



# WisconsinRisk

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## Risk Management Strategies for maintaining an effective provider/patient relationship

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Whether it is a physician, nurse, physical therapist or social worker, health care providers of every kind will sometimes have patients on their service with personality's traits one might classify as dysfunctional and that have the potential to impact the quality of the relationship. Some providers might label such patients as difficult or disruptive and choose to terminate them from their practice. As healthcare moves to being more transparent and patients are encouraged to be more engaged, providers may also experience more patients who from their perspective, go beyond engaged to assertive or demanding of care that is unsupported by good clinical judgment. Also as patients become more aware of options for screening, testing, procedures, and medications, discussing treatment options and managing patient expectations might require more time, patience and a change in how one defines "difficult".

*While it is important for patients to be provided written instructions and educational resources it is equally important to make sure patients grasp the important elements of the information given them.*

Patient-centered care strives to ensure that all patients have timely access to quality care that reflects their values and preferences. In 2001, the Institute of Medicine (IOM), in *Crossing the Quality Chasm: A New Health System for the 21st Century*, recognized those attributes and identified patient-centered care as one of six interrelated aims of quality healthcare, broadly defining the concept as care that is respectful of and responsive to individual patient preferences, needs, and values and ensures that patient values guide all clinical decisions. (IOM) While health care grapples with how best to achieve patient-centered care and patients are becoming more involved in health care decisions the burden for successful provider-patient communication continues to lie with the provider. This is not to imply that patients don't have any responsibility, but society and the courts have deemed that providers have the ultimate responsibility for initiating, facilitating, clarifying, documenting, and reinforcing discussions related to their patient's condition, treatment, and prognosis.

The focus of this article is not to address all of the intricacies or elements of developing a patient-centered practice but to suggest some communication and documentation strategies to enhance the provider / patient relationships and mitigate adversarial relationships; and if necessary how to deal with a non-compliant patient.

Despite the abundance of clinical practice guidelines and information available, many healthcare decisions that patients must make involve interventions for which there is no universal agreement. Thus providers have the challenge of not only identifying which patients want to be actively involved in managing their care but also knowing what information is important to their patient. The process of shared decision making is a collaborative process in which a provider communicates to the patient personalized information about treatment options and outcomes, taking into account the best scientific evidence available, including the scientific uncertainties of available treatment options.

#### **References**

- AMA Foundation, *Removing Barriers to Better, Safer Care*; 2007
- Bender A, et al; *Communicating with Patients*; Forum, December 2000
- ECRI Institute, *Patient-Centered Care*, Healthcare Risk Control, November 2012
- ECRI Institute, *Patient Satisfaction*, Healthcare Risk Control, May 2013



Patients that arrive for appointments with internet forms, such as “Ask-me-Three” ([www.npsf.org/askme3](http://www.npsf.org/askme3)) or “How's your Health,” ([www.howsyourhealth.org](http://www.howsyourhealth.org)) can generally be classified as patients who want to be actively involved in decisions about their care. However, the anxious patient who asks for something that they have heard or read about, e.g., an MRI after a negative mammogram, may or may not be a patient who wants to be actively involved in decisions about their care. And many patients and providers are still accustomed to the tradition of “doctor knows best,” which relegates patients to a passive role. Patients may need to be encouraged to tell their providers what is important to them. All of these patient “types” need to be empowered by their providers to ask questions and express their feelings and made to feel that they can do so in a safe environment that is open to their voices and concerns. At the same time as a provider you need to use your clinical judgment to provide advice and treatment options. Incorporating evidence based decision aids (online, paper, and/or video) into your practice can help patients understand treatment options. A 14 minute video *Coaching Patients for Effective Self-Management* is available from the California Healthcare Foundation [www.chcf.org](http://www.chcf.org).

Unfortunately, at times providers and patients will differ on the expectations they hold for one another. Collaborative goal setting is a way to connect the clinical concerns and treatment planning of the provider to the priorities and preferences of the patient. Goal setting helps patients and families know what to expect. A goal for a simple treatment plan may be to have the patient perform self-monitoring and keep a daily log of blood glucose or blood pressure. Tools to assist providers with complex treatment plan goal setting are available at *Partnering in Self-Management Support: A Toolkit for Clinicians*. [www.innovations.ahrq.gov/content.aspx?id=3158](http://www.innovations.ahrq.gov/content.aspx?id=3158). From a risk management perspective we encourage providers to keep copies of patient self-management logs and records.

