On November 30, 2005, Randolph W. Evans, MD, a neurologist in private practice in Houston, saw something in *The New York Times* that made him indignant for the sake of his profession. It was an article provocatively titled, “When the Doctor is in but You Wish He Weren’t,” in which patients described their physicians as “arrogant or dismissive,” “impatient, with his hand on the doorknob,” “patronizing” or “callous and judgmental.” He read the accounts of several patients who said their doctors refused to tell them what the diagnosis was, made rude assumptions about their lives, or gave them the impression that they had no time to listen to them.

Dr. Evans says it’s not uncommon for patients to complain about their physicians, and sometimes they are perfectly justified to do so. But he began to think about how often he sees disparaging stories about physicians’ mannerisms in both the mainstream media and in physician publications, and how rarely he sees anything said about the sorts of complaints clinicians have about their patients. Like most physicians, he has his share of anecdotes about patients’ antics. Curious to learn the most common grievances among his colleagues, he decided to investigate, administering a 30-point questionnaire to 191 physicians who attended the Texas Neurological Society’s Winter Conference in Austin in February 2006.

The answers from the 78 neurologists who responded indicated several patient behaviors that they found bothersome, including patients who either did not show up for their appointments or were late; who are not compliant with the physician’s instructions; who are verbally abusive to staffers or the physician; who take phone calls in the middle of the office visit; and unnecessary phone calls made to the physician’s home from patients as well as their friends and family members. “Their behaviors may not only impact the neurologist, they may be deleterious to the patient’s health care,” says Dr. Evans.

Respondents also provided examples of the unnecessary phone calls they received after hours, and comments about other grievances; these are included in the appendices to “A Survey of Neurologists on Bothersome Patient Behaviors,” available online at www.medscape.com/viewarticle/546878.

While this was a small study and the questionnaire was far from exhaustive, it provides an interesting snapshot of the real-world problems that no amount of medical training can prepare...
a practitioner for. There is simply a dearth of data on these matters and little guidance beyond the physician’s gut instinct on how to treat rude, disruptive or even abusive conduct. Indeed, one of the respondents commented that there is often a state medical board toll-free number for patients to call to complain about physicians, but nothing similar for physicians to call to complain about patients. In this article, we’ll look at how some practicing clinicians deal with these problems.

The No-Show Blues
Whether your schedule is booked for months in advance or if you have room to squeeze in new patients on short notice, no one appreciates it when the patient does not show up despite receiving reminders such as confirmatory phone calls and postcards. “Some people just don’t care,” says Dr. Evans. “And most of the time there’s no penalty for those who don’t show up.”

Dr. Evans says physicians often debate how to handle this problem,
Bothersome Patients

and some make it a policy to charge the absent patient anyway. One survey respondent suggested the patient’s insurance should still pay if the patient does not show up. However, Dr. Evans says that’s unlikely. “We have enough trouble getting payment from the patients who do show up,” he says.

Although physicians may be annoyed by patients who arrive late for their appointment, Dr. Evans says patients frequently complain about the amount of time they spend in the waiting room or the examining room waiting to be seen. “Being on time is important, but it’s not the most important thing to us,” he says. “For us, the most important thing is delivering the best health care possible, and sometimes that will mean spending more time with a particular patient” at the expense of others.

Sometimes the delays may be caused by an emergency situation where the patient is better off seeing a neurologist than an ER physician, but Dr. Evans says that delays are also caused by managed care requirements. For example, he says sometimes patients with HMO insurance forget to bring their referral documentation, and the physician has to get this to secure the patient’s reimbursement. “It takes 20 minutes to half an hour to get this form, and by then the day’s schedule is off,” he says. “We’re left running behind because the patient did not bring in the insurance form.”

Trust Me, I’m a Doctor

Stephen Gollomp, MD, a private practitioner in Wynnewood, PA, says the behavior he finds the most troublesome is a patient who has not been following his instructions. “That makes me buggy, because I’m spending hours figuring out what they may have done,” he says. “It also puts me in jeopardy, because I’m misled about what they’ve done and what they’re doing.”

To help keep his patients following their treatment regimen and make it clear that he’s done all he can to encourage them to do so, Dr. Gollomp says he puts all his instructions in writing. He gives one copy to the patient and keeps the other in his records to show what he advised. “When writing the directions, you have to give as little room for error as possible, and that may mean using graphics and using very clear language,” he says. “For patients with sight issues, this may mean putting it in large print.”

Especially vexing, Dr. Evans says, are patients who stubbornly challenge the physicians’ opinion on their diagnosis or treatment based on information gathered from less-than-credible sources. “They read something on the internet or hear something from their friend or their second-cousin, and it may not be right but they’ll challenge the physician with it,” he says. “I’m not saying people should have a paternalistic view of physicians, but they should have some respect for them.”

Dr. Evans says it’s important for physicians not to dismiss patients’ questions or concerns, and not just for the sake of politeness. There are occasions when they could be right or they could have come across some new knowledge that the physician was previously unaware of. “If you don’t want to look stupid, it’s good to say, ‘Let’s check it out’ and do some research with the patient,” he says.

There are also situations where the problem is not too many possibilities but too few, and the patient again begins questioning your expertise. “There are cases from a medical perspective where even though you can’t control it, the patients perceive the physician is more than they are,” says a neurologist who wishes to remain anonymous. “The patients who have been difficult to me are those who perceive that I am required to give them answers, the patient who heard from a general practitioner or another physician that the neurologist will have the final answer, but there are cases where the final answer simply won’t be apparent. Here, I think the physicians become as frustrated as the patients.”

