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Managing Your Practice

Advisory No. 6

How to manage non-compliant patients

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Patients who are noncompliant with their doctor's recommendations or medical advice risk injury to themselves and pose a liability threat for their physician. Noncompliant patients typically are those who do not follow post-treatment instructions; don't keep appointments; don't report information about worsening symptoms; fail to follow through on referrals to a specialist; don't get recommended diagnostic tests; or don't take their medications properly.

Reasons for noncompliance

Noncompliance is not always a deliberate act. Among the reasons some patients may not follow the doctor's advice:

- they didn't understand instructions;
- they forgot the doctor's oral advice;
- they didn't appreciate the seriousness of a medical condition;
- they were not aware of the urgency of a recommended follow-up visit, test or referral