

Difficult Patients Present Challenges for Practices

One of Dr. Jack D'Angelo's patients at the Institute of Physical Medicine and Rehabilitation in Staten Island, N.Y., asked him for a medical excuse so he could avoid jury duty. But the man was fairly healthy, so Dr. D'Angelo denied his request, explaining that the only way he could be excused from serving on a jury was to be seriously ill or totally disabled.

The man didn't argue or shout. Instead, he calmly stated that if

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the doctor didn't provide him with a medical excuse by the end of the day, he would wait for him by his car in the parking lot after work.

Dr. D'Angelo, a psychiatrist, began laughing and said, "Are you serious? You would beat me up over jury duty?" The man thought about it for a moment, then agreed that his threat was ridiculous.

"You always have to introduce humor," Dr. D'Angelo says. "You can't let the moment pass."

Every physician has them—the problem patients who miss appointments, constantly complain, pay their bills late or not at all, don't take their medicine or follow instructions, or become verbally abusive because of something the doctor, nurse or receptionist did or didn't do.

Regardless of the situation, doctors need to take the high road when confronted by a challenging patient. "We're supposed to be teachers, communicators and healers," says Dr. D'Angelo. But it's not always easy when someone is screaming at your recep-

tionist in the middle of the waiting room or threatening to sue you because you don't have any miracle cures.

Doctors' time is often split between those who really need and deserve their attention and those who demand it. But there are strategies that physicians and staff can use to minimize and even avoid difficult patient encounters that drain energy and consume valuable time. Many were created by doctors themselves, mostly out of necessity, and involve situations ranging from noncompliance to violent episodes.

Sometimes problems can actually be started or escalated by staff. Dr. D'Angelo believes that patients can be unfairly labeled "difficult" by practice employees when, in reality, the patients are afraid of doctors or angry or frustrated with the healthcare system. Other times, minor communication problems occur over the phone and are quickly blown out of proportion. Then these patients are treated differently because somebody has branded them a problem.

Consider patients who become angry because they've waited more than 20 minutes to see their physician. One time, after dealing with several back-to-back emergencies, Dr. D'Angelo walked into an exam room 40 minutes later than his patient's scheduled appointment. As soon as he entered the room, the woman began scolding him.

He recalls their conversation:

"What do you think I was doing before I walked in here?" he asked the patient.

"I'm sure you were taking care of patients," she said.

"That's exactly what I was doing. I wasn't out playing golf or checking with my stockbroker. Then why did you feel the urge to scold me?"

The woman then explained how tired she was of having to wait for everything, from standing in line at the supermarket to rush-hour traffic. Dr. D'Angelo says his office was the one place she felt safe enough to complain. Then he suggested different ways she could handle the stress of waiting.

"As physicians, maybe it's our role to hear that," he says, adding that a little compassion goes a long way.

As professor and vice chairman of family medicine at East Tennessee State University in Johnson City, Tenn., Dr. Forrest

Lang also digs deep to uncover a patient's anger. As an example, he points to a former patient, an elderly woman living in a nursing home. She suffered from bedsores and didn't interact, speak with or even recognize her two daughters.

Dr. Lang briefly met with her daughters to discuss her quality of life and readdress their wishes to resuscitate her if her heart stopped. He explained that her ribs would most likely be broken and that she could wind up on a respirator, which, considering her medical condition, would be more cruel than allowing her to pass peacefully. While one sister was nodding in agreement, the other daughter verbally attacked him, saying that he didn't care about her mother and only wanted to rush her to her grave.

At that point, he asked about similar discussions she had had with other physicians. Apparently, she was very unhappy with them, believing that they wanted to reclassify her mother as a no-code so they wouldn't have to care for her any longer.

Dr. Lang realized that she was transferring her emotions for the other doctors onto him. So he reemphasized his concern for her mother's comfort, then reframed his question: If your mom were able to make such a decision, what would she do?

Within 24 hours, her whole approach toward her mother's care had changed as well as her attitude toward Dr. Lang. He says that reframing his question and restating his commitment to her mother's comfort successfully converted the daughter's anger into understanding.

Dr. Jack D'Angelo of Staten Island, N.Y., says that patients can be unfairly labeled "difficult" by practice employees when, in reality, the patients are afraid of doctors or angry or frustrated with the health-care system. Other times, minor communication problems occur over the phone and are quickly blown out of proportion.

Deceiving Behavior

When Dr. Dana Simpler of Baltimore first practiced general and internal medicine, she became a likely target for many drug-seeking patients. Although she believed she was pretty savvy in identifying them, she was no match for experienced con artists and was scammed on several occasions.

Once, a patient pretended to be in extreme pain from a kidney stone. He described all the classic symptoms and even added a drop of blood from his pricked finger into his urine specimen. Others would fake chronic pain along with an allergy to all anti-inflammatory medicine, which is usually the first choice for any kind of pain problem. So Dr. Simpler would write them a prescription for narcotic analgesics. A day or two later, she would receive a phone call from a local pharmacist, informing her that the patient had indeed duped her and was coming in every week with different doctor prescriptions.

