Challenging Patient Encounters (for Medical Students)

Committee on Physician Health and Wellness ◆ Providing Education for Medical Students
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Learning Objectives

Upon completion of this course, medical students should be able to:

1. List five types of patient encounters that might be considered challenging;
2. Describe the effects of challenging patient encounters on the physician's practice;
3. Discuss methods for ethically and professionally managing these encounters;
4. Recognize that students' attitudes and behaviors can contribute to challenging encounters;
5. Apply the principles of dynamic listening and effective communication skills; and
6. Demonstrate changes in clinical practice that will help manage challenging patient encounters successfully while maintaining high ethical standards.

Focus

This material is designed for medical students to help them learn how to respond effectively to challenging patient encounters.

Target Audience

Medical students

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I. Introduction

Most encounters with patients are positive. However, just as any enterprise has difficult and demanding consumers, physicians and students also face their share of challenging patient encounters. Challenging patient encounters occur about a sixth of the time, according to several published articles. The nature of challenges faced in the medical profession is unique and varied. Hence, physicians and students need to have a thorough understanding of patients and their problems. They also require knowledge about how to deal with challenging situations in their daily medical practice.

As a student, you must first establish a vision of how you want to practice medicine—how you want to be perceived by your patients and staff. You also should recognize your contributions and the effects these encounters have on managing yourself and your practice. This activity will provide a solid footing for medical practice guidelines, and rules for patients, staff and fellow staff members. *(Jackson 1999, An 2009)*

II. Factors Contributing to Challenging Patient Encounters

"Difficult" Versus "Challenging": Perception Makes the Difference

Reframing the perception of a difficult encounter as more of a challenge rather than a nuisance empowers the physician to manage these situations effectively. Effective management leads to fewer incidences of reported challenging patient encounters.

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Remember, the Chinese word for "problem" is also the word for "opportunity."

Case Study No. 1: Needy Behavior

- Patient has leg stent placed for treatment of peripheral arterial disease with good result
- Previous history of failed heart stent resulting in coronary artery bypass
- Two weeks after procedure, patient begins calling office repeatedly with various complaints
- Despite multiple reassurances from mid-level provider, continues to call

This is an example of a needy patient, who continues to call his surgeon's office despite reassurances that he has a good result and there are no problems. The office refers the calls to the mid-level provider, who normally responds to such calls. We will revisit this later in the presentation to discuss possible solutions.

Physician and Student Factors

Inherent Stressors

- Disease model versus holistic model
- Increased patient volume
- Communication difficulties
- Increasing administrative burdens
- Lack of clear policies and guidelines

Stress and Burnout

- High levels of stress and burnout lead to the perception that more encounters are "challenging"
- Conversely, more "challenging" encounters result in higher levels of stress and burnout for the physician and student

Although evolving, the American medical education system traditionally has taught physicians to focus on the disease process rather than developing a holistic view of the patient. But when patients have a symptom, they are often more concerned with its effect on health-related quality of life and the subjective experience of the illness.

The highly structured, often impersonal character of medical care also tends to hinder the care of patients. Increasing bureaucratic requirements and decreasing resources for patients in contemporary medical practice make it ever more difficult for the unhurried dialogue that is necessary to get to know patients as people. More on communication skills will be presented later in this module.

One changing aspect of patient care that has added to medical student stress in the recent past is the changing role of medical students on hospital services. Previously, medical students were considered an integral part of the health care team. Often, they performed tasks that busy residents did not have time to do. This contributed to good feelings of value and self-worth.

As the climate of medical care in the United States has changed, students do not participate in patient care to the same degree as in the past. Their roles are less "important" to patient care—they don't write notes, rarely see patients independently, and in general are less involved. Patients will sometimes decline to allow a student to participate in their care. This can lead to the perception that patient encounters are more "challenging," and to loss of feelings of self-worth that are so important in a person's development.

The PHW Committee offers a CME course regarding medical student stress and burnout.

Physician and Student Factors (continued)

An article based on the Physicians Worklife Survey shows the following characteristics for physicians who report frustrations with patients:

- Younger
- Decreased training hours
- Works longer hours
- Subspecialist
- Perception of greater number of patients with psychosocial problems or substance abuse

As physicians gain experience and confidence, they become more effective in dealing with challenging patient encounters. *(Krebs 2006)*

Patient Factors

- Fear is often an unrecognized, underlying factor
- Feeling mistreated, misunderstood, or neglected
- Stress of illness or other life problems
- Personality traits/disorders
- Cultural differences

Some patients may feel that they were mistreated by a physician, overcharged, or simply not heard by their physician. Acute stressors in the patient's life; e.g., serious medical illness or social/financial problems, also may disrupt an otherwise positive patient-physician relationship. Certain personality characteristics may predispose patients to misunderstandings and poor communication.

