Chapter 13
Treating the Difficult Patient

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Ride tall in the saddle you take more arrows.
John Wayne (maybe).

Introduction

The challenging patient is a fact of life and part of our practice. The clinic that understands the complex issues of dealing with difficult patients and responds to threats appropriately will minimize risks. Risk can come in the form of malpractice claims, board of medicine complaints, Employee Equal Opportunity Commission (EEOC) charges, employee whistle-blowers, and patient allegations that lead to a financial and time drain.

Interventional techniques are sophisticated, medications are complex, and pain medicine involves treating a rainbow of complex patients. We as medical providers love to talk to our "good" patients; patients that are difficult, angry, needy, threatening make us cringe. How do healthcare practitioners navigate through the myriad of ill will thrust our way? Offering the latest treatment is of little value if conflict leads to disciplinary action and poor patient satisfaction.

There are many factors involved in dealing with patients with difficult personalities. Difficult personalities are in the office or hospital, or around the corner. Difficult people thrive on conflict. Land mines are abundant, and government agencies exist for the sole purpose of rendering recourse to the provider or employer that does not give the outlier a good day.

Challenging people may manifest personality disorders that may be ready to erupt. A physician's office is a building of *accommodation* and expected to service

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a broad range of problems and people [1]. Expect conflict. React with appropriate professional integrity, and you will inevitably defer the next stages of drama.

It is the purpose of this chapter to assist the provider with the most difficult part of the medical process—not patient management, but people risk management. Risk management prevents loss of time, money, professional status, and a calm sense of self-being. The ever-changing temperament and conflict that surrounds the daily practice of medicine cannot be avoided, but it can be managed. There are 400 physician suicides a year and underreported death by substance abuse, all preventable and tragic [2]. It is important to keep the issues in perspective and not allow those with personality disorders to ruin the practice of medicine. This chapter strives to be practice-protective and provides strategies to keep the practitioner happy.

Vignette

> Patient—"I've heard about you, people in the waiting room said that you had an attitude. They also complain about your bedside manner. They said you also judge. I am not an addict and you make me feel like an addict. You are rude."

Physician response—Incredibly, common terms are used commonly by difficult people. It seems that the term "rude" is used as an accepted polite way to say that they don't like you and you're not acting their way. This type of interaction is a personal affront. The first response you might have is one of anger and desire to confront. As we shall see, this is not our best approach. We shall see that people act as a reactionary. I'm going to call this behavior based on emotion. Neurobiologically, there are pathways that become altered or diminished in the difficult patient, particularly the patient that is suffering from pain, situational depression, anxiety, reliance on opioids, and other controlled substances (the alprazolam band aid…). Your communication skills are your best defense. For example, you might respond with "I am sorry that you feel that way. I hope to convince you that what you have heard is not accurate and we can establish a fruitful doctor–patient relationship."

Introduction to Communication

> *There is a difference between hearing and listening.*

Communication skills are not an exact science and neither is the practice of medicine. Over the course of the day, the provider is expected to extract a history, define medical decision making, apply a care plan, and then repeat this over and over in the course of a daily practice. The process might involve a minor care issue, or an experience that an individual will consider life altering. The provider is a source of

inspiration and hope, or a point of conflict. All the while, the extraneous factors that include nurses, administration, ancillary personnel, and ever more burdensome regulatory requirements are forever perpetuating a background noise that can't be ignored. The day can be good, or it can be driven by distraction. It all points to the leadership the provider offers and that requires communication skills.

Providers are paid less and less, with the expectation of more skill sets and time given to the practice of medicine. The regulatory burden is relentless, and the paperwork is endless. Patients want a perfect outcome, and, of course, always want to retain the right to litigate if imperfection results in an unforeseeable outcome. Most providers want an uneventful day and rewarding experiences, because a career in medicine should be fulfilled for all. If communication skills are robust, it's odds on that the day will end without consequence. Unfortunately, providers are frequently poorly trained in communication skills. Communication skills, however, are as important as any healing tool the physician has; no laboratories, scans, X-rays are more important.

The physician, or provider, that lacks fundamental communication skills will not be able to manage difficult people and patients. Difficult people often see themselves as ***victims***. They believe their priorities are foremost, and they are posed to retaliate if their immediate needs are not met. There is no more dangerous consequence in medicine, that is of higher risk to the provider and the care environment, than the breakdown of communication between an angry person who perceives themselves as a victim.

Vignette

> Patient—"I'm here because my doctor sent me here. I don't want to be one of those "pain patients." Those people are out for drugs. I'm not here for drugs. I just want to be honest with you; I am a person of religious conviction. It's not that I don't want to give you a urine screen, but I just want to be honest with you. I think honesty is the best policy. My mother was seeing me suffer so she gave me her Percocet."

Provider—It is your unfortunate burden to utilize patient care agreements, extra documentation, and practice-protective language to ensure that there is "no barrier to communication." In other words, these people are sure that you didn't tell them something, or they didn't hear it. They didn't read it, they didn't understand it. They just got what they wanted. The difficult person, or patient, requires a level of documentation, and practice policy that will be known as the *rules*. You or your staff ensure they understand the terminology and received adequate informed consent. It is labor intensive, takes time, but it is worth it [3]. An appropriate response to this patient might be "I understand your concerns regarding the urine drug test, but is a policy for all our patients, and I assure you that you are not being singled out."