“As soon as I get the feeling that a patient is drug seeking,” says Dr. Dana Simpler of Baltimore, “I lean over to them and say, ‘I just want to let you know that I never give narcotics to any patient on their first visit. If you’d like to leave right now, I won’t charge you for the visit.’”

One patient, she recalls, received prescriptions for 30 Darvocet tablets from 30 different doctors.

By now Dr. Simpler had had enough. Episodes like this were occurring every other week. So once she became more familiar with the drug seekers’ methods, she refused to write narcotic prescriptions for people who were suspect. If she didn’t give in to

their demands, they would argue and leave her office in a huff, usually yelling loud enough so other patients in the exam rooms and waiting room could hear them say, “This doctor is an idiot.”

Searching for another alternative, Dr. Simpler created what she refers to as the perfect lie-detector test. “As soon as I get the feeling that this patient is drug seeking, I lean over to them and say, ‘I just want to let you know that I never give narcotics to any patient on their first visit. If you’d like to leave right now, I won’t charge you for the visit.’”

She says that the strategy works beautifully. Everyone from the suburban homemaker type to burly men covered with tattoos simply says, “Thank you,” and heads out the door without a fuss, never to return.

But what happens when Dr. Simpler’s radar is simply off? What happens to patients who really need strong pain relief?

That’s what happened to one patient whom she suspected of being a drug seeker. It was his first visit, and he was complaining of lower back pain. After she made the same statement to him,

he replied, “Well doctor, if you don’t think I need narcotics, I don’t need narcotics. Whatever you think I need is fine.”

Apparently, patients with legitimate pain aren’t offended by this approach, she says, adding that it is an effective way to separate the drug seekers from those who may be in real need of pain relief.

Dr. Edward Ryter, an internist at Hampton County Physician Associates in Ludlow, Mass., says his patients who are prescribed narcotics on a routine basis must sign an agreement that addresses the potential side effects of the drugs, the risks of being dependent upon them and two golden rules: patients can use only one pharmacy and one doctor for prescriptions. If they violate the agreement, he says, the drugs will be discontinued and the patient will be discharged.

“When patients come to you for the first time, you have to keep your antenna up,” says Dr. Ryter. “You have to ask what their history with pain medications is and whether they ever had a problem with them.”

Watch for Drug-Seeking Behavior

Patients who are seeking narcotics often exhibit distinctive behaviors, such as the following:

- The patient requests a specific medication by name, sometimes mispronouncing it to suggest unfamiliarity. The patient claims to be allergic to alternative non-narcotic medications or says they do not work.
- The patient may give a vague or evasive medical history or refuse to be examined. Sometimes the patient will describe symptoms that cannot be substantiated through the physical examination.
- The patient may insist on obtaining a narcotic prescription on his or her first visit.
- Drug-seeking patients often present in hospital emergency rooms. They claim to be from out of town and to have forgotten their medicine at home or to have run out of it. They may show up in every ER in town, with the same complaints, to obtain multiple prescriptions.
- Some patients try to manipulate the physician by disparaging his or her medical skills and insisting that a “smarter” or “more caring” doctor would write the prescription. Sometimes the patients become angry, threatening and agitated when their request is refused.

Back in 1990, Dr. John William Kinsinger was an emergency-room physician and experienced many problems with drug seekers. He remembers many patients who came to the ER claiming to have migraine headaches.

Once, when he was beginning his shift, the doctor going off duty warned him about a near altercation with a young woman for whom he wouldn't prescribe the drugs she wanted. She left angry, and he believed there was a good chance she would return.

Several hours later, a 25-year-old woman was admitted into the same ER. This time around, she was accompanied by a man and

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was completely covered with cuts and abrasions. She claimed to be so distraught that the other physician wouldn't give her a prescription for a narcotic that she tried to kill herself by throwing herself out of a moving vehicle.

Now Dr. Kinsinger faced two problems: besides her drug-seeking behavior, he had to patch her up without a confrontation.

He suddenly came up with a unique idea. As a physician, if he believed this patient was an immediate threat to either herself or anybody else, he could call the sheriff and request an emergency order of detention. An officer from the sheriff's department would then come to the hospital, pick up the patient and transfer her to the nearest inpatient facility, where she would be locked up for 72 hours.

"I plainly told her that because I was concerned for her health, I called the sheriff's department who was on the way," he says, adding that he was just bluffing. "She immediately jumped off the table and ran out, never to be seen again. It turned out to be exactly what I thought. She wanted drugs."

Now Dr. Kinsinger works as an obstetric anesthesiologist at two hospitals in Oklahoma City. While he no longer encounters drug seekers, he did experience a sexually aggressive patient.

