Legal Corner

The Difficult Patient

Have you ever had a patient with open disdain for his oncologist that increased with each visit; who was offended by the physician's expression of concern, when what he wanted was cheering up? How about the patient who flung furniture around the office in a fit of rage? Or the pseudoexpert who continually lectured staff about their professional shortcomings in providing cancer care?

These incidents may sound like hypothetical examples from a hospital seminar, but they are not. They are case histories from oncology practices across the country. And, if anecdotal reports in the medical literature are any indication, the problem of angry and disruptive patient behavior appears to be worsening.

Why the discord in cancer care? Margaret Backman, PhD, a New York psychologist and author of the book, *The Psychology of the Physically Ill Patient: A Clinician's Guide*,¹ said misconceptions between oncologists and patients are common, and they can cause conflicts. For example, she has worked with women who were fretting about disfigurement or scarring from surgery, but who were reluctant to address those concerns because the oncologist seemed focused on treatment success.

Journals as diverse as *Social Science in Medicine* and *Qualitative Health Research* suggest additional possibilities for doctor-patient conflicts. The former, in a 2003 survey, revealed that patient distrust had increased along with the growth of managed care. The latter journal, in a 2006 report, showed that patients with terminal cancer who were considered "cranky" by nurses became more cantankerous as the disease progressed.

A cancer diagnosis almost always is psychologically stressful, the treatment can be disruptive—requiring changes in daily living and causing adverse effects—and cancer often is a chronic condition. Patients may spend a lot of their time feeling unhealthy, and the mental and physical toll on them can be enormous. "It takes extra patience," noted Patricia Legant, MD, an oncologist who practices in Salt Lake City, Utah.

Perhaps even the array of treatment decisions creates more room for misunderstanding. Sara J. Knight, PhD, is coauthor of a 2005 study in *Health Psychology*,² detailing how men recently diagnosed with prostate cancer perceive their therapeutic options. The physicians for these patients felt that they generally shared the same views on treatment. However,

it turned out that the urologists often were wrong about their patients' opinions.

This doesn't mean either party was to blame. "There ought to be better methods for assessing patient preferences," said Dr Knight, who works at the Veterans' Affairs Medical Center in San Francisco, California.

Dr Legant cautioned that even if the line for acceptable behavior is more elastic in oncology than it may be in other practice settings, at some point, certain behaviors become unacceptable. "If a patient no-shows eight times, despite encouragement, it may be time to fire them."

At that point, it is both too expensive and too legally risky to retain responsibility for their care, she suggested. "We call any patient that doesn't show up for their appointment. If we fail to reach them after a couple of tries, we send a postcard. If there's still no answer and the patient has an illness that requires medical follow-up, we send a certified letter urging them to seek medical attention elsewhere."

Dropping a patient from practice is a serious act, but for patients with cancer, it can be a necessary one, agreed Mark Hiepler, an attorney who specializes in patient-advocacy litigation in southern California. Commitment to treatment is essential and a string of skipped office visits constitutes the kind of noncompliance that may require termination, he said, but cautioned: "What you want to do is to present the situation in a way that is the opposite of abandonment."

"First, you need to have a full disclosure of the circumstances" that led to the decision, he advised. "It is a good idea to get the patient to acknowledge that," he said, adding that any opportunity to put such information in writing ought to be taken: that paper trail contributes to legal protection.

No patient ever should be turned away without a referral to another doctor. In fact, the patient should be given the names of several of them, preferably a group of oncologists, as many as possible, he said. This may be unrealistic for patients in rural areas, however. This is particularly true of a patient who behaves irrationally or with hostility, and who lacks social support, he added. Frequently, they are the people who vent anger through litigation, and "their story will be coming with one voice to an attorney," he said.

That advice also can be found in the legal text, *Problems in Health Care Law*,³ which warns that a physician who

discontinues care before the relationship is legally terminated can be liable for abandonment.

Dr Legant cited another problem facing oncologists: what to do with patients who fail to pay their share of insurance, especially when they seem to have the resources to do so. In contrast to other specialties that perhaps deal with less life-threatening illnesses, it is difficult to turn away a cancer patient for financial reasons, she said.

It is just better “to suck it up,” Hiepler said. “After all, how does it look to refuse to continue treatment on that basis? Somewhere between not good and totally heartless,” he observed.

If there is a way to prevent troubling patient behavior, it may lie in identifying those at risk for it, by testing for stress levels—and by putting the patients with high scores into a support system, according to several studies.

Fifteen years ago, investigators at the Royal Marsden Hospital in Surrey, England, showed that patients who were diagnosed with cancer and received psychological counseling showed better coping skills than those who didn’t get such

intervention. More recent investigations have indicated that psychological support serves as a kind of pressure valve during treatment, deflating the duress that can build up. Participation in cancer support groups help mitigate the feelings of isolation and anxiety that can make patients difficult to treat.

Of course, it isn’t just patients who are under stress. A century ago, the term doctors’ disease was coined to reflect a professional malady suffered by physicians, whose job tension resulted in a poor physical state. Back in those days, doctors were advised to consider such an ailment an adverse effect for a life well spent—as privileged healers.

“Make it a rule never to be angry at anything a sick man says or does to you,” urged Benjamin Rush, MD, who confessed to being tempted to give in to his own patient-directed ire at times. “Sickness often adds to the natural ability of the ability of the temper,” he explained. “We therefore (need) to bear the reproaches of our patients with meekness and silence.”

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