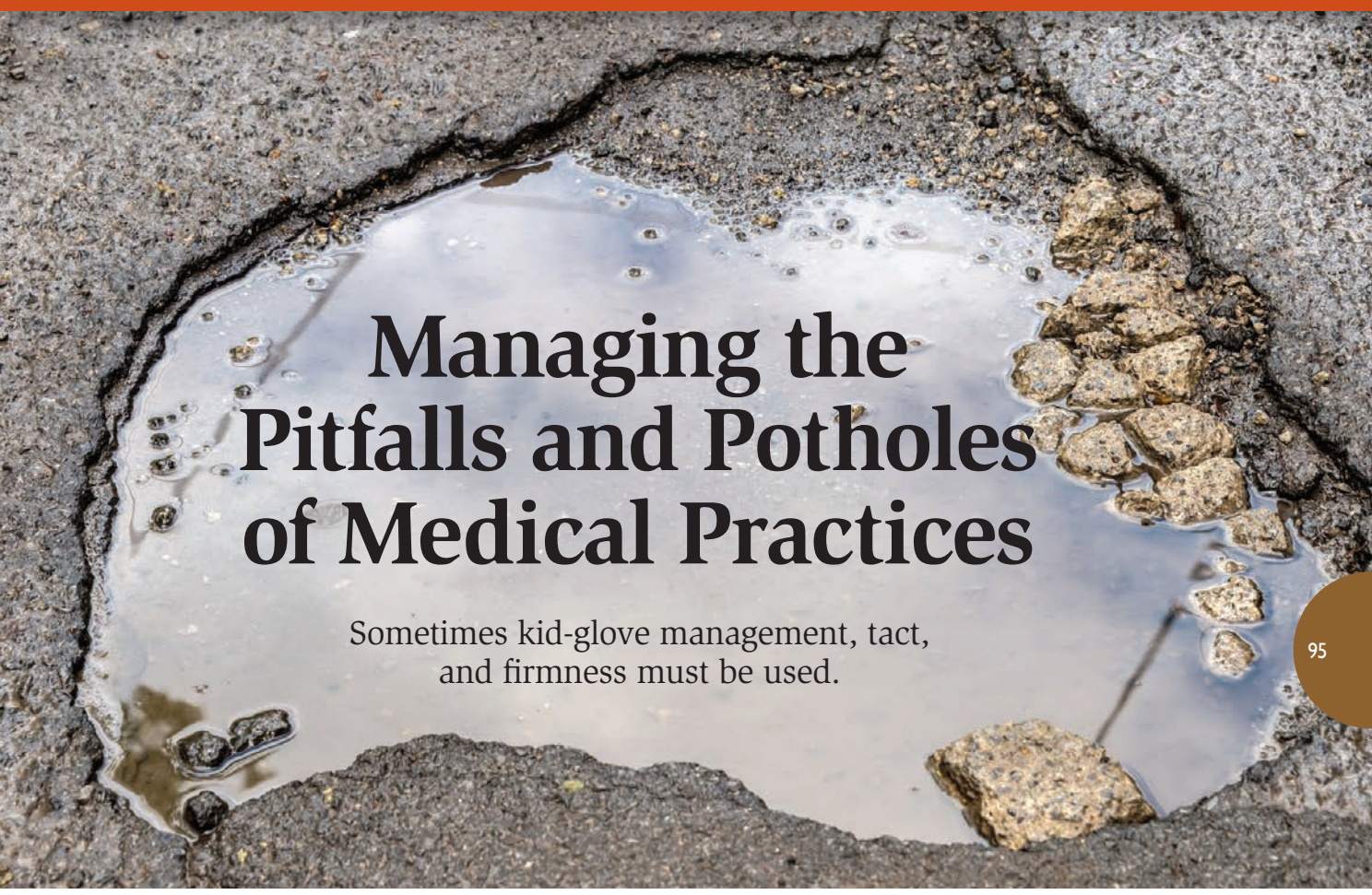

Managing the Pitfalls and Potholes of Medical Practices

Sometimes kid-glove management, tact, and firmness must be used.

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Doctors are not perfect, and problems are likely to occur. Our success, enjoyment of our profession, and even keeping burnout at bay depend on how we manage those potholes and pitfalls that will certainly come our way.

This article discusses six of the potholes and pitfalls that nearly every practice will experience at some time. The authors have a total of more than 120 years of experience in both private practice and academic practice and have enjoyed nearly every one of those years. We have, for the most part, successfully navigated our way through the potholes and pitfalls that we have encountered. We wish to pass along our experience to you, and of course we welcome your own management suggestions for these obstacles that we all experience at one time or another.

As with so much in medicine, prevention can be the key.

Unhappy Patient

If you recognize that a patient is not happy, either by his or her demeanor or from feedback from the nursing staff, it is possible to rescue the visit. If the patient is, indeed, unhappy, he or she should be returned to an examination room to discuss the problem, which may be all that is needed to ameliorate the situation. If another room, such as your private office, is available to discuss the issue, this can often be a better option than revisiting the exam room.