Years ago, when he was examining a pregnant woman who required a caesarean, she exposed her entire body to him and

started making sexually suggestive comments. He ignored the comments and carefully kept the conversation on a friendly, professional level. “Just go right on to the next question,” he says, explaining that he never examines female patients without a female nurse acting as a chaperone. “They usually give up on the issue.”

It’s a bad idea for physicians to respond to inappropriate sexual comments or behavior from patients. If you do respond, you take the chance of leading patients on, enabling them to believe that their behavior is acceptable. Or you may hurt their feelings in some way, causing them to feel rejected. If this scenario should happen to you, remember to stay on task, be professional and complete the exam.

Hostile Encounters

Occasionally patients will walk into an office without an appointment, demanding to be seen immediately by the doctor. In these scenarios, everyone loses. You’ll have either a disgruntled staff or unhappy patients who possibly change doctors.

Since this scenario happens in nearly every practice, consider carving out time for walk-ins, says Rosemary Nelson, a consultant at the Medical Group Management Association (MGMA), based in Englewood, Colo. Pediatricians, for instance, schedule special hours for sick children. During flu season, some physicians inform their patients that every Tuesday and Thursday they can walk in and receive a flu shot. Others reserve every day from noon to five o’clock for blood pressure checks or allergy shots.

This approach is also effective with elderly people who are hard of hearing. It’s too frustrating for them to call, so they walk in unexpectedly and try to deal with their health issue in person, she says.

Another suggestion: script appropriate responses for front office staff so they have some procedure to fall back on, says Nancy Adams, executive director of the Monroe County Medical Society in Rochester, N.Y. Ms. Adams co-created a course called *Dealing with Difficult People*, which is offered by the medical society to its members several times a year.

Under all circumstances, she says, employees need to remain calm and avoid becoming as emotionally charged or upset as the

patient. If they listen well to what the patient is angry about, they can use reflective listening techniques or offer responses that reflect the patient's own concerns.

If patients walk in without appointments, for example, instead of reacting negatively to the situation, telling patients there's nothing you can do, try these responses:

■ “It looks as if you're in a lot of pain or discomfort. It must be upsetting to be sick. Now let's try to figure out how we can help you.”

■ “Your usual doctor is tied up with patients right now, but would you like me to see if the nurse practitioner or PA can see you right now? We've also got an opening at 4 p.m. Would you prefer that?”

“Look for points of agreement, compromise, then transition into options,” says Ms. Adams.

The same approach works well with people who demand a drug like an antibiotic for their child or parent. In this example, a mother is demanding an antibiotic for her daughter, who has recurring ear infections. Listed below are two different ways staff can appropriately respond:

■ “It must be very upsetting that your daughter keeps getting sick. We both have your daughter's best interest at heart and need for you to bring her in so the doctor can take a look at her ear and know exactly what's going on this time.”

■ “There are some types of infections that require antibiotics and some that don't. We don't want to overprescribe this medicine for your daughter. We want to be sure to give her the best medicine for this problem.”

Your billing staff can use a similar strategy. Since more patients are adopting consumer-driven health plans, the potential for patients to become upset or angry over their bill will probably escalate. Take the patient who receives a \$200 doctor bill but is used to paying only a \$15 co-payment. The response below starts out with a few comments that are reassuring, validates your understanding of the situation and presents options:

■ “We understand that the high cost of healthcare can be very upsetting and difficult to cope with, especially when you're used to paying only a small part of the charges. However, you had some tests while you were here. So let's set up some sort of payment process. Would you like to charge it or pay a little every month?”

However, if long-time patients become so angry that they threaten to sue you or make other verbal threats, sometimes this response could calm them down and put the situation into perspective:

■ “It’s really not like you to make threats, Mr. Jones. We’ve always had a good relationship.”

But if Mr. Jones persists, Ms. Adams says, staff has no safe option but to call 911. What’s more, physicians should consider training their staff on how to identify dangerous situations. Make

Disarming the Hostile Patient

Remember the last time a patient scolded or yelled at you or your staff? Maybe he was disputing a bill or she was complaining about how she was treated. Regardless of the reason, the situation is bound to happen again. So next time a patient becomes angry or frustrated, use these effective tips offered by Kristine Eckis, president of Bottom Line Medical Administrative Consultants in Lake Wales, Fla.:

■ Move patients to a private area like your office to keep others from overhearing your conversation. Ask them to sit down.

■ Let them vent. Ask them to explain the problem without interrupting. By doing so, you’re pumping them dry of negative emotions. If they start off screaming, reassure them that you will listen to their whole story, but they need to lower their voice. When they’re finished, ask if they’ve told you everything or have anything else to add.

■ Speak in a low, reassuring and sympathetic tone, which will ensure a higher probability of agreement. If you speak in a monotone, patients are likely to be less responsive. If your tone is cold and indifferent, it will arouse antagonism and make the situation worse. If your voice is high pitched, it may appear annoying and reduce the possibility of reaching an understanding.

■ Don’t argue, be defensive or take the complaint personally. Keep in mind that if you win, the patient loses, and he or she will feel bad about it. Your goal is to resolve the problem constructively and save the patient relationship.