He says this usually happens when the patient presents with complaints of chronic lower back pain or non-specific pain, where it’s hard to do objective laboratory studies to determine the cause. “They call the physician because they feel pain, but the physician is frustrated because he or she doesn’t know how to treat it.”

Since there is no apparent clinical solution for these dilemmas, the best course of action is to educate the patient and family. You have to let them know you are doing everything you know how to do, and then you should refer the patient to another physician for a consultation. A similar problem, this neurologist says, is how to deal with a patient who reports unexplained symptoms but has no apparent condition. He says that if the patient is reporting pain that is out of proportion to the pathology, it’s time to suspect the patient’s motives for coming in because he or she may be seeking unwarranted disability compensation or pain treatments.

Patients with pain-related complaints may also have some issues that could affect their compliance. More specifically, they may have comorbid mood disorders, such as depression or bipolar tendencies. “That may complicate the efficacy of pain treatment, and it may be frustrating to the neurologist who wants to treat not just the condition but the whole patient,” he says.

Another challenge that may arise is how to handle a patient who becomes verbally abusive to the office staff or to the physician. Dr. Gollomp says he has yet to discharge someone from his practice, but under extenuating circumstances he would do so. “If anyone abuses my staff, I’ll tell them to go elsewhere,” he says. “I don’t need that kind of aggravation.”

Can You Hear Me Now?

Everybody has their own stories about encountering people being rude or inconsiderate with their cell phone, and Dr. Evans says he has a few aggravating ones that are set in his clin-
ic. “Cell phone calls are bothersome enough to movie watchers, but it’s worse when a neurologist is taking a history and the patient not only answers the phone but proceeds to have a conversation right there,” he says.

Just as there is a lack of commonly-accepted rules regarding cell phone etiquette, there’s a lack of guidance on how physicians should handle a patient like this. Dr. Evans says he has read of physicians doing everything from walking out of the exam room to inquiring about the legality of cell phone signal jammers. Some physicians have created office policies asking that cell phones be turned off and put up signs in the waiting room that are often ignored, while others accept it as a fact of modern life. “Personally, I just ignore it,” says Dr. Evans.

Dr. Gollomp says he seldom has trouble with patients taking on their cell phones in the exam room. On the rare occasions when it does happen, he says he handles it by staring at the patient until they get so uncomfortable they hang up. For his part, Dr. Gollomp says he tries not to use his cell phone while seeing a patient. “It’s important to be respectful in turn,” he says, adding that he will still answer a call if it is clearly an emergency; in these cases, he will excuse himself from the room.

Dr. Evans says that physicians taking cell phone calls during an appointment is a common complaint among patients. “Patients feel you should have a block of time set aside for them,” he says. Dr. Evans says he will take cell phone calls when seeing a patient. “I, personally, strongly disagree with my colleagues who feel they can’t answer calls because they’re with a patient,” he says. “If you don’t take the call then, you could be imposing on the caller later when they’re not available.” Of course, Dr. Evans says he would not take a call when doing a sensitive procedure such as a lumbar puncture.

The Three a.m. Calls
Dr. Evans says that although cell phones in the practice are an annoyance, a worse problem is how to deal with calls to his home after work hours for simple or unimportant matters. The survey’s respondents reported getting such calls as: a midnight call to try go get an appointment at the practice, a two a.m. request for a prescription for sleeping pills, and headache patients who do not show up for their appointments but call when the headaches occur. “Someone calls at three a.m., it wakes my family and me up, they ask a trivial question, and I have a hard time going back to sleep,” he says. “The information we give on these phone calls is a gratis service, but we’re liable for any advice we give at three a.m. or a holiday, and many of us feel this isn’t fair. They wouldn’t call an attorney at three a.m. on Christmas day for advice and expect not to pay.”

However, Dr. Evans says he is concerned that charging patients for these calls could discourage them from calling in the legitimate emergency cases. He also says that a strict calling service may seem like an easy solution, but again this could prevent some important calls from getting through. “There are arguments on both sides of this issue,” he says.

Dr. Gollomp says one of his grievances is that it isn’t only the patient’s name on his caller ID. “I sometimes get calls from three or four family members,” he says. “I tell them to pick one spokesperson for the group so I don’t have to talk to so many different people, which dilutes the value of the advice given.”

A Physician’s Life
Physicians may commiserate with their colleagues about the odd things they experience in their practice, but even though the problems may be widespread the solutions are far more varied. “Different practices have different ways of handling these things,” he says.

Dr. Evans says that a number of these behaviors would aggravate anyone, regardless of whether they were a physician or not. But then, most people would not want to do their jobs without getting paid for it. Physicians, though, often offer free care on a voluntary or charitable basis. “We don’t complain about that,” he says. “We understand that some patients have financial hardship, that’s part of the deal.”

And while troublesome patients may be found in every practice, neurologists deal with some of the hardest-to-handle cases. It is the neurologist who sees the intractable epilepsy patient, the advanced Alzheimer’s patient, or the patient with mysterious chronic pain. “It may be a handful, but we don’t complain,” says Dr. Evans. “That’s part of being a neurologist. We take care of these people.”

Sound Off: What Patient Behaviors Do You Find the Most Bothersome?

The top 5 most bothersome patient behaviors in this survey, from most to least, were the following:

1. No show for appointment
2. Verbally abusive with your staff
3. Poor compliance with medications or treatment
4. Late for appointment
5. Do not know the medications that they are taking

Is there something in your practice that patients do that gets under your skin that we haven’t mentioned? Or have you found a way to deal with troublesome behaviors that you could share with your colleagues? If so, send an e-mail to letters@practical-neurology.com and we’ll include your tips in a future issue.