While it is important for patients to be provided written instructions and educational resources it is equally important to make sure patients grasp the important elements of the information given them. Successful education can improve healthcare outcomes, reduce hospital readmissions, and improve patient and family satisfaction. Use of communication techniques, such as “Teach-back” is one way to confirm that you have explained to the patient what they need to know in a manner that the patient understands. “Teach-back” resources are available at [www.nchealthliteracy.org/toolkit/tool5.pdf](http://www.nchealthliteracy.org/toolkit/tool5.pdf).

Patient noncompliance can take a variety of forms. Frequently, it presents as an obstinate unwillingness to adhere to a recommended course of therapy, exemplified by repeatedly missing appointments, rejecting obvious diagnoses and standard treatment recommendations, and refusing to follow through with consultations or take prescribed medications. It may also be expressed through disregard for practice rules, non-payment of bills or unwillingness to provide vital information.

Chronic noncompliance typically reflects a patient's refusal to take responsibility for his or her own care. It can be distinguished from a simple difference of opinion between patient and provider in that it is often accompanied by manipulateness and an inclination to blame others. When dealing with uncooperative patients, even basic expectations must be articulated and clarified. Standardized educational materials, appointment reminders, and other teaching and decision aids can help foster a better rapport with noncompliant patients. That said, it is also important to remember that there may be other causes of noncompliance such as financial issues, problems with transportation or domestic violence. And the patient may be hesitant to discuss these unless prompted in an appropriate manner and setting.

Providers should document a patient's actions to follow advice, take medications, obtain requested diagnostic studies, keep an appointment with a consultant, or other actions that patient takes or fails to take that could cause or contribute to an injury or delay in resolution of a medical problem. Provider documentation should objectively represent what the provider recommended and patient did or said. Documentation should also include discharge and follow up instructions, or education about the use of medications.

The following documentation examples are more objective with the italicized text included: “patient and husband refuse internal fetal monitor; *limitation on our ability to identify fetal distress emphasized;*” “patient refuses hospitalization and surgery; *patient and wife informed of risks of surgery delay, including sudden death;*” “patient says he often forgets to take HTN meds; *gave him written time/dose schedule for all drugs and discussed dangers of not taking all as ordered;*” “patient refuses breast exam, says her GYN will do it next month; *I stressed urgency of prompt evaluation of lump she said she felt.*”