■ Understand the patients’ point of view. There are many phrases you can use to demonstrate that you understand their perspective. Here are several: “This never occurred to me,” “Tell me more about it,” or “You know, you may be right about that.” These types of responses give patients the feeling that you’re really listening. And when they feel that you understand their side, their hostility diminishes.

certain that they realize which situations require a call to the police. Let's say a patient threatens to blow up the office or injure an employee. Staff must know that it is okay not to continue the conversation and that they should call for help.

Dr. Philip Bonanni recalls the time the son of one of his elderly patients actually grabbed another doctor by his collar. The son was an auto mechanic in his mid-50s and was referred by another physician, says Dr. Bonanni, associate chairman of the department of medicine at Unity Health System in Rochester,

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N.Y. He appreciated the referral and believed it couldn't hurt to form an ongoing relationship with an auto mechanic.

The son brought in his mother, who was in her early 80s, for an exam and told the doctor that he didn't know what was wrong with her. He grew angry when Dr. Bonanni told him that she would need additional tests that weren't covered by Medicare.

Still, Dr. Bonanni knew that something was seriously wrong.

Her blood counts were way off. After a series of tests, she was diagnosed with leukemia and admitted to the hospital for treatment. Several days later, Dr. Bonanni was making rounds and caught the son holding a hematologist by the collar against the wall outside his mother's hospital room, angrily shouting, "If you let my mother die, I'm going to get you."

Dr. Bonanni immediately pulled him off the doctor and settled him down by telling him that the doctor was doing his best to help his mother. Meanwhile, his colleague's rapidly beating heart began slowing to a normal pace.

"I knew the man well enough to do that," he says, adding that the son was not armed with a gun. "We could have called security and had a big hullabaloo. As long as he backed off, I felt it was safe. This was not the most pleasant moment in my career."

Although the mother responded well to treatment, she was back in the hospital later on with pneumonia and was placed on

a respirator. This time, the son threatened to sue Dr. Bonanni for malpractice if his mother died. At that point, Dr. Bonanni laid his cards on the table.

“I said, she’s got a life-threatening illness, and we can do everything humanly possible, but I’ve got to tell you something. You’ve got to realize that all of us have a time [to die].”

By talking to him as an individual and not confronting him, the son’s anger diffused. The mother then slipped into a coma. Dr. Bonanni discussed with the son whether to take the mother off life support. The son agreed to remove her respirator, only after coming to terms with his mother’s inevitable death. She died peacefully in her sleep. There was no lawsuit. There were no more threats. The son never showed up at the office again.

Fortunately, violent episodes are not a daily occurrence for many physicians. However, they do happen. If one of your patients suddenly became confrontational, would you know how to handle the situation? Not all physicians do, so consider these tips from the Texas Medical Association:

- In a confrontational setting, your tone of voice should become slightly firmer and deeper, not louder.
- Be careful to keep a calm, businesslike tone even though it is very easy to be sarcastic or patronizing.
- Put yourself at the patient’s eye level. If the patient is standing, stand up, or if the patient is sitting, sit down. Also, if you are much shorter or smaller than the patient, you may appear to be at a physical disadvantage. Asking the patient to sit down with you reduces that difference.
- If possible, move an angry or disruptive patient to a private office so that other patients and staff are not disrupted.
- Asking the office manager to join you or take over the problem may be an option, but always use the situation as a learning experience so that you will be able to handle similar problems on your own. Remember that solving patient problems is part of your job, so learn to be an expert.

Regardless of the circumstance, Dr. Bonanni says that physicians must be able to adapt to all types of patients, including those who are simply annoying.

Another one of his patients, an attorney, would read about a new medical test in the morning newspaper and show up at his

office, expecting the test to be performed that afternoon. Since his insurance was an HMO, his out-of-pocket expenses for such tests were minimal.

“He would try to milk out as much medical care as possible because of his low co-pays,” says Dr. Bonanni. “I could only explain to him that he didn’t need these tests. He would not let up.”

So Dr. Bonanni took the next logical step and called the patient’s HMO, explaining that the patient was demanding that unnecessary tests be performed. He says that the managed-care plan then contacted the patient and presented him with three options: stick with Dr. Bonanni and follow his advice, change

Steps for Saying Goodbye to Problem Patients

Patients fire their doctor all the time. They just never return. But can a doctor fire a patient? You bet, says Michael Fleischman, vice president of Gates, Moore & Co., an Atlanta practice management consulting firm. There can be many reasons, such as not paying their bill or abusing prescription drugs. If you have patients who fit into any of these categories, Mr. Fleischman offers the following steps for saying good-bye:

- Ask your office manager to handle patient dismissals. It insulates you as the physician from leaving the wrong impression—that you’re abandoning the patient—and turns it into a business decision.
- Send a letter to the patient that explains why he or she is being dismissed. Don’t spell it out in detail; offer just enough information so the patient understands the reason. For example, “We’re terminating our relationship with you because you haven’t paid your past-due bill.” Also avoid open-ended phrases like “If you want to come in and discuss this...” Be straightforward and firm.
- Give the patient two weeks to find a new doctor. State in the letter that you will be available during this time only on an emergency basis.
- Send the letter to the patient’s last known address. Mail it certified, return receipt requested, so you have proof that it was received. If the letter is refused, keep the postal documentation in the patient’s file along with a copy of the letter to avoid further problems.
- Contact the medical director at the patient’s insurance company to explain why he or she is being dismissed. Often, the insurance company can intervene and remedy these situations, such as those involving delinquent payments.

doctors or change insurance plans.