Cultural differences can have a profound impact on patient behavior. It is up to the physician to be sensitive to these differences and take them into account during treatment.

According to Fiester 2013, an understanding of the patient's motivation is essential. *(Fiester 2013)*

Potential Adverse Outcomes on Physicians, Students, and Health Care Providers

- Reduced time, energy, and patience
- Decreased revenue
- Negative publicity
- Threat of malpractice suits
- Complaints to hospitals, practice partners, supervisors, and/or Texas Medical Board (TMB)

Taking the time now to learn effective ways to manage difficult encounters, even though it may seem cumbersome, will be beneficial in the long run.

Key Strategies

- Communication skills
- Time management
- Written guidelines
- Documentation
- Second opinion, consultation, and referral
- Terminate services

The above list includes prevention strategies to manage the encounters. Staff and office guidelines and patient information/guidelines will make the clinic policies and procedures very clear, which will prevent confusion or misinterpretation of verbal interactions. Effective time management will allow the physician or student to budget time for challenging encounters.

The other strategies, such as communication skills, documentation, second opinion/consultation/referral and termination are effective means to deal with the encounters. All of these strategies will be addressed. *(Elder 2006, Baum 2009)*

Communication Skills

- Practice active listening skills
- Acknowledge patient's opinion/feelings
- Discuss specific concerns
- Think before you talk
- Express yourself clearly and succinctly
- Lessen distractions
- Do not interrupt
- Provide tactful redirection
- Show empathy
- Control your emotions
- Avoid premature closure
- Restate patient's concerns
- Clarify shared treatment plan

Effective communication skills include active listening, acknowledging others' points, discussing specific points, thinking before talking, and expressing yourself clearly and succinctly.

Patients notice when you are **not** listening. Make sure that you are not talking to someone on the telephone or one of your colleagues pretending to be listening to the patient. No one does this intentionally, but it happens on occasion.

To have effective and fulfilling patient encounters, physicians and students need to reduce distractions when they are in the room with the patient, and to reduce distractions from staff, patient family members, and electronics (further discussed).

When a patient is not being succinct, gently redirect him or her to the medical issue at hand. This should be done without making the patient feel that he or she was cut off or interrupted. Sometimes when patients are agitated and angry, physicians or students subconsciously become angry themselves. However, it is very important for the physician to remain calm with the attitude of trying to resolve the issue that is causing the patient to be agitated and/or angry. Physicians and students need to show openness and willingness to listen to their patient's side of the story first even though emotions and observations may point to something else.

It is important for patients to complete their train of thought, and they should be allowed to do so without interruptions from the physician or student. It is perfectly okay to ask questions at appropriate times if the physician needs clarification. When the patient has finished talking, the physician should restate succinctly and with clarity what are the patient's concerns so that the patient understands that the physician was listening. After restating the patient's concerns, the physician or student then should lead into solutions and treatment plan.

After the physician has listened to the entire story, it is important to apply his or her knowledge, wisdom, and skills to generate a conclusion. This conclusion should be shared with the patient in a succinct and clear manner so that he or she understands the physician or student analysis. When the treatment plan is formulated, it is important for patients to have ownership in the treatment plan, and this should be done as a give and take on the part of the physician rather than in a paternalistic way.

Electronic Communication Skills

- Electronic health records
  - Maintain frequent eye contact
  - Consider a scribe
  - Explain to patient the importance of accurate medical records
- Phone calls and texts
  - Silence phones (patient and physician)
  - Answer phone and text only for emergencies

During direct patient encounters, communication is especially important in the age of electronic health records. Patients consistently complain that the physician did not make eye contact and he or she was busy typing on the computer. Minimize distractions by silencing cell phones and focusing on the patient rather than the electronic health records.

Effective Time Management

- Allows more time for physicians and students to deal with challenging patient encounters
- A single strategy may not work for everyone
- Many time management models are available

Time management is crucial for the physician and student to be able to devote adequate time to challenging patient encounters.

There are many time management theories and strategies available. Physicians and students are encouraged to review journal articles, books, and online resources related to professional and personal time management.

Staff Guidelines

Review written guidelines for:

- Managing psychiatric and medical emergencies
- Maintaining professional boundaries
- Managing common encounters

Guidelines should incorporate information from patient satisfaction surveys.