Types of People We Meet

Our mothers told us not to judge others and place labels. That is exactly the opposite of how we are trained as medical professionals. The differential diagnosis is full of labels, and ICD-10 has about 150,000 of them. If the ICD-10 defines an injury from a burning water ski (they do; V91.07), then we're all a label waiting to happen. There exists a medical diagnosis for everyone. So it makes sense that having a label is not so bad. The types of people we meet can be described, and labeled, into a few distinguishable types. There may be variants, but generally speaking, patients and people in general don't deviate too far from basic personality foundations.

Personalities

There are four temperaments dating from Hippocrates' day, felt to be present in humans [4]. Hippocrates believed humans humorous. They were felt to be affected by body fluids, behaviors, and their environment. Hippocrates observed human moods, emotions, and behaviors and felt they were caused by excess fluids in the body, thus "bodily humors." These included blood, bile, and phlegm. They were believed to keep a body in balance. Adding on this theme are the four "temperaments" defined by Galen [5].

1. Sanguine
2. Choleric
3. Melancholic
4. Phlegmatic.

The Sanguine is a lively, talkative, pleasure-seeking individual, but flighty. These people are chronically late, forgetful and have trouble with tasks.

Choleric is ego-centric, task-oriented, and strong willed. They often have a strong work ethic.

The Melancholic is introverted and paranoid. They are, however, conscientious trying to get the job done, but unsociable.

The Phlegmatic is retrospective, very private, thoughtful, and pensive. Fast forward through multiple philosophers and generations of pundits, and we have a new generation of personality types.

These are defined by culture, experience, social demand, and the recently unrestrained environment of the Internet and social media.

Personality Disorders Have More Recently Been Defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-5)

Narcissistic Personality Disorder

> *The only difference between you, your employees, and your patients is that your patients are usually Axis II.*

Difficult people understand that you will be working in your comfort zone, by intellect and reason, whereas they are operating on *instincts* and *emotion*. The narcissistic personality is manipulative and demands that you give them what they want, not what they need [6]. This is where you will find a black and white personality that is best handled by policy over policing. Dialectic over confrontation. Communication skills require restraint, because people with this personality disorder desire conflict. Policies avoid these misunderstandings. Most people understand that part of their day has to have something upset, and no day is perfect. The patient with a **narcissistic personality** believes they are never wrong, utopia is right around the corner, and every day should be on their terms.

Many times the narcissistic personality may become more than a neurosis, but a bonafide personality disorder (axis II) and they attempt to transfer their emotional issues to you. They want to draw you into their world and expect a reaction. The narcissist understands that they are best served when they elicit a reaction from you. They will challenge the rules, and anything that exists in the way of their construed expectations. A narcissistic personality will walk into a room and expect to be first and foremost the center of attention and make no distinction between your office and the cocktail party. They are goal-oriented and will insist that all eyes be on them. Not a lot else exists, only their needs (for example, if it is opiates they desire). Some of the most successful, and unsuccessful, people in history have had narcissistic personalities. There is not a person or group that will continually forgive their intrusions and demands, and they will eventually self-destruct.

Borderline Personality

The borderline personality is impulsive and often unable to remain stable when disappointed or refused a desire. The borderline personality is at risk for substance abuse [7]. The narcissist and borderline personality often coexist peacefully with each other within a chronic disease state, such as pain, addiction, and depression. They are rarely observed alone.

Vignette

> Patient—"I really want to thank you for being the world's best doctor. You seem to understand me and we have an understanding that your care model is in my best interest. Thank you so much for getting me that Percocet. Oxycodone of course is the only thing that helps."

Provider—"We have other medications that work better, that are pharmacokinetically more correct, and I don't have to worry about so many side effects. Oh, and that acetaminophen, we have to be careful because you have Hepatitis C."

Patient—"What? You're not going to give me oxycodone? Are you kidding me?" (Escalating voice.) "You are a horrible doctor. I am going to report you to the medical board and I will call my attorney" (borderline).

A Narcissistic personality might say: "I have been diagnosed by several people and have come to the conclusion that I have this condition which can only be managed by oxycodone." As an opioid stress test, you suggest other options. Push back is common, and anger followed by threats is the norm, not the exception.

Solution—The ***narcissistic and borderline personalities*** are individuals who do not understand "no." This is where the concept of ***script*** comes into your daily routine. Staying predictable, you respond "this treatment course is in your best interest and safety." If escalation is occurring, they likely will exhibit their borderline personality. Document and state your course. This is your clinic, and this is how you practice. You are the one that is trained.

Narcissistic and borderline personalities are many things, and from a risk management perspective, they also may be retaliatory. When they feel they are wronged, there must be justice. Some of the successful narcissists find safe haven in a profession, where bold individualism is tolerated, even respected. Professions are replete with narcissists found in medicine, law, and, of course, politics. We've all met them. We all know them. The problem is, when they are a patient, and they are expecting a treatment course, they will not see any other way than their perception, making it your problem. Using the dialectic technique, and reflective interviewing, the narcissist receives what he/she needs, not what they want [8].

An example of reflective interviewing is when the patient asks a question, and you ask the patient that question [9]. "So why do you think you need Percocet?" "Because nothing else works." "What do you mean by work?" "What is your ideal outcome?" "What are your benchmarks at 3, 6, 9, and 12 months?" "Of course there is an exit strategy to opioids, isn't there?" "You don't want to be on these the rest of your life do you?" Let the narcissist believe they are controlling the interview, and confrontations will melt away. Direct confrontation and the fight to nowhere is what the narcissist craves, consciously desired or not, and you have effectively taken it away.