The patient chose the first option. Since then, Dr. Bonanni says that the quality of his relationship with the patient has suffered somewhat. Still, he says, he does not deprive the attorney—or any other difficult patient—of the best possible medical care.

Making assumptions about patients can also create unnecessary trouble. Roughly five years ago, a man walked into an emergency room at three o'clock in the morning. His chief complaint was that his toe had been hurting for six weeks, says Dr. William Schumacher, who practiced emergency medicine for 15 years and is now the founder of The Schumacher Group in Lafayette, La., which supports about a thousand ER physicians.

One nurse became angry at the patient because he didn't take care of the problem sooner. She complained that he was wasting their time, especially since the ER was full of patients that morning, and she believed that he was abusing the healthcare system.

"The stage was set for me to walk in there and reprimand or educate this patient for being there at 3 a.m.," he says. "Sure enough, that's what I did. I walked into the room, hardly listened to what he had to say and started to reprimand him about how he should have gone to a clinic for something that was causing him problems six weeks ago."

Then Dr. Schumacher decided to remove the man's boot. Not only did the boot come off, but so did the man's toe.

At that moment, Dr. Schumacher realized he had been influenced by his own bias—and the nurse's—against people abusing the healthcare system. He says that he fell into the trap of not objectively looking at the needs of the patient.

By that time, the patient's anger had escalated. He jumped off the table, prepared to walk out the door. But Dr. Schumacher managed to calm him down and convinced him to stay.

The man turned out to have multiple health problems, including high blood sugar. Without enough cash or any health insurance, he had neglected his health for a long time and showed up at the ER because his physical pain had become unbearable.

Dr. Schumacher says that a physician's biases or a patient's anger can often cause doctors to stop listening and fall into a dangerous trap of emotionally buying into the conflict. Bias minimizes your ability to objectively analyze the patient.

Now, when a patient is angry or makes him angry, he leaves the room and returns saying, “I want us to start all over. I’m really sorry that we started off so badly. I am interested in treating you and want to treat you properly.”

Dr. Schumacher continues: “It’s amazing what that will do in a conflict situation. Nine times out of 10, those people are willing to drop their anger and start the whole encounter all over again.”

When a patient is angry or makes him angry, Dr. William Schumacher says he leaves the room and returns saying, “I want us to start all over. I’m really sorry that we started off so badly. I am interested in treating you and want to treat you properly.”

He says that people in health-care are often so wrapped up in the details that they forget about the human aspects of the care that they’re supposed to deliver. He believes that up to 50 percent of cases are exacerbated due to a lack of understanding. And from a risk-management perspective, that can lead to bad outcomes for patients

and ugly lawsuits. In such cases, he adds, everyone loses.

No Payment, No Service

Sometimes even loyal patients ignore your invoices. The reasons can range from being short on cash that month to finding your bill too confusing. Ms. Nelson at MGMA says that some of her physician clients send an invoice that resembles a credit-card statement and clearly states the amount due. She says that the more figures you list on the statement, the more confusing it becomes for people to understand.

Some doctors have also asked patients to sign a pre-authorization form to allow them to charge all fees to the patient’s credit card. This way, physicians no longer have to send bills or worry about payment, and patients have one less bill to worry about. “Sell the convenience,” Ms. Nelson says. “It works.”

Another time, a physician had performed surgery on a patient who was paying out of pocket. But the patient never responded to the physician’s repeated invoices, says Pamela Moore, a healthcare consultant who educates physicians about management issues.

Eventually her account was sent to a collection agency, where

the only thing it collected was dust. Several years later, the patient called the office to schedule another surgery. The physician wondered if he was legally obligated to treat her.

“He was in a bit of a tricky spot because he needed to make sure that the patient had continuity of care and didn’t want in any way to be accused of not supporting the patient,” says Ms. Moore.

Her advice was for the physician to create a written policy on when patients will be dismissed from his practice and to apply it consistently so that there’s no hint of preferential treatment. She says this rule could have prevented this situation.

Meanwhile, she says, he had three options: he could see the patient and ask her to pay half of his service fees in advance, then agree on a payment plan for the remainder of the balance; ask her to pay the amount she owed before performing the next surgery or decline to treat her because she failed to respond to their repeated requests for payment.