The physician or physicians who own the practice should take a proactive approach to develop and distribute clear written guidelines. These guidelines should include, but not be limited to, such topics as psychiatric and medical emergencies, boundary issues (acceptance of gifts), the common types of challenging patient encounters, and a summary of patient policies that apply to appropriate staff, such as refill policies, release of medical records policies, and others. Office policies should be dynamic and sensitive to patient feedback.

Students should review and learn to produce written guidelines for future practices.

The PHW Committee offers a course regarding professional boundaries.

Patient Guidelines

- Clinic policies and procedures
- Informational handouts
- Referral lists
- Payment policies

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Patient guidelines should be established. Some things to keep in mind when establishing guidelines include the following:

1. When the patient should call for refills;
2. When the patient should expect a call from the physician regarding lab tests;
3. When the patient is expected to arrive for appointments;
4. Whether special clothes should be worn for certain tests, etc.;
5. Cancellation and no-show policies; and
6. After-hours coverage

These guidelines could be contained in a brochure and provided to each patient. Having copies of the guidelines in the waiting room may improve patient compliance.

III. Strategies for Addressing Challenging Patient Encounters

Complete and accurate documentation is your best defense in a lawsuit.

- Office visits
- Telephone conversations
- All interactions with patient

Despite tort reform, the medical practice remains a high risk occupation for civil lawsuits. Additionally, there is regulatory oversight by the TMB, as well as a variety of insurance companies including Medicare and Medicaid. In this atmosphere, it is critical to have complete and accurate documentation of patient encounters. This should happen even if it occurred on the telephone and the physician is not getting paid for the encounter. A well-documented phone conversation or patient encounter, including date and time, goes a long way in the event of a lawsuit or investigation by a regulatory body.

When making medical documentation, it is important to write what happened in that encounter and to avoid editorial comments in patient records. Additionally, it is highly recommended that a physician not openly criticize another physician's care. However, if a physician has concerns, he or she should discuss it with the colleague rather than enter it into the medical record.

Consultation and Referral

Consultation and referral results in:

- Reduction of patient concerns
- Documentation of responsiveness to patient concerns
- Sharing challenges of complex patient
- Appropriate termination of current patient-physician relationship if indicated

Consultation and referral serves multiple functions. These include reduction of patient concerns, documentation of responsiveness to patient concerns, sharing challenges of the complex patient, and the appropriate termination of a current patient-physician relationship if indicated. Consultations can include second opinions, which can be very useful in allaying patient concerns.

Challenging Patient Behaviors

- Demanding
- Drug-seeking
- Complaining
- Non-paying
- Angry
- Violent
- Needy
- Seductive
- Poor adherence
- Manipulative

The challenging patient encounter will be elaborated upon in the upcoming sections. Poor adherence involves a spectrum of behaviors, such as frequently rescheduling, not taking prescribed medications as ordered, arriving late for appointments, and Substance Use Disorders (SUDs).

Case Study No. 2: Demanding Behavior

- 50-year-old male, unemployed, lives off mother's social security check
- Chronically depressed, multiple medications and counseling failures
- In his first visit with you, demands, "I want you to make me happy and make all my problems go away!"

Would this be a challenging patient encounter for you? One approach would be to emphasize that the patient must take an active role in his treatment versus expecting the physician to provide a magical cure.

Strategies: Demanding Behaviors

- Set limits
- State realistic goals
- Keep visits short and focused

A demanding patient reflects an imbalance in the emotional chemistry between the patient and the physician. Physicians must decide whether their efforts are helping the patient and if not, consider how the situation might be improved through open communication.

Setting limits, restating common goals, scheduling regular visits, and keeping visits short and focused are some strategies of responding effectively to a demanding patient.

However, patient demands such as being seen after work hours deserve a physician's careful consideration since many people who are employed are conscientious about missing work. Based on the number of requests from patients, physicians might consider having late office hours one day a week to accommodate such demands.

Case Study No. 3: Drug Seeking Behavior

- Patient calls OB-Gyn for hydrocodone tablets; small, one-time prescription given
- Patient calls OB-Gyn's call partner on duty for dysmenorrhea; prescription given
- Patient calls for another prescription; denied
- At next office visit, patient discloses she was recently treated for an SUD

A woman called her OB-Gyn on a Thursday, the day her primary care physician was out of the office. She asked for just a few hydrocodone tablets as she had a migraine and she did not want to call the on-call physician. A review of the chart revealed the patient had listed the medication and the purpose at her last visit. A small, one-time prescription

was given to the patient by calling the pharmacy.

The patient called in on a weekend and the call was taken by the OB-Gyn's call partner. She asked for another prescription stating that her regular OB-Gyn prescribed them for her dysmenorrhea. Another prescription was called.