Types of People We Meet and the Concept of Risk Shift

What is the secret to success? Right decisions. How do you make right decisions? Experience. How do you get experience? Wrong decisions.

John Wayne

The concept of credibility and risk shift is real. The everyday reality is that a website, patient, or even an anonymous source creating a rating online has more credibility than the provider. Gone are the days of the highly respected physician rendering advice and the patient (and/or significant other) who nod in agreement and acquiescence. Many are suspicious of our intent and retain the 1980s mind-set that doctors do things to get rich. There is better advice on YouTube® than you are giving. You don't practice in a major metropolitan area where good doctors practice so they need a referral to the big city. "Your online reviews were not very good, you know, and those are always right." Just like Craigslist. Our care is judged the same as a plumber when rated on Angie's list (no offense to plumbers, just an illustration). We meet all kinds and must be agreeable to most, or we're out of business.

Let's start our day.

The Agreeable Type

You must know your enemy. To know your enemy is to also know your friends. The Art of War.

Sun Tzu

Our travels through the Web describe different personalities by cute names or acronyms and provide trite explanations of difficult people, which are dumbed down and not useful. Examples are Angry Andy, Bashful Bob, Gregarious Gary, or whatever. Psychiatrists spend careers trying to figure these people out, and the Web leads us to think that most are benign, when they are not. The personality is a complicated inter-relationship of environment, genetics, life experiences, and emotion—not to mention the personality altered too easily by what medications are consumed. The proliferation of benzodiazepines, antipsychotics, antidepressants, opioids, and sedatives leaves little doubt that a personality is often altered by external influences. Patients are stressed. And in the pain clinic environment, these tones spill over to the front desk, nurses, and even the back office. The entire clinical environment can be caught up in the complexities of a personality that can't be touched, felt, or measured, only experienced. The fact that the provider must control the interview cannot change. Patients are not your friends, and friends are not your patients. The most vulnerable patients feel almost powerless in a clinical environment. So they agree. It's easy and effective. The agreeable patient/person will agree with everything you are saying and have a personal agenda waiting to be released. An agreeable type is often suppressing a personality disorder. There will never be a push back, and they are happy to be overwhelmingly supportive of your

decision making, but plan to do nothing that you recommend. In fact, lurking behind the curtain may even be a "you never told me that" attack. I will be agreeable until you don't suit me. These people will never be loyal or safe.

The Bully

Bullying is a new media favorite. Bullying is a process. These people are rarely dangerous because they're so obvious, and you can protect yourself. The caveat is the potentially explosive personality with poor impulse control, such as those with traumatic brain injuries, or the addict. They are out there and easy to see coming. A bully will impose his/her values on the environment of care, without boundary or restraint. They seek out and manipulate people whom they feel are vulnerable. If a patient, or coworker, feels that you are easily bullied, and you do not have a direct response to their aggressions, the bullying will continue. This is a case where the patient or individual that postures can be called out. Never raise your voice, do not argue. You have more control over your emotions than they do, so you will always own the conversation. A word of warning. The physical bully is another story, and workplace violence is more common than most believe.

Mr./Ms. Negativity

These people are exhausting. You should have very few patients and employees that are always downers. You don't have the energy for these people. They are joy drainers. Reflective conversation and interviewing will keep the time and emotional drivel to a minimum. Reflective interviewing—"what do you mean by that remark?" "You feel everyone is out to get you?" etc. You get it.

Difficult patients are teachers in the value of strong communication skills. They often cannot control their reactions, but want to control yours. They often operate on emotion, and not logic. Many are only happy when you are unhappy. The negative person is ultimately telling you they are unhappy. Once again, they are a victim and you are responsible.

Dealing with Challenging People

People don't care how much you know, until they know how much you care.
Teddy Roosevelt

During the process of communicating, there is input and output. Many patients are just tired of being tired. Whatever problem they have, it is magnified by the fact that

they do not perceive themselves as getting well. Those with a chronic condition often do not believe you are helping them get well, but they understand that you are charging them. Techniques to teach the wellness and keep the positive momentum forward include behavior modification, such as the dialectic technique. A dialectic approach is a standard therapy for solving communication and interview problems. Too often, chronic pain care devolves to a prescription per month plan instead of a real plan. Where are you going to be 3, 6, 9 months from now? These are benchmarks. If they aren't realized, questions should follow.

Vignette

> Provider—"Let's be clear on our benchmarks. I think these are very important. It just doesn't make sense for us to see each other every month to obtain a prescription. Same old story. The frustrations you are experiencing I think are because we haven't clearly outlined our goals."

What to do—This is one of the simplest and most often ignored parts of pain practitioner's daily routine. The provider and patient forget about goals. A goal can be set in months, weeks, or years. It depends on the pathology. That is up to you, and your patients' diagnosis. Clearly, somebody with fibromyalgia will respond to exercise, increasing function, and working on quality-of-life indices such as smoking cessation, weight loss, etc. Benchmarks can be set for those ideals. Somebody with post-laminectomy syndrome may need other solutions, such as interventional procedures, and proper selection of optimized medications. If function is not enhanced, it doesn't make any sense to continue the current course of care. Pain is not an opioid deficiency. If opioids aren't helping, they are an item of risk and we acknowledge the patient's best interest by finding alternative ways to address their pain. This may include adjunctive medication and techniques such as cognitive behavioral therapy [10]. Both are powerful tools that are often underutilized.