The key is to identify the issue or the problem. Most often, it is the result of poor communication; maybe it was a problem that was not identified or addressed. It certainly could have to do with the patient's expectation as to what he or she anticipated from the visit and the reality of what was experienced.

It is reasonable to offer an apol-

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ogy and ask, "How can I make this right?" In many cases, it is something simple, such as not receiving a return call they expected. In such situations let them know you agree (if you do) and that you and your staff will do everything possible to avoid such adverse events in the future. It is important to document in the patient's record what occurred. Some options that can go a long way to improve how the patient feels include asking the patient to return at no charge when there is more time, offer free follow-up appointments, or even provide some sample medications. Finally, let the referring doctor know that the patient was not happy with the experience in your office, and include your efforts to rectify the issues with the patient.

As with so much in medicine, prevention can be the key. At the close of each visit ask the patient in words to the effect of "Do we have a plan?" or "Does what I'm recommending make sense to you?" This way, the patient has the opportunity to express their understanding and agreement—the "last word," so to speak.

Referring Provider Error

Referring physicians often are not specialists in your field and may lack your particular expertise. They may not have performed the best study or prescribed the optimal medication. Their diagnosis may not be correct. It is important not to make disparaging comments about the care rendered by referring doctors, denigrate them, or offer to explain their reasons or actions. Sometimes, the issue can be something as simple as not having the necessary documents to provide a diagnosis or plan. If appropriate, inform the referring physician about the encounter.

When There Is a Potential for Litigation

A complication or a possibility of litigation needs to be identified in an honest but factual manner. Offer no excuses—but an explanation of what occurred, with an apology, is appropriate. It is important to be empathetic, caring, and available to respond to their concerns. It is imperative to document the conversation. Do not, under any circumstance, alter the medical records. It is important to notify the malpractice carrier. In the case of a significant issue, such as a complication, it is important not to refund or pay any medical bills without consulting an attorney.

The Drug-Seeking Patient

As physicians, we are particularly aware of the extent of the problems of drug usage, drug abuse, drug overdosing, and drug-related deaths in the United States. The annual number of U.S. drug-related deaths currently exceeds 70,000. Opioids and benzodiazepines, as well as stimulants such as amphetamines, are the major sources of inappropriate drug use.[1]

The physicians and nurses in emergency departments need to be able to recognize and identify drug-seeking patients.

Most physicians will encounter drug-seeking patients. Emergency departments (EDs) are reported to be a particularly vulnerable point of entry for these individuals, because many make repeated visits to the ED, often at many different hospitals. The physicians and nurses in EDs need to be able to recognize and identify drug-seeking patients by paying attention to the following:

- Requesting medications by generic or trade name, and often claiming that all other medications in the class fail to help or that the patient has severe side-effects or other allergic reactions to the other medications;
- A questionable and vague medical history;
- Pain levels ("Doctor, it's an 11 on a 1 to 10 scale!") out of proportion to the physical findings, lab tests, or imaging studies;
- A history of "doctor shopping" or seeing multiple other physicians for the same problem, with no one able to discern a diagnosis;
- Excessive criticism of previous physicians;
- Manipulative and aggressive behavior;
- Chronically missing appointments;
- Requiring refills before the refill is due;
- Repeatedly coming to clinic without an appointment;
- Excessive flattery;
- Excessive or unnecessary phone calls;
- Trying to contact the "on-call" physician to prescribe the desired medication when the prescribing physician has declined to refill the medication;
- Requesting increasing dosages of medications;
- Unwillingness to consider alternative therapies;
- Claims of lost medications;
- Being more concerned and interested in the drug than in the condition for which the drug is allegedly being prescribed;
- Deteriorating home, school, or work life;
- Family discord; or
- Mild to moderate depression.

When we are faced with a drug-seeking patient, it is very important to obtain a careful history and perform an examination and testing as indicated. While obtaining the history, identify when the patient's medication needs started, what were the circumstances, was surgery involved, what medications have been used, and what was the patient's response to the medication? Did the patient try to stop taking the medication? What happened when the patient attempted discontinuing the drugs?

When a patient requests a medication with abuse potential, it often is appropriate to inform the patient that the medication is not indicated,

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or that you simply don't prescribe these medications. It is appropriate to recommend alternatives and to consider appropriate referrals to a pain management specialist. In some situations, contacting the authorities may be appropriate. Depending on the situation, building security or even local police should be contacted. The U.S. Department of Justice has an online reporting form on their website.[2]

In an office practice with more than one physician, it is important to alert the other physicians and their staffs that a known drug abuser may try to contact them after hours and that you advise their not filling requested prescriptions for such individuals. It is important that careful documentation of all encounters be performed, not only to provide an appropriate record of all discussions, but in case the patient should become litigious.

Drug-seeking patients are very common in most communities, and careful management with sensitivity and compassion is of paramount importance.

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Difficult Patients

Some patients start their encounter with a negative bias toward physicians and medicine in general. All of us in the healthcare profession have had the experience of interacting with a difficult patient. It doesn't matter if you are a pathologist, plastic surgeon, pediatrician, primary care physician, or podiatrist, you will have the experience of managing the difficult patient. Fortunately, difficult patients make up only a small percentage of the patients that we care for. Doctors report that about one in six patients is "difficult." That translates into potentially three or four difficult patients each day.[3]

Unfortunately, few of us have had any formal training on how to manage a difficult patient. It is something we have learned, or maybe not learned, by trial and error. Often, errors associated with managing a difficult patient can lead to undesirable consequences, complications, and even litigation.