When the patient called for another prescription, again on her primary care physician's day off, the prescription was denied with a note in the chart to discuss with the matter with the patient at her next office visit. At the next visit, the patient disclosed she had recently been treated for an SUD.

Several opportunities for improvement are evident in this case study, which is taken from an actual clinical experience.

Drug-Seeking Behaviors

- "Doctor jumping"
- "Lost" controlled substance prescriptions
- Request specific medication and dose
- Medication "allergies"
- "Last-minute" refills
- Absence of objective findings
- Uncooperative

Telling the difference between a legitimate patient and a drug abuser isn't easy. Recognize behaviors that are potential red flags for identifying patients who may be seeking drugs for fabricated or exaggerated medical conditions.

Strategies: Drug-Seeking Behaviors

Explore your patient's request for reinforcing medications:

- Have you prescribed an appropriate medication at the correct dosage?
- Does he or she need additional diagnostic tests?
- Are there complicating medical and/or psychiatric factors that are aggravating the patient's condition?
- Are there ethical dilemmas between under-prescribing for legitimate conditions and enabling or inducing addiction?

There are two types of patients who are seeking drugs, most commonly benzodiazepines or opiates: those with legitimate medical conditions and those who may have an SUD. There are patients who travel between emergency departments (ED) seeking narcotics. While this may not be indicative of the majority of visits to the ED, it is difficult in EDs to determine whether the patient has a drug addiction or a legitimate medical emergency.

DO:

- Perform a thorough examination appropriate to the condition.
- Document examination results and questions you asked the patient.
- Request picture ID, and place a copy in the patient's medical record.
- Call a previous practitioner, pharmacist, or hospital to confirm the patient's story (with a signed release form from the patient).
- Abide by current regulations.

Conversely, the TMB disciplines physicians for indiscriminate writing of narcotics prescriptions. None of us likes distrusting our patients or directly confronting our concerns, but it is part of our professional role. The PHW Committee offers a course that discusses appropriate pain management.

Texas Controlled Substances Act (Texas Health and Safety Code)

Physicians may issue prescriptions for opioids up to total of 90 days if:

1. Each separate prescription is issued for legitimate purposes
2. Physician writes instructions on each script indicating the earliest date on which pharmacy may fill each script; i.e., Do not fill before 12/6/14.
3. Physician concludes that providing multiple scripts does not create undue risk of diversion or abuse
4. Issuance is in compliance with other applicable state and federal laws

Hydrocodone by itself or in a single dose larger than 15 mg has been a Schedule II drug since 1971 when the federal Controlled Substances Act was passed. But in lower doses, in combination with a non-narcotic analgesic, it has been a Schedule III drug.

In 2012, U.S. physicians wrote more than 135 million prescriptions for hydrocodone, making it the most prescribed drug in the country, according to government figures. It also is the most abuse prescription drug and mainly responsible for a 300% rise in overdose deaths since 1999, according to the DEA.

The DEA issued a notice of proposed rulemaking earlier this year and the final rule was published on August 22, 2014, moving all hydrocodone combination products to Schedule II. The rule is effective October 6, 2014.

Only regular Schedule III prescriptions for hydrocodone issued before October 6, 2014, and their authorized refills may be dispensed by the pharmacist, as long as such dispensing occurs before April 8, 2015.

Starting October 6, 2014, all prescriptions containing hydrocodone must be written on official Texas Schedule II forms, which must be obtained from the Texas Department of Public Safety, at (512) 424-7293. The Controlled Substances Act can be found online; look for the form rules at 481.074-5. Old triplicate forms are still valid if the physician's DPS number and address are still the same. However, the middle form must be destroyed and only the top form given to the patient.

Schedule II prescriptions may not be refilled. In addition, no verbal prescriptions will be allowed except for a 72-hour supply in an emergency, which must then be followed with a written prescription. DEA and Texas rules allow a practitioner to issue multiple Schedule II prescriptions to provide up to a 90-day supply of medications with the notation, "Do not fill until (date)." Schedule II prescriptions may not be repeated after 90 days without another face-to-face visit.

In Texas, advanced practice registered nurses and physician assistants may prescribe Schedule II drugs only in a hospital facility-based practice or in a hospice setting.

If a physician plans to write prescriptions for hydrocodone combinations; i.e., Vicodin, Lortab, etc., he or she should (1) get his or her Texas DPS prescription forms as soon as possible and (2) learn the Texas Schedule II prescribing rules.

