In Defense of Difficult Patients

By Bob Keaveney [6]

One woman's declaration of love for her physician shouldn't mean dismissal. Or should it?

Though it's been nearly a decade, I'll never forget my interview with a solo internist in private practice whose little office had become overwhelmed by an off-balance patient who imagined herself part of the practice "family" and sought to ingratiate herself in its regular workings. She would show up almost daily and just hang around trying to keep herself busy.

At first, staff took pity. She was obviously lonely, and seemed harmless. But over time she demanded more attention, becoming particularly enthralled with the physician and turning snappish with any staff who tried to run interference. One day she arrived for a scheduled physical. The doctor's jaw dropped when she saw that the patient had written — on her own stomach, in marker — a declaration of love to the doctor.

Fortunately, most difficult patients are not quite as difficult as the Cookie Lady, but the problem she presented then is as common in American practices as ever, and may be getting worse — if only because physicians have less time and fewer staff. That's why I green-lighted our first-ever cover story this month on the proper way to end a patient relationship, by Aubrey Westgate: "Patient Dismissal: The When, Why, and How."

The physician-patient relationship is voluntary for both sides, and technically the doctor can end it for virtually any (nondiscriminatory) reason. And when your best efforts to get through to a noncompliant or belligerent patient have failed, isn't it better for the patient, and not just for you, that he see someone else? "It's not the patient who's terminated that keeps the doctor up at night," explains risk-management consultant Susan Keane Baker. "It's the one who should have been terminated but wasn't."

Yet physicians must tread carefully, for reasons both ethical and legal. Today's difficult patient can be tomorrow's plaintiff, a fact that argues both for dismissal — and against cavalier dismissal. On the one hand, a properly executed patient discharge can help you avoid a world of legal trouble down the road. Suppose a noncompliant patient develops avoidable complications, and then blames you. A lawsuit may ultimately prove futile but not before turning your life upside down for a few months (or years).

Yet if you dismissed every patient who didn't follow all your instructions, you'd have a lot of mornings free. And a new article by Autumn Fiester in The American Journal of Bioethics has gotten me thinking. The director of the Center for Bioethics at the University of Pennsylvania Medical School argues for a reconsideration of the meaning of "difficult." Too often, physician-patient conflict is blamed on the patient, and is usually explained by "the presence of a psychiatric disorder," Fiester writes. The Cookie Lady would certainly fit that bill, but many other so-called difficult patients are merely reacting to a Byzantine and frustrating healthcare system by which they're feeling mistreated or ignored — often for good reason. Are they reacting constructively? Perhaps not, but they are sick or injured, after all. A bit more empathy would go a long way, Fiester suggests. (She also argues for the deployment of formal mediation processes administered by hospitals' Joint Commission-required ethics resolution offices to deal individually with clinician-patient conflict. That strikes me as a nice idea, but if doctors and nurses had the time for such mediation, there wouldn't be as many angry patients.)

Moreover, an already unhappy person might see a poorly executed discharge as the "last straw" prompting him to seek redress from his friendly neighborhood trial lawyer. Rock, meet hard place. Here's my take: Dismissal should always be a last resort, but when you've tried it all, and the relationship isn't going to work, it's better, and safer, to move on. For both sides. Just do it right.

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