Humans add an emotional component to a chronic therapeutic plan. As part of your therapeutic goal, it is necessary to present the premise that you are working with the individual instead of against them. Developing a good dialectic technique is something every provider eventually matures to varying degrees, and these communication skills are the cornerstone to a wellness plan. We would expect a psychiatrist or internist to be very good at this, and the family practice doctor that is taking care of the individual for years to be the best. Some specialties, especially those that heal pain from an anesthesia background, may not be as adept at such techniques. Anesthesiologists will have limited training in long-term emotional management. Remember, some people you can't help. You are there to help heal, not cure.

Communicating—The Pain Chronicles

You're short on ears, and long on mouth.

John Wayne

Challenging people will often hear when you are speaking, but they will not necessarily listen. The active process of listening assumes that the recipient understands. In medicine, this is not always the case. Patients, in particular, are overwhelmed by the clinical environment and the medical experience. To you, it is a daily and repetitive event. Walking into a room, time pressured and efficiency driven, you are often multitasking. Then there's your action. The story is presented to the listener, an expectation of action is assumed by the patient, and you reference your conclusion as a gesture. For example, writing medications is an expected point of reference. The communication that follows is perception of understanding. Often our communication experience is received, and sometimes it is not. Challenging people's expectations are driven by an action. If they don't get what they want, they act on emotion, become demanding, and intimidating the environment of care. You cannot avoid patients that will not cooperate, will not follow medical advice, or will not keep appointments. Patients that are disruptive and abusive to the provider and staff seem to be on the rise. We all have them, so script your response based on logic. Logic trumps emotion. Good communication skills reduce conflict.

Vignette

> Patient—"I called your office six times at least and got no response. I almost went into withdrawal, and I didn't know what to do. I went to the Emergency Room, and they wouldn't give me anything because they said I was under a contract with you. You are negligent, and you don't have good office practices. I don't know how you stay in business."

What to do—In this situation, your communication skills will suppress a progressively angry encounter. Remember every one or two patients that are unhappy with you, will message 10–15 others. It might be in your waiting room, it might be in the community, quite probably posted online. The point is, your best offense is a reflective moment, and to step back. "I see that this is something I may need to look into." "Do you have the names of people that you have talked to in this office?" "I do have somebody that you can talk to and I want to make sure you have that contact information." "Let's make sure you have a good experience here." "Certainly we're all busy, but we are interested in you first and foremost."

Consider the process of transference, defined as unconscious redirection of feelings from one person to another, which is a deficit in personal security and results in one-way communication [11, 12]. Challenging people feel their opinion can only be understood when they are aggressive and posturing. A feeling that control must remain with them, and they feel they are in a position of power.

Particularly in medicine, and especially in pain medicine, personalities can clash. These challenging patients come with the territory. The practice of pain medicine is expected to be a unique and challenging specialty and is a high-risk experience. Often patients come to you exhausted, having seen multiple providers, with multiple encounters, of which many are not good. Patients know that you are suspicious of them, and developing a patient/physician relationship is very difficult when trust is fractured. You are not the primary care physician who cares for a family, or long-term medical need, and, over time, has developed a strong patient/physician relationship. The pain physician is one more roadblock in a series of frustrations to obtain a desired goal—relief, anxiolysis, and ultimately, a prescription. When their wishes are denied, they threaten you because this is their perceived position of controlling their environment. Your patients will believe that they have certain rights, and will conceive retaliation if they do not obtain their medications, or a desired treatment course.

Vignette

> Patient—"I don't care if I tested positive for marijuana. It is legal in some states, and even the Federal government doesn't care. I know this for a fact. I've been to other places where I've had a positive test for marijuana and they didn't care. I've been on these pain medicines for a long time and just because I went out and smoked a little weed don't mean you won't give me my prescription."

Provider—"That is true. In some states marijuana is legal for various reasons." "However, my DEA certificate is a Federal certificate, and marijuana still remains a schedule 1 drug." "That means there is no legitimate use for it." "Someday this may change, as we discover different forms of marijuana that might have medical use." "I understand you take marijuana to help with your pain but we have other options." "I have to know what you're taking." "Smoking marijuana is not FDA approved, or metered." "What I mean by metered is there is no way to tell the dose or quality of what you are getting." "That is not how I want to practice medicine. I think you can understand that. Let's just clean up, I'll go ahead and continue treating you with other options, but please, understand the policies of our practice and our desire to help you. Let's not use illegal drugs."

Patients often tell you what tests to order, what medications to prescribe, make demands for frequent and immediate access to a physician, and define which medications are the only pharmaceuticals they will accept. "Percs, Roxis, that's all I can take." "I can't take anything with acetaminophen. I'm allergic to everything but Percs." "Nothing else really works." "Why change it if you know what works?" The demanding patient will expect the office staff to bend schedules, break rules, abandon established office protocol, and always accommodate them. They will often threaten the practice. Difficult patients are the bane of many physicians' professional existence and try their professional patience, test their limits, and challenge the core ability to provide care.

Patients may also be exhibiting effects from a true life stressor. This includes job loss, economic crisis, and crushing family responsibilities. This makes compliance with the treatment regimen one more burden, and you are the lightning rod. Because, once again, who is the most powerful person in the room? Not you. It's the ***victim***.

Vignette

> Patient—"I've been to a lot of doctors, and they usually help me with my problem. As you know I can't work, I've applied for disability, and if that idiot hadn't left that water spot on the floor I wouldn't have slipped and fell. They owe me. My lawyer and I are going to work on this together."

What to do—Physician—"Yeah, sure I understand your frustration. I understand you are getting angry. But let's think. Has anger ever accomplished anything? No. Actually, thoughtful treatment of your problem will probably help you get better. Let's go through that."