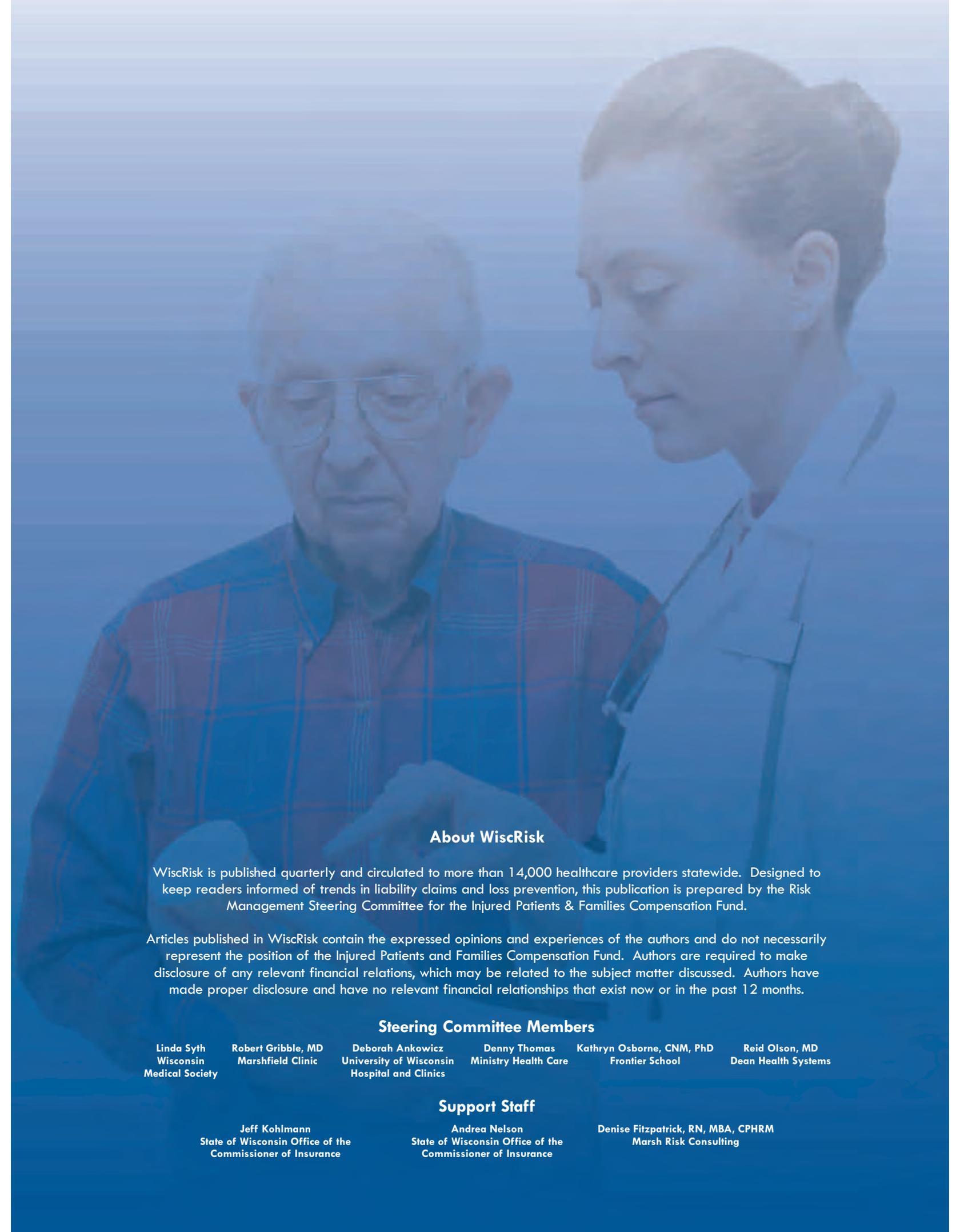
Occasionally, written reminders fail to improve compliance and it becomes necessary to schedule a face-to-face discussion between patient and provider in which each side's concerns can be voiced. Prior to holding such meetings we recommend providers review the medical record and plan for these discussions, consider having another member of the practice participate in the meeting, and document the meeting in the patients' medical record. We also suggest including a patient's family member, significant other or friend, when appropriate, in these discussions as a support person and resource to the patient.

If it becomes necessary to communicate with noncompliant patients by letter we suggest the following risk management strategies:

- Send the letter by certified mail and place a copy in the patient's medical record.
- Notify the patient's health insurance plan (if applicable) by copying the member/beneficiary services department on the correspondence. Inform the health plan that you are caring for a noncompliant patient, who may require referral to another panel provider if the behavior fails to improve.
- Be accessible to the patient, and provide instructions for contacting the office to reschedule or otherwise rectify the situation.

Some situations when practices should consider termination of the physician-patient relationship were discussed in the Spring 2011 issue of WiscRisk. In that issue we also provided elements that should be include in a formal termination process as well as required aspects to include in the written letter of termination notification. For an electronic copy of the Spring 2011 issue of WiscRisk send an email to [denise.m.fitzpatrick@marsh.com](mailto:denise.m.fitzpatrick@marsh.com). A sample termination letter is available on the Wisconsin Medical Society web site at [www.wisconsinmedicalsociety.org](http://www.wisconsinmedicalsociety.org).

Establishing a mutually agreeable level of participation and collaboration for diagnosis and treatment planning is the infrastructure for patient compliance. Developing and confirming reasonable expectations for outcome of pending treatment at the outset of that treatment enhances the ability of both parties to address disappointing results in a cooperative, rather than an adversarial manner.



## About WiscRisk

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