First, most patients in the healthcare setting, such as in our offices or in the hospital, are out of their comfort zone. Even the most self-confident patient, when placed in a situation of uncertainty, may become uncomfortable, anxious, and even hostile when he or she does not know what to expect. The best way to avoid creating a difficult patient is to always explain what examinations and tests you plan to perform. This relieves the patient's

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anxiety and can make the patient much more mentally comfortable when confronted with a medical test, procedure, or diagnosis with an unfavorable prognosis.

Second, patients often are in a stressful situation. Remember, what is commonplace to each of us is probably a first-time experience for our patients. Take, for example, the history and physical examination. Patients will be required to reveal personal secrets and issues that they wouldn't share with their partners, best friends, or clergyman. Then they will commonly get undressed just a few minutes after meeting the doctor, put on a gown that seldom covers the entire body, and then be probed in areas of the body that have never been touched or explored before by another person.

Finally, health issues and fear of the unknown lower a person's threshold for anger, potentially precipitating a conflict and making the patient a management problem. Therefore, it is imperative that all of us in the healthcare profession, which includes receptionists, office managers, file clerks, and insurance and billing agents, as well as the doctors, nurses, and physician assistants, to be aware of the potential for patients to become anxious, uncomfortable, and psychologically disoriented in the medical environment.

Just as there are signs and symptoms associated with various diseases and conditions, there are signs that you may have or may create a difficult patient. First, listen carefully to the tone of voice. If the patient is speaking louder than expected or more rapidly than usual, then the provider must modulate and speak more slowly and softly. Watch the patient's body language. Look for signs of agitation such as wringing of the hands or tapping of the feet, which is a sign of impatience. Clenched fists and clenched teeth are signs that you are dealing with a difficult patient.

A patient who is in a defensive position, such as sitting with crossed arms, often will provide clues about the intense conversation that is about to take place. Pay attention to the breathing pattern. A restricted breathing pattern or sighing is an indication that the patient is upset.

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Another warning sign of a potentially difficult patient is the doctor-shopper. If a patient has seen multiple physicians for the same complaint, just plan on spending more time with this patient. If a patient with this history is rushed, plan on having a difficult patient and poor patient satisfaction scores!

Allow the patient to complete his or her explanation of the medical problem without any interruption.

Allow the patient to complete his or her explanation of the medical problem without any interruption. During the average patient encounter, the physician often interrupts the patient after only 16 seconds![4] Make every effort to remain focused, listen to the patient, and do not interrupt until the patient is finished talking.

If possible, try to have your discussion with a difficult patient in a private location where it cannot be overheard by others in the office. Escort the difficult patient from the exam room to another secure location in the office so that you can talk in private and without interruption. If you can, sit next to the patient in order to avoid any barriers, including physical ones, separating you and your patient.

Abusive Patient

We've all been there: the patient is rude, is demeaning, or even says sexually explicit things to you or to a staff member. What do you do when the patient crosses the line?

There are often explanations for abusive behavior by patients. Sometimes, when a patient is in pain or has just learned of an ominous diagnosis, he or she may lash out at those who are helping them. On other occasions, this behavior may be caused by a medical illness, a psychiatric illness, or drug withdrawal. It may be a spontaneous or automatic response when a patient is out of his or her comfort zone. Although that may be how they're instinctively dealing with something, it does not make it acceptable. They may just need a little firm, but respectful, reminder that there are better ways to deal with difficult situations.

As a physician, you are still obligated to provide care for the patient. Most patients will cease the abusive behavior once you have drawn the line and requested to be treated more respectfully.

Although most abusive patients can be managed with the cease-and-desist approach just described, there are circumstances where additional responses are required. If, for example, a patient is cursing, threatening, or disrupting the care of other patients in the office, it is time to call security and have the patient escorted from the premises. On the rare occasion when patients hear that you are requesting security, they receive the message and their behavior takes an about-face and the behavior becomes quickly more civil.

Finally, if a patient is a repeat of-

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fender and not likely to change his or her behavior, then it is appropriate to terminate the patient from the practice. This consists of sending the patient a certified letter stating that the doctors in the practice will no longer provide care for the patient. The patient usually is given 30 days to find another physician. The letter should clearly state that medical care will be given only for emergency care.

All healthcare workers are likely to encounter aggression and, on occasion, violence. Practice design and policies as well as staff training can help manage these uncommon events.

Every practice and every doctor is going to encounter problems caring for patients.

Bottom Line

Every practice and every doctor is going to encounter problems caring for patients. Although the majority of patients are appreciative and grateful for the care we provide, there are occasions where kid-glove management, tact, and firmness must be used. **PM**

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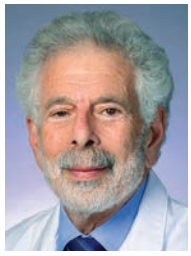

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