The Victim—The Most Powerful Person in the Room

How can we work with those patients who seem "the victim" without compromising the risk of liability? The victim constantly leads to a strain on the patient/physician relationship. Why do these patients persist on misusing or even abusing the patient/physician relationship? Because to them, every day is like the Jerry Springer Show. Chaotic lifestyles might be a problem, and coping skills may be poor. This victim is a poorly defined DSM V diagnosis, but very real. Acquiescence and compromise has been the response prior to an encounter, and out of fear, most providers do not want a confrontation, and patients know this.

The victim demonstrates manipulative behavior and noncompliance. However, noncompliance is not always a poorly understood mystery. Sometimes misunderstanding is born of ignorance and fear. The victim, however, takes a defiant stand. You are expected to bend.

Vignette

> Patient—"My medication isn't working, and you keep putting me on ones that don't work. I have to take more, and you don't seem to understand that I am running out of medicine because you're giving me junk. I just need my Percocet®, and everything will be fine."

Provider—"We discussed this. I have other tools, and better medications than that medication that has acetaminophen in it, which might hurt your liver. I'm going to help you understand where I'm going with your benchmarks at 3, 6, 9, and 12 months, because we always have an exit strategy with opioids. That means we don't plan on keeping you on opioids forever, it is just one of the options in our bag, but not a long term interest. Let's stay the course."

The physician is expected to be the compassionate provider, to be predictable, and allow policies to be strained. Some patients may want to do exactly what the physician says, but cannot for various reasons, and communication skills are tested. The physician may need to make concessions or compromises, but a definition is required. Is money an issue? Spouse? Internet? Cultural? Any cultural or religious factors that influence their beliefs about the medical problem and potential treatment can strongly influence the decision-making response and a positive outcome. Determine how the patient understands the problem or disease and their interest and ability to participate in their own care.

Vignette

> Provider—"I want you to take your medication four times a day, on a full stomach, and don't forget to take your patch off at three days. Do you understand how that works? That means if you put it on Monday, you will change it on Thursday. Why? Because Monday, Tuesday, and Wednesday are three days, then you change on Thursday …"

Patient—"What?"

Solution—Make a plan. Have your nurse follow you, because you are in a hurry. Most providers don't realize when they walk out of the room, many of the patients don't understand what you just said, and likely forgot most of it. The pharmacists are another point of the treatment triangle, and they'll have all sorts of medication inserts describing a myriad of side effects that no one discussed in the clinic. The patient will only see a little label on the side of a pill bottle that is so small it is hard to read. This is particularly problematic with the elderly, as they often have no idea how to follow your directions unless they are clear, concise and in a common language. You may not be the one to convey this information. It is not a bad idea you have somebody come behind you with a reinforcement of your instructions.

Ode to the Law

The noncompliant patient's communication disruption may be the reason behind why many treatment discussions are not understood, and why more than 2/3 of patients don't take their medicine correctly [13, 14]. Remember the 9-min rule.

The 9-min rule was taught to me by my father. A defense malpractice attorney, he noticed one thing to be a constant. Somewhere around 9 min the risk of an

adverse encounter in the examination room drops. It may be communication; it may be understanding, or just a comfort level. But at about 9 min, the risk of confrontation diminishes. You can use this to your advantage.

Vignette

> Patient—"Young man, my nephew gives me $15 for each one of those pills. That pays for my heart medicine, and helps pay for electricity. You have no right to tell me that what I bought is your business."

Patients may simply not understand their part in the healthcare model. The remaining half of the noncompliant patient population is just noncompliant by choice. A number of patients never fill their original prescription. The chosen medications may be too expensive, or not necessary, but most commonly they don't understand why and what they are taking it for. A common observation is that patients cannot name the medications they are taking, so pharmacy and record checks are mandatory. 40–75 % fail to follow the instructions for taking their medications and 20 % take other people's medication, that is, 1/5 of your patient's sharing pills in the family and community [15, 16].

Diversion

Protecting the community is important. If you suspect misuse, abuse, or diversion in any of your patients, you are concerned about your patient and the community as a whole. With prescription drug overdose deaths currently killing 40 people a day, these drugs require professional vigilance. You are the tip of the pen and as difficult as it is, you must protect the community. Know where your prescribed medications are going and practice robust adherence monitoring.

When patients are noncompliant, the provider is obligated to acknowledge personal and professional limits. You set limits with patients, and strictly adhere to them. It is better to do some things well than to fail by trying to do everything. Know your boundaries and express them.

What Are the Problems? Keeping Your Patients from Becoming "Difficult"

Communication. Your Staff Can Kill You

> *Tomorrow is the most important thing in life. It comes to us very clear at midnight. It's perfect when it arrives and puts itself in our hands. It hopes we learned something from yesterday.*
>
> John Wayne

The most important person in your office is the "go-to" person. Who is that? Often it is the receptionist. A bad interaction with the receptionist, or miscommunication with the receptionist, can result in disastrous consequences. Errors can spill over into the ring of adverse legal considerations. The patient often does not understand the seriousness of their condition. The communication void might be one of vocabulary, denial, or lack of physician emphasis and understanding. The patient often forgets verbal instructions, and tense patients are likely to misunderstand most of the visit and instructions. Others may feel intimidated and fail to ask questions that arise during the discussion. Remember, providers in the environment of care can be intimidating. The reason for failure to take medication might be simple reluctance, such as the World War II generation that doesn't want to "get hooked," or "I can bear the pain" crowd, while others are just plain afraid of the unknown. The receptionist is the first and last person a patient will talk to. Commonly, they will be the telephone voice of reassurance or concern. An untrained front desk person can devolve a repairable conflict to disaster. A good communicator, can, and does, reduce conflict before it starts.