“I’d err on the side of the patient,” Ms. Moore says. “I would ask them to come in and ask what happened last time; was there a crisis? Talk about what happened and how it affected our practice. [Ask] what we can do this time to make sure you pay us.”

Lack of Compliance

Problems with patients aren’t always so dramatic. Often the most frustrating patient is the noncompliant one. But noncompliance, specifically noncompliance with medications, can stem from a variety of factors, including lack of communication, dissatisfaction with the practice, financial difficulties, cultural issues or a lack of understanding.

A recent survey of Americans over age 50 conducted by AARP found that one in four respondents who have taken a prescription drug in the past five years said that they had not filled a prescription written by their doctor in the past two years; 40 percent cited cost as the main reason. Other reasons cited—such as “thought drug wouldn’t help much” and “didn’t think I needed it”—could indicate that the physicians were not effectively communicating the need for the prescription to the patients.

The Merck Manual of Diagnosis and Therapy lists a number of causes for noncompliance with prescribed drug regimens:

- Misunderstanding of prescribing instructions

- Forgetfulness
- Denial of the illness or its significance
- No faith in the drug's effectiveness
- Reduction, fluctuation or disappearance of symptoms
- Concern about taking drugs (i.e., adverse effects, addiction)
- Financial concerns
- Apathy
- Physical difficulties (i.e., swallowing tablets or capsules, opening bottles, getting prescriptions filled)
- Complex regimen (i.e., frequent dosing, multiple drugs)
- Inconvenient or restrictive precautions

Physicians need to address their patients' concerns about medications to improve compliance,

The Office of the Inspector General of Health and Human Services estimates that about 10 percent of hospital admissions and up to 23 percent of nursing home admissions may be due to elderly patients' inability to self-administer medications. Noncompliance results in the need for emergency care, increased physician visits, additional diagnostic tests and unnecessary alternative treatments.

especially among older patients and those with chronic illnesses such as diabetes or heart disease. Noncompliance can have serious consequences among the elderly, according to a 1990 report by the Office of the Inspector General (OIG) of the Department of Health and Human Services. For example, OIG estimates that about 10 percent of hospital admissions and up to 23 percent of nursing home admissions may be due to elderly patients' inability to self-administer medications. Noncompliance

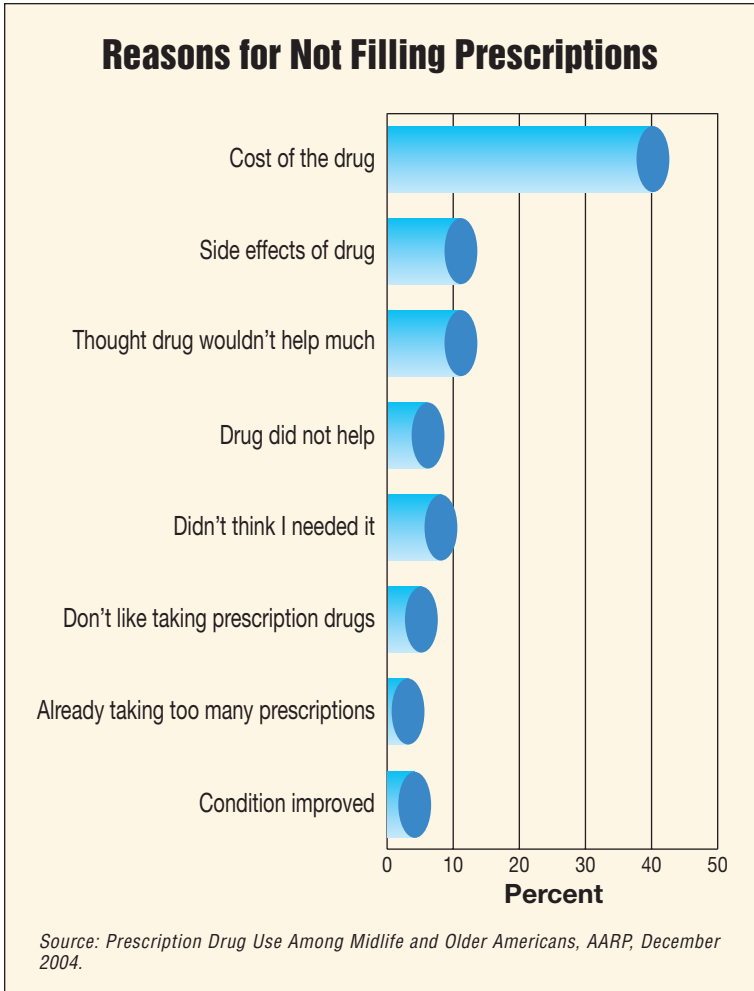
results in the need for emergency care, increased physician visits, additional diagnostic tests and unnecessary alternative treatments, says OIG.