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Case Study No. 4: Complaining Behavior

- 40-year-old woman with leg swelling and pain
- Duplex ultrasound showed reflux in the great saphenous vein; patient underwent successful ablation
- Patient returned to clinic monthly after surgery complaining of ongoing leg pain
- Repeat ultrasound shows no abnormality

In this case, the patient continued to have pain in the leg despite a successful treatment of the underlying venous abnormality. Moreover, the swelling that the patient had preoperatively resolved after the surgery.

When the patient continued to complain of pain after the procedure, the physician examined the patient carefully and ordered several additional tests to make sure nothing had been missed, including the venous ultrasound, ultrasound of the arteries in the leg, and MRI of the back. All were normal.

After several months, the patient's primary care physician referred her to a mental health practitioner. This physician was able to determine that the patient's husband had recently begun working in another city. The patient was afraid her marriage would suffer, and acknowledged continuing to complain of leg pain in the hopes that her husband would feel obliged to move back home.

Strategies: Complaining Behaviors

- Evaluate the physiologic basis for each symptom
- Conduct a thorough medical evaluation
- Refer for consultation if needed

There are some patients who tend to complain no matter how well they are doing. To evaluate the physiologic basis for each symptom, physicians need to understand a patient's emotional patterns without labeling the symptoms as real or psychosomatic. Diagnosis of symptoms should be based on objective clinical and laboratory findings.

If a physician has exhausted the studies and cannot find the cause, the patient should be assured that there were no serious findings. Another option is to refer the patient to another physician for a second opinion. In either case, it is imperative to document such complaints in the patient's medical chart. Therefore, if the patient alleges that the same symptoms were experienced during the past two years and the doctors did not pay attention to the results, documentation as to the sequence of events exists in the medical record.

Make a list of patient complaints and actions taken to address them. If any of the complaints cannot be resolved, obtain input from other practitioners.

Strategies: Non-Paying Behaviors

- Disclose fee structure with patient
- Establish a payment plan
- Warn patient in writing of consequences of nonpayment, which would include being discharged

There is an ethical dilemma of providing free care versus preserving your practice. Disclosing your fee structure to patients prior to their first appointment is ideal. Physicians should first consider why a patient is not paying a bill. A patient may be facing a temporary financial crisis and unable to pay a medical bill. On the other hand, a patient may be unhappy with the care being received and contemplating a lawsuit.

The patient's reaction when confronted about an unpaid bill will serve as a useful indicator as to the root of the problem. A patient who has been unable to pay because of financial reasons will likely be receptive to a payment plan if offered, whereas a patient who is angry may reject the offer of a payment plan. Communicating with the patient will reveal the source of the problem and thus a method to resolve the problem.

If attempts to collect on a bill are unsuccessful, the patient should be warned in writing of the consequences of nonpayment, which would include being discharged. Only after attempts to resolve the matter should the physician mail a letter discharging the patient.

The challenge is to provide a balance between accommodating those who are indigent and maintaining financial viability of the practice.

Strategies: Angry Behaviors

- Invite patient into a private space; maintain personal safety
- Maintain your composure
- Determine the cause
- Involve patient in the resolution
- Reach an agreement with patient about what will be done
- Follow through with agreement
- Inform your patient of his or her right to see another physician and your availability to assist with referrals

Patients may be angry for a variety of reasons. Physicians should make every effort to learn why they are upset. A calm communication in the presence of an office staff person might help to unravel some of the reasons why the patient became angry.

A physician may be surprised to learn that the patient believes he or she was treated unfairly (calls not returned, biopsy not followed up on, mistake made in their schedule, wrong test done, long wait in the office, then appointment cancelled because of an out-of-town patient). If a patient gets angry, ensure patient privacy, maintain composure, and listen to what the patient has to say. Make a list of the patient's complaints and start searching for meaningful answers and solutions.

Empowering the patient in the process of addressing his or her concerns may improve the situation. Reach an agreement with the patient about what will be done to resolve the issue, and follow through with the agreement in a timely manner. Inform the patient of his or her right to see another physician and of your availability to assist them with referrals.

Responding to an angry patient in this manner may not only solve the patient's anger, but also improve the patient-physician relationship.

Strategies: Violent Behaviors

- Prevention is preferable
- Warning signs
  - Pacing
  - Loud vocalizations
  - Clenched fists
  - Veiled threats
  - Gritting teeth
- If violence occurs, call 911 or security team

Preventing a violent situation is much better for all concerned than allowing a situation to escalate. Warning signs of aggressive or violent behavior include, but are not limited to, pacing, loud voice, clenched fists, veiled threats, or gritting teeth. When these signs occur, do not try to intervene yourself; seek assistance from a trained professional. Once violence occurs, do not try to stop it yourself: Call 911 or the security team. Staff members need education and written procedures on how to respond to violence.