Why Can't Our Patients Be More Responsible?

The No-Show

The no-show does not value the time commitment of a patient encounter and the stretched resources of a physician's office. A purposeful no-show is unacceptable and represents a form of noncompliance to treatment. Therefore, it is incumbent upon the provider to understand if the patient did not remember, if they got what they wanted by phone, or if you and/or your staff just made them mad and they are acting out. It is best to have a policy about the no-show, such as charging for a no-show. All fees are laid out and understood in a document at the initiation of such a policy, with no barrier to communication. No shows are complex.

Vignette

> Patient—"Why are you discharging me just because I've missed a couple of appointments? I called the office, I've talked to everybody, and I know you can't do this to me. I need my medicine, you can't just drop me."

Physician—"You've missed three appointments in a row, and we have no record that you called to let us know your whereabouts or the reason you missed the appointment. This is an enormous drain of clinic resources, and we have no other alternative."

Patient—"I'll Sue You."

What to do—Policies need to be in place to explain to the patient, with no barrier to communication that no shows can't be tolerated. Certainly calling ahead, with 24-h notice, should be documented in the care plan. Confirming appointments 24 h in advance by staff is also recommended, but is labor intensive and not always practical. If it is not and there is no record that the patient called in, you have to use your professional judgment. It also is about your relationship with the patient. The disease state may matter. Be cautious at discharge, particularly for now shows. Beware of abandonment. Understand the patient's personality and communicate clearly. Document your decisions. Discuss this with an attorney, your medical society, even your medical board.

Most likely, the difficult patient is angry at, or depressed about, the chronic condition that necessitates a visit or treatment. The patient may not feel comfortable with the physician or the treatment plan of action. Those with chronic illness often long to be "normal." They tire of treatment that reminds them of weakness, failing health, the stigma of a condition, or even mortality. A patient who feels that you are a disengaged provider is unlikely to share his or her concerns. Those that explain little, exhibit no interest or empathy, or belittle complaints are often the reason behind treatment failure. Refusal to follow a course of care may be as simple as denial, or it might be as complex as a death wish.

Secondary gain is always consideration with a noncompliant patient, conscious or not. It is fueled by an external motivator and seen in many diseases, not just chronic pain. Most frequently, however, blatant noncompliance is about miscommunication. The patient and the physician have differing expectations or goals for prescribed treatment, the action step of the encounter. The physician may simply want improvement, whereas the patient expects a cure. The result is divergent thoughts and a course of care that leads to an unlikely growth and understanding on both sides.

Why Don't They Take My Medicine Correctly?

Most often, the patient finds a drug or treatment regimen too complex. Understanding a complex treatment regimen is not as intuitive as we might think. Patients often take multiple medications, at different hours. Directions are daunting, some require an empty stomach, and others required to be accompanied by food, and the ever-present risk of drug interactions spelled out in microwords given to them by pharmacists that don't truly reflect reality. The insert for a well-known sleep aid states "may cause drowsiness." All medicines cause "headaches." Some just cannot afford that pill and ask for generics—"just give me my Lorcet plus." With many prescriptions now costing over $100, patients are at risk to avoid the medications they need.

Vignette

> Patient—"I know what's right for my body, and you don't know the pain that I have. If you understood you wouldn't be saying these things. I know I have rights and I have a patient advocate. That's me!"
>
> Well the problem is, I didn't understand what you said last visit. You said I take my what how many times a day and the other one with food or what? I didn't understand. I found that I was sleepy all day long, and I am glad that you helped me understand why I shouldn't be taking my Diazepam with my Gabapentin and Hydrocodone, but I do need my migraine medicine, that one I call the Barbie doll pill (barbiturate).

Others just forget. Patients who are tense in a physician's office are likely to forget most of what is said. This is where written instructions are so important. Clearly written instructions, in simple language, are recommended to accompany oral instructions.

There are cultural influences as well. People may also have religious and cultural beliefs that prohibit a certain treatment or medication. We all know that some religious belief systems refuse blood or blood products, such as Jehovah's Witness. Others reject immunizations. A few refuse antibiotics. Usually, everybody, however, loves oxycodone. The list goes on. These beliefs are not mere adjuncts to a person's life, and they often lie at the person's very sole. If treatment is to be successful, these beliefs need to be explored, understood, and to the extent possible accommodated.

Benchmarks

Clinicians also have to know where they are now in a natural history of disease, and where the direction will be in the future. These are benchmarks, or a proficient forward timeline of management. Often, pain management consists of repetitive visits for reevaluation and medication renewal, with no clear understanding of a plan. It is important to know these benchmarks at 3, 6, 9, and 12 months. If benchmarks fail, understand why these benchmarks were not obtained and respond accordingly.

Vignette

> Physician—"So let's try this. I want you to write down 10 goals for me, put it on your refrigerator, and make them reasonable. We will look at them at 3, 6, 9, and 12 months. We will probably amend them as you reach your benchmark, but think like this."

Patient—"I know I can walk 200 yards three times a week, and I bet I can get up to ¼ mile at the high school's track by 3 months. I can also cut my calories by at least desserts and pizzas. I think I can do this."