“Effective counseling by the physician and pharmacist may be the single best intervention for patients with compliance problems,” states the OIG report. “Attempts to improve compliance through educational and other behavioral strategies do work, as long as they are matched to the individual patient's needs. There is evidence to suggest that with the proper education and support, the elderly can overcome compliance difficulties.”

The problem is not limited to the elderly. For many, the fail-

ure to follow the physician’s orders is due to low health literacy. “Nearly half of all American adults—90 million people—have difficulty understanding and using health information, and there is a higher rate of hospitalization and use of emergency services among patients with limited health literacy,” says a recent report from the Institute of Medicine (IOM) of the National Academies.

The report states that “over 300 studies indicate that health-



related materials cannot be understood by most of the people for whom they are intended.” Moreover, limited health literacy affects more than just the uneducated and poor, according to IOM. At some point, most individuals will encounter health information they cannot understand. “Even well-educated people with strong reading and writing skills may have trouble comprehending a medical form or doctor’s instructions regarding a drug or

Do Your Patients Understand You?

One out of five American adults reads at the fifth-grade level or below, and the average American reads at the eighth- or ninth-grade level, according to the Partnership for Clear Health Communication. Considering that most healthcare materials are written above the tenth-grade level, many patients have trouble understanding what physicians tell them about their condition, and about half take medications as directed.

What’s more, patients with low literacy skills are at 50 percent more risk of hospitalization when compared with patients who have adequate literacy skills, states the partnership, which has developed a “Words To Watch” fact sheet that translates common medical terms into more patient-friendly words. Several examples are listed below. The full list can be accessed at www.askme3.org/pdfs/words_to_watch.pdf.

Problem Word	Consider Using
Benign	Will not cause harm; is not cancer
Condition	How you feel; health problem
Dysfunction	Problem
Inhibitor	Drugs that stop something that is bad for you
Procedure	Something done to treat your problem; operation
Referral	Ask you to see another doctor; get a second opinion
Adverse	Bad
Increase gradually	Add to (example: add five minutes of exercise each week)
Progressive	Gets worse (or better)
Wellness	Good health; feeling good

procedure,” the report says.

More than a measurement of reading skills, health literacy also includes writing, listening, speaking, arithmetic and conceptual knowledge, IOM says. Health literacy is defined as the degree to which individuals have the capacity to obtain, process and understand basic information and services needed to make appropriate healthcare decisions.

Health literacy skills are needed for discussing care with health professionals; reading and understanding patient information sheets, consent forms and advertising, and using medical tools such as a thermometer or blood-sugar monitor.

Despite the extent of the problem, some doctors have found creative ways to combat healthcare illiteracy. One doctor, says Ms. Nelson of MGMA, writes a summary of each patient visit or bullet points on her prescription pad indicating what the patient needs to do. A bullet point might state, “Take this pill twice a day in the early morning and before bedtime.” Even if it’s a routine exam, the physician still recaps the visit. In this case, she might write, “We talked about your blood pressure—it’s great,” or “Continue drinking plenty of water.”

Ms. Nelson knows of another doctor who created education videos, then posted them on his Website. If a young boy with asthma needs to use an inhaler, for example, he receives training from a nurse in the physician’s office, and he can also watch a video on his home computer that demonstrates how the inhaler must be used.

“Patients become difficult because they’re anxious, not well, confused, concerned,” Ms. Nelson says, explaining that physicians need to focus on the issue, not the person. “Somehow we’ve missed the boat. We’re not totally servicing them.”

Lost in Translation

Language barriers are also a contributing factor to patient non-compliance. According to Perspectives, a newsletter published by the risk-management department at ProMutualGroup in Boston, more than 300 languages are spoken in the U.S. Even bilingual staff can experience trouble translating medical terminology, especially if the language supports different dialects.

When Linda Greenwald worked as a clinical nurse at an urban

hospital, she was often asked to translate English into French, since she had majored in French in college. “The French I learned in no way prepared me to ask questions about whether a patient

‘Best Practices’ for Overcoming Language Barriers

Dr. Kevin Larsen, an internist at the Hennepin County Medical Center (HCMC) in Minneapolis, sees a large number of patients with language barriers. “We have many patients of multiple language and ethnic groups for which we provide care—I would estimate 25-to-30 percent are of limited-English proficiency,” Dr. Larsen says.

Due to the large number of limited-English proficiency (LEP) patients, HCMC has established a department of interpreter services with 40 full-time interpreters. Last year the interpreter department had over 123,000 patient encounters in 53 languages.

According to Dr. Larsen, physicians often utilize extra resources to care for LEP patients. For example, he says, if physicians can’t understand what a patient is saying, they may order a CAT scan or other extra tests to avoid missing anything. Moreover, providing care to an LEP patient takes more time than a similar encounter with an English-speaking patient without additional reimbursement, he says.

“If there is no interpreter, I spend a long time trying to communicate by any means possible, talking to family members, using phone interpreters or simply repeating myself in many different ways,” Dr. Larsen says.