Case Study No. 1: Needy Behavior (revisited)

- Patient with leg stent who called office repeatedly after procedure
- Mid-level provider eventually arranged follow-up appointment with physician
- At appointment, patient acknowledged fears of procedure failure
- Schedule set for phone calls and monthly clinic visits

In this case, the patient was calling the office repeatedly because he was afraid the procedure would fail and he would require open surgery, similar to what had happened with his heart stent. Reassurances over the phone from the mid-level provider were not sufficient to allay his fears.

Eventually, the patient had a face-to-face appointment with the physician, who was able to at least temporarily reassure him. A schedule was made where the patient was allowed to call the mid-level provider once a week, and have an appointment with the physician once a month. The patient agreed not to call more frequently unless he felt a true emergency was occurring.

Strategies: Needy Behaviors

- Set limits
- Schedule regular appointments
- Keep visits short and focused
- Refer to support groups

Some patients need more attention, explanation, etc., than others. Physicians may find that they need to repeat the symptomatology over and over again. Patients may ask the physician to reiterate recommendations many times.

After listening to the needy patient, physicians must set limits, schedule regular appointments, and keep visits short and focused to deal effectively with these patients. Referral to a support group may help satisfy excessive dependency needs.

Case Study No. 5: Seductive Behavior

- Young, single woman has initial visit with a single male primary care physician
- Patient gives compliments; schedules another appointment; brings cookies; gives more compliments
- Patient invites physician to charity event; physician attends and offers ride home
- Patient invites physician insider her home; results in sexual intercourse

A young, single woman has her initial visit with a single male primary care physician. She compliments him on his tie and hairstyle, and asks about his training and background. At her second visit, the patient brings the physician homemade cookies and engages in conversation about personal likes, hobbies, etc.

Next, the patient sends the physician an invitation to a charity event. He decides to attend since it's a good cause. The young woman also is at the event and they converse. After several glasses of wine, he offers to drive her home. She then invites him inside and the result is sexual intercourse.

Strategies: Seductive Behaviors

- Emphasize that this is a strictly professional relationship
- Utilize chaperone throughout interactions
- Obtain consultation/referral if needed
- Institute and enforce written office guidelines

An intimate relationship within the patient-physician context has a profound and negative impact on a physician's medical practice and personal life. It is unethical for a physician to get romantically involved with current or former patients and is the basis for civil and possibly criminal liability. Seductive patients may already have significant emotional problems, and a temporary relationship that turns sour may ignite their emotional instability.

If there is even the slightest hint that a patient may have seductive motives, a physician should express due diligence in following standard office guidelines, which includes having a chaperone in the examining room, making certain that all office visits are within regular business hours, etc. The TMA Board of Councilors has addressed the use of chaperones during physical exams in one of its *Current Opinions*.

If efforts to address a seductive patient are not successful and continue to be a concern, consultation with a professional or referral of the patient to another physician may be necessary. This topic is addressed more thoroughly in another course offered by the PHW Committee.

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Case Study No. 6: Poor Adherence

- 40-year-old woman with chronic schizophrenia and mild mental retardation
- Lives in small RV on brother's property
- Has chronic auditory hallucinations and blames you for lack of response to current medications
- Admits to only taking current medications three of the last seven days, despite all staff efforts to improve adherence

One approach to address this patient encounter would be to remain calm and to not react to blaming. Explain, in simple terms, that current medications must be taken every day for maximum benefit. Involve the patient in problem-solving to improve adherence.

Strategies: Poor Adherence Behaviors

- Involve the family, friends, and/or social services when possible
- Provide patient with written notification of the potential consequences of failing to follow medical advice
- Inform the patient, in writing, of the need of ongoing care

With patient consent, family and/or friends may be extremely helpful in improving patient compliance. Social services, such as home health visits, also may be useful.

Patients who are not compliant exist in all practice settings. Challenges include failure to keep appointments and noncompliance with treatment plans.

Education goes a long way in helping patients understand the importance of following medical advice. Informing patients in writing of the potential consequences of failing to follow medical advice may be the impetus for patients to understand the value of adhering to such advice.

Case Study No. 7: Manipulation

- Patient has undergone two leg bypasses for peripheral arterial disease; he continues to smoke and eventually the second bypass clots off, resulting in a non-viable foot. He is admitted to the hospital.
- Vascular Service recommends amputation; the patient refuses and spends most of his time outside the hospital smoking.
- Patient demands large amounts of intravenous pain medicine for his non-viable foot.