Non-payment of Bills

Difficult patients who expect free care may need to be terminated from the practice. Before taking this step, however, the practice needs to consider the underlying issue regarding this noncompliance, and determine whether there are extenuating circumstances that make it difficult for a patient to meet his or her financial responsibilities. Some of the factors that may cause a patient not to pay a medical bill are job layoff, termination of unemployment benefits, illness, death of a family member, and even depression.

Vignette

> Patient—"I don't know how to tell you any differently. I just don't like what I'm doing. I don't want an injection, and I don't think these medicines are helping me. The only thing that seems to help is my Oxycodone, and I've never misused or abused it. I am just being honest." (The patient is behind on your bill.)

Risk Management Suggestions

Set up a payment schedule that is workable for the patient and ensures the payment of a certain amount of money on a regular basis. Patients who do not pay anything for a service devalue that service, while some form of payment ensures patient "buy in" to your treatment. From a risk management perspective, the physician would be wise to post billing practices in a visible location and let patients know at the time of the first visit how they are expected to handle bills, including co-payments. Continue to see the patient who is making good-faith efforts to pay a bill, or who has a reasonable excuse for not doing so, at least temporarily. Consider referring the patient who makes no effort to pay to a collection agency. These solutions, however, are inefficient and expensive options. If the contracted collection agency's policies are not known by you and deemed unscrupulous, the provider will carry the burden. Consider terminating the professional relationship with the patient who is a chronic or persistent non-payer.

Vignette

> Physician—"I'm not going to be able to see you if we don't resolve the financial issues here. This will be our last visit. I don't think you should have a prescription until you pay your bill, and I think you should be more responsible. You are taking time out of my schedule, and I know you don't get your milk and bread for free. Your car had gasoline put

in it, and I see that pack of cigarettes. Can't you make proper choices?" (Communication disaster!)

An office manager, or someone from the billing department, would be the person that suggests, in a positive manner, that they will work with the patient and try to find out if there is an underlying reason and examine financial stressors. Threatening to withhold care based on financial concerns is construed as a form of abandonment [17].

Managed Care Adds Complications—Discharging the Patient Part 1

Some contracts make it difficult to discharge patients, even troublesome ones. An insurance panel may limit a physician's ability to act unilaterally. You could be in violation of your contract, unless you check with the plan and its protocol for discharging troubled patients. In order to determine whether you are able to discharge assigned patients, someone in your organization must read the contract carefully. For example, what form of notice you must give to the patient, and what in-office discharge policies do you have. In most cases, a patient can break the contract at will, simply by not returning to the doctor's office. Unfortunately, it isn't as easy for a physician to show a patient to the door. Care must be utilized when you discharge a patient from your practice to avoid accusations of abandonment or discrimination, which can lead to a complicated legal fight. All said, no doctor has to subject themselves to abusive or threatening behavior by patients. With traditional fees for service and governmental insurance, a physician can dismiss almost any patient as long as he/she provides [18] adequate notice [1] helps the patient find another physician and [2] doesn't stop caring for that person in the midst of a medical crisis. Most plans require that a physician accept all patients who choose him/her from the plan, and many want to be contacted before a doctor dismisses them or does not accept a patient. Try to limit the problem. Patients may be overwhelmed by a multitasked treatment regimen. Let the difficult patient know the professional relationship will be terminated if unacceptable behavior persists. Consider terminating the professional relationship with the patient who disregards the physician's advice and/or abuses the professional relationship. Help the patient solve the problem. However, tempting, but not helpful, is offering an immediate solution to the problem identified by the patient. Don't just give in. Patients who assume an active role in their healthcare planning are more invested in the treatment plan and have better outcomes than those who are simply told what to do. In the case of a very challenging patient, you may want to follow a standard risk management protocol for terminating a professional relationship. It is wise to ask your medical board or medical society how to proceed, apply appropriate recommendations, or even obtain legal counsel. Most importantly, if you do decide to

discharge a patient, document it in the record with a letter that has been sent by certified mail. Document any refusal to accept the certified letter as well.

Beware of Abandonment

Document all indications of noncompliance on the part of the patient. Establishing a pattern of "contributory negligence" can be extremely important in a malpractice or abandonment claim. Explain why you cannot care for him/her. Give him/her 30 days to find a new physician and provide resources for finding an appropriate specialty physician of patient need, such as an addictionologist. Suggest you will send his/her records to the new provider with a properly executed release and meet any emergency needs he/she might develop during that time. Remember, chronic pain is not necessariily an emergency. Proper recognition of the potential for withdrawal should be considered, but if a patient is misusing or abusing medications, particularly when diversion is identified, the physician has no obligation to continue medications. Referral to services for withdrawal or developing a medication protocol to limit withdrawal symptoms is recommended. Suggest that he/she go to an emergency department if, after one month, he/she has not found a new physician. Remember, once again, chronic pain is not an emergency.

Vignette

> Patient—"You aren't giving me what I need. I want the Oxycodone because that's the only thing that works, you are my doctor and you should take the responsibility to see that your patients get what they need. I shouldn't have to go through this, and you're abusing me. I am going to turn you over to the Better Business Bureau, the Medical Board, and tell my doctor that you have a terrible bedside manner. If I don't get these medicines, I'm going to go through withdrawal and if I have a problem I'm going to sue you for damage."

Solution—Empathize with the situation. Try to reason, explain your position and educate the patient. It is always about communication. Do not be intimidated by the threat of a law suit. Do document what is medically justified. Termination should be reserved for patients who are not at a critical point in their treatment and beware of the protected class.