Dr. Larsen outlines some “best practices” employed by HCMC and the state of Minnesota for treating LEP patients, including:

- A large full-time interpreter staff.
- Language phone lines staffed by interpreters to access any part of the health system.
- Language-specific multidisciplinary clinics to organize care around interpreters and cultural brokers.
- A citywide health consortium across practices that shares language materials translated into multiple languages over the Web so that each system can avoid the cost of translating its own materials.
- Clinic signage in multiple languages.
- Development of language-specific videotapes for LEP patients with low literacy in their own language.
- Training of medical students in how to work with interpreters.
- Reimbursement for the cost of interpreters’ services through Medicaid managed-care plans.

had diabetes,” says Ms. Greenwald, editor of risk management publications at ProMutualGroup. “I would have to use 25 words to get around the one I was never sure they understood. I know how inadequate I felt.”

Likewise, when family members act as medical translators, all sorts of problems can erupt.

Consider the following information that was published in the Winter 2005 issue of *Perspectives on Clinical Risk Management* by the ProMutualGroup:

“A number of unskilled translators have either omitted significant information because they didn’t know it mattered or added words or explanations of their own. Some, in using the third person to speak to the physician about the patient, have become advocates rather than interpreters. Others, without medical background or education, have correctly translated what they incorrectly heard.

This all-too-common practice has resulted in such egregious (and potentially lethal) errors as *Hib vaccine* becoming *HIV vaccine*, *brain stem* being translated as *steam in the brain*, *womb* becoming *wound* and *endoscope* being translated as *hunting rifle*.”

Ms. Greenwald suggests avoiding the use of medical terms whenever possible and employing a skilled interpreter. There are many companies that provide phone interpretation by medically certified interpreters in 150 languages; some examples include Language Lines (www.language.com), Network Omni (www.networkomni.com) and CyraCom (www.cyracom.net).

When working with interpreters, talk directly to the patient, Ms. Greenwald advises. Communication needs to be between you and the patient, not you and the interpreter. Also document the name of each interpreter used, or require patients to sign a written form acknowledging that they refused interpreter services.

It is also a good idea to ask patients to repeat what they heard. A “yes” answer isn’t necessarily an indication that they under-

When working with interpreters, talk directly to the patient, says Linda Greenwald at ProMutualGroup in Boston. Communication needs to be between you and the patient, not you and the interpreter. Also document the name of each interpreter used, or require patients to sign a written form acknowledging that they refused interpreter services.

stood your directions. A simple instruction like “Take two pills every four hours” could be easily misconstrued as “Take four pills every two hours.”

If you diagnose patients with a life-threatening illness, such as cancer, they may become so frightened that they won’t be able to digest anything else you say, no matter how important. So try repeating the message in various ways. Hand them something in writing, she says, or call them the next day and ask them specific questions.

Filling out medical forms can pose serious problems for those who don’t read or write English very well. If you practice in an area where English is the second language, consider translating all documents into your patients’ native language. Or provide extra training for employees at your front desk so they can help patients with the forms.

While a language barrier can lead to patient noncompliance, it’s still only one piece of a big puzzle. Culture also dictates patient behaviors and attitudes. For instance, Ms. Greenwald says, if your patient regularly attends a three-hour religious service every Sunday, don’t expect him or her to take a prescribed diuretic on Sunday mornings.

Susan R. Levy, a researcher and fellow at the Institute for Health

Research and Policy at the University of Illinois in Chicago, works with doctors who practice in a large Hispanic community on the southwest side of Chicago. She says that an extremely high percentage of the adult and adolescent Mexican population suffers from diabetes, so she works with local physicians on ways to prevent the disease.

In the Mexican culture—especially among older woman—feet are considered a private area of the body, she says. But with diabetics, feet exams are critical. So while being culturally sensitive, these physicians are explaining to their patients why they shouldn’t refuse foot exams and in fact, insist upon them.

Back in the 1990s, she also worked with physicians who were treating Russian immigrants. One of the social service agencies quickly discovered that some of these individuals believed they had to bribe physicians in order to receive treatment.

“They had to be acclimated into our healthcare system in what you do and don’t have to do,” she says. “There would be great

anxiety before they walked into the office. Doctors need to be aware of whom they're dealing with and why this might happen in the office."

Filling out a patient history and other medical forms can also pose serious problems for those who don't read or write English very well. If you practice in an area where English is the second language, consider translating all documents into your patients' native language. Or provide extra training for employees at your front desk to enable them to help patients answer questions on the forms.

Some questions may need to be further defined, she says. For example, instead of simply stating, "Do you have insurance?" add a second question like, "Are you worried about being able to pay your bill?"

This becomes an important question considering that medical practices frequently offer payment options like reduced pay and payment plans. For vulnerable patients who are not savvy about healthcare practices, this sends an important message: they no longer have to avoid seeing the doctor or skip important doctor appointments if they don't have insurance or enough cash.

"It's being intuitively helpful, but the staff has to be trained," Ms. Levy says. "They really need to know their population."