This is a case where the only realistic option for the patient is an amputation. However, rather than accepting the inevitable and taking responsibility for his part (smoking), he blames the physicians and refuses to accept their recommendations. Moreover, he continues to occupy a bed in a busy hospital and expects that he will be treated with intravenous medication for his pain.

This is an example of a patient who is manipulating his medical care.

Strategies: Manipulative Behavior

- Arrange a meeting with the patient; emphasize the importance of the patient being in his room at the meeting time.
- Thoroughly explain the options; allow the patient time to ask questions and clarify.
- If the patient is still unwilling to proceed, offer the patient a second opinion, transfer to another physician, or discharge to home or a skilled nursing facility until he is ready to proceed.

In the case of the manipulative patient, it is important to spend the time to ensure that the patient understands the situation with regard to his or her medical care, and what you as the physician are recommending. However, if the patient is still uncomfortable or unwilling to proceed with your recommendations, it is appropriate to assist the patient with finding another physician, or discharge the patient from inpatient care if this is feasible.

The patient should not be allowed to manipulate his or her care if doing so would require the physician to do something he or she does not feel is right.

The issue of discharging a patient from your care is an ethical one, which is addressed in the next section.

IV. Treatment Termination and Summary

Treatment Termination

- Properly document the termination notice
- Provide a reasonable timeframe for patient to find another physician to manage his or her care
- Continue to treat patient during the transition time when he or she is locating another physician
- Avoid anything that may be seen as abandonment, which may have legal and ethical consequences

There may be times when you want to withdraw yourself from certain patient care or services. When doing so, make sure that you follow ethical practices and inform the patient in writing and provide ample time for the patient to find another physician. The TMA Office of the General Counsel has an article regarding termination of patient-physician relationship.

Some institutions may not let physicians terminate patients. For instance, if you are a physician in a safety net system (provider of the "last resort," such as a county tax-supported hospital district), the institution may require you to see dangerous patients. It is important for those physicians to arrange with employers for their own safety.

Summary

- Utilize holistic patient model
- Adopt clear policies for specific patient challenges
- Improve communication
- Implement staff, office, and patient guidelines
- Maintain comprehensive documentation
- Refer and/or terminate when appropriate

Disclaimer

The PHW Committee hopes this activity is useful educational information and welcomes your suggestions regarding these or other educational materials you think should be made available to Texas medical students.

V. Source Page

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Topics Offered by TMA PHW Committee

Topic	Cat. 1 Credit	Ethics/Professional Responsibility Designation	Live Presentation	TMA Website	Home Study
Challenges of Professional Boundaries	1	1	X		
Challenging Patient Encounters	1	1	X		
Coping With Malpractice Litigation	1	1	X		
Intervention for Physicians Who May Be Impaired	1	1	X		
Physician Retirement: Are You Ready?	1	1	X		
Physician Stress and Burnout	1	1	X		
Practice Dilemmas of the Aging Physician	1	1	X		
Professionalism in Medicine	1	1	X		
Psychiatric Illness in Physicians	1	1	X		
Substance Use Disorders in Physicians	1	1	X		
Communication Skills: Talking With Your Patients	1	1	X	X	X
Cultural Competence	1	1	X	X	X
Depression and Suicide in Physicians	1	1	X	X	X
Domestic Violence: Ask!	1	1	X	X	X
Ethical Aspects of Monitoring Physicians in Recovery	1	1	X	X	X
Ethics and Regulation of Pain Management	1	1	X	X	X
Fatigue in Physicians	1	1	X	X	X
How to Create and Maintain Life Balance	1	1	X	X	X
Patient Safety and Peer Assistance	1	1	X	X	X
Spirituality and Medicine	1	1	X	X	X
The Art and Science of Happiness	1	1	X	X	X
The Family in Addiction and Recovery	1	1	X	X	X
Tobacco Cessation: Ethics and Strategies	1	1	X	X	X
Women in Medicine: Contributions and Dilemmas	1	1	X	X	X
Aging and Retirement: Practice Dilemmas	2	2		X	X
Challenges: Professional Boundaries and Patient Encounters	2	2		X	X
Coping With Stress and Burnout in Medicine	2	2		X	X
Identification and Intervention for Substance Use Disorders in Physicians	2	2		X	X
Psychiatric Illness and Disruptive Behavior in Physicians	2	2		X	X

Texas Medical Association

Physicians Caring for Texans

Committee on Physician Health and Wellness

Providing Health and Wellness Education for Medical Students

History

The Texas Medical Association House of Delegates established the Committee on Physician Health and Wellness in November 1976. The committee's charge is to "promote healthy lifestyles in Texas physicians and to identify, strongly urge evaluation and treatment of, and review rehabilitation provided to physicians with potentially impairing conditions and impairments." (TMA Bylaws, Section 10.621).