Discrimination—Discharging the Patient Part 2

A physician's office is a place of public accommodation and subject to state and educate the patient. It is always about communication. Do not be intimidated by the threat of a law suit. Do document what is medically justified. Termination should be

reserved for patients who are not at a critical point in their treatment and beware of the protected class.

Discrimination—Discharging the Patient Part 2

A physician's office is a place of public accommodation and subject to state and federal civil rights laws. The American Medical Association's position is that a physician may not decline to accept patients because of sex, color, creed, race, religion, disability, ethnic origin, national origin, sexual orientation, age, or any other basis that would constitute *invidious discrimination* [19]. Physicians cannot refuse to see a patient who is protected by law against discrimination.

Violence in the Workplace

> Patient—"Pain medicines are our right. I'm in pain"

Response—Incorrect. Do not enter into an argument with the patient or family. If a patient becomes threatening, suggesting physical violence. Try to calm him/her and try to reason with them. Attempt to isolate the individual (it may be someone other than the patient) to prevent injury to staff and other patients. Do not hesitate to summon police when necessary.

Boundaries

Your office should have in place appropriate documentation of what boundaries are. This avoids potential for law suits relating to harassment, patient boundary violations, and misunderstandings among staff and patients. Education is mandatory, and policies are defined in the employee handbook.

Vignette

> Patient—Medical board complaint. "He was in the room and when examining me, he touched me there. I was horrified. I was so scared I didn't move."

Even the implied boundary violation requires an immediate investigation and response. Take these very seriously as it is not always possible that a nurse accompanies the provider into the room, and if a patient has an agenda, this type of complaint is bound to register a response. Your quick response and documentation can reduce, but maybe not eliminate, the potential for a media circus, an

investigation, or even legal concerns. It is protective, however. Obtain immediate legal advice.

How to Handle a Complaint

Complaints come with the territory. We are dealing with controlled substances, and people that act on emotion, and not logic. People come to us with problems, are the victim, and captivated by their class. This is a perfect environment for complaints. There is a right way and a wrong way to handle complaints. Remember, you are in control, do not let the environment control you.

The Board Complaint

A board complaint is a process. It is not an indictment of your personal and professional existence. It is the board's responsibility to protect the community and maintain knowledge that a practitioner is providing care within standard. It is not personal. It may seem like it, but it is not. Most states allow a period of time for you to respond to these board complaints and take that seriously. A timely response is a reflection of confidence. If you are practicing within the community standard, you have nothing to worry about. You don't necessarily have to go talk to a lawyer. Develop an organized approach to resolution. Keep it simple. They just want the facts. So, make sure the medical record is complete and tells the right story. This does not mean you change one word in the medical record. If an addendum needs to be made, it is done with an explanation. Altering the medical record with this scenario will implicate you. There is no need to do it. Most medical boards just want to see the story, follow your medical decision-making, and that's it. Your records should be neat and well organized. You might place them in a 3-ring binder with tabs to each section, emphasizing your progress notes as your clinical story. Occasionally, it is worthwhile to have another member of the staff, such as your nurse, or someone in the know, to include a paragraph with their interpretation of the complaint. Ironically, very good pain doctors have quite a few board complaints. They are doing the right things for the right reasons, and patients, reacting out of emotion and not logic, retaliate.

The Digital Environment

Nowhere is it easier to complain about a provider than on the Internet. These complaints are anonymous, and the companies that claim to be responsible rating services are relying on drama to get the advertising revenue. Under certain

circumstances, with great effort, the complaint can be managed, but it's not necessarily bad that you have complaints on the Internet. Most people that read these reports can see through those complaints as retaliatory, anonymous, faceless, and inappropriate. You may have to, from time to time, discuss a complaint with a patient. Rarely is it so that a new or existing patient will drop you because of complaints on the Internet. They know you. Be consistent, professional, and predictable.

I Am Going to Sue You

Patients want perfect care, infallible, and the right to sue. It is a one-way street, and we carry insurance for this. If you are threatened, and you believe a patient will truly initiate a legal challenge, notify your insurance carrier. Let them handle it from there and do not engage the patient. This is what insurance companies are for; this is what you pay them for.

Conclusion

We chose pain medicine as a profession because it is rewarding, a progressive specialty in a rapidly changing medical landscape. Pain medicine requires vigilance, patience, and strong communication skills. A good pain medicine provider convinces the patient that the light at the end of the tunnel isn't a truck. We all have our issues, and during our professional existence, it is the rare individual that remains unscathed, with a smile on their face and a song in their heart saying "I enjoyed every minute of it." Most all of us will agree, we have encountered many challenging work and patient problems and didn't always know how to respond to them. It's not a perfect world.

You need a tough skin to practice pain medicine these days. If you have a problem, a board complaint, or you get greedy and just don't see why you're doing this, think again. If you are at the depths of frustration, despair, even depression, reflect on what you are. You are of value to society, and this is a high-quality career choice. Whatever the challenge or obstacle, get over it. Whatever it was, get over it. If you need help, get help, but they will tell you the same thing. Get over it. Move on and continue to be the valued member of the society that you are.

Remember, challenging patients and people want to pull you into their world. It is your professional responsibility to maintain your world, predictable, and professional. Finally, you can fix about anything by remembering these three words: Bless her heart. No matter what it was, the problem will roll off your shoulder when you look at these difficult people and you love them where they're at. Set your boundaries, balance your life, and let difficult people live their life without intruding

on yours. Don't forget those that love you. Pet your dog. Get a hobby. Take care of your health. Medicine is a job. It's not a life. Bless their hearts.

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