Composed of physicians who are concerned about the health and well-being of their colleagues, the PHW Committee endeavors to provide help and assistance. The function of the committee is three-fold: 1) to promote physician health and well-being, 2) to ensure safe patient care by identifying physicians who may have a potentially impairing illness, and 3) to advocate for the physician while maintaining confidentiality and the highest ethical standards.

Educational Materials

The PHW Committee offers several ongoing courses on a wide range of topics to educate physicians, TMA Alliance members, hospital administrations, and others. PHW activities encourage physicians to promote and maintain their health and wellness, which fosters healthy lifestyles in patients. The PHW Committee is committed to providing ongoing education of all physicians and medical students regarding physician health and wellness as well as services for health-related conditions that may affect a physician's ability to practice medicine with reasonable skill and safety.

Speakers' Bureau

PHW Committee courses can be given upon request as live presentations at meetings of county medical societies, hospitals, and other entities. An administrative fee is charged to offset speaker travel and administrative expenses. To ensure that we can secure a speaker for your program, please make your request at least one month before the scheduled presentation. Contact Sasha Toj at TMA at (800) 880-1300, ext. 1343, sasha.toj@texmed.org for additional information.

Speakers who participate in the PHW Committee's regional education teams are knowledgeable about physician health and wellness issues. The committee offers training annually for new team members, which also serves as a refresher course for other team members.

Services

As advocates, the PHW Committee helps with:

- Intervention;
- Referral for evaluation and treatment, if necessary;
- Monitoring upon return from treatment; and
- **Education** for physicians, family members, and support staff regarding possible impairments.

The PHW Committee seeks to rehabilitate, rather than punish, physicians who are impaired. All referrals made to the committee are confidential — both for the physician who has a potentially impairing illness and for the individual making the referral. The committee is interested in the health and well-being of the physician, patient, and families of all constituents.

Activities

- 24-hour hotline: **(800) 880-1640**
- Continuing medical education programs
- Drug screen program for physicians
- Physician Health and Rehabilitation (PHR) Assistance Fund
- Outreach to medical students and resident physicians
- Hospital/Joint Commission Standard re: Licensed Independent Practitioner Health

A 24-hour toll free number is available that anyone may call if he or she is concerned about a physician who may have a potentially impairing illness.

The PHW Committee provides CME activities on a wide variety of topics related to physician health and well-being. In addition, the committee offers statewide conferences and local workshops each year.

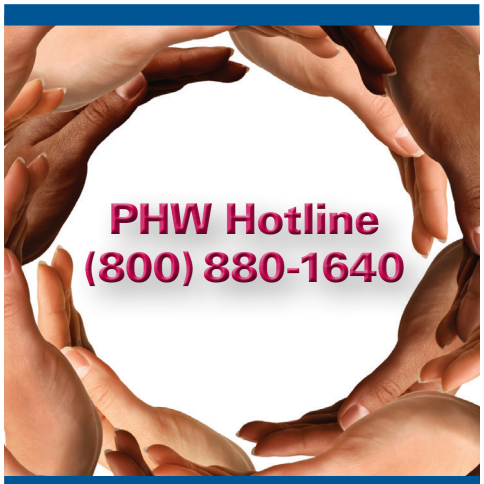
The drug screen program for physicians provides a statewide, consistent method for random drug screening of physicians under agreement with county medical society PHW committees, district coordinators, and hospital-based peer assistance committees.

Through the PHR Assistance Fund, financial assistance is available to physicians who cannot afford treatment for depression, substance use disorders, or other problems. Financial assistance also is available for short-term living expenses while a physician receives treatment. Donations to the fund are appreciated and are tax-deductible.

The committee also offers assistance, education, and literature to help medical students and resident physicians who may know of a peer who needs assistance or who may need assistance themselves.

The PHW Committee developed resources available to hospitals to help them respond to the Joint Commission requirement related to physician health.

Continued on Back Cover



Physicians and medical students may be referred to the TMA PHW Committee 24 hours a day by calling the toll-free hotline number, **(800) 880-1640**. The direct line to committee staff is **(512) 370-1342**.

Table: Recent Statistics

Type	Percentage of Cases
Substance Use Disorders	47%
Depression	9%
Stress/overwork	4%
Disruptive behavior	3%
Cognitive impairment	3%
Physical disabilities	2%
Other psychiatric disorders	32%

(TMA PHW Hotline Calls and Quarterly Reports 2013)

Committee on Physician Health and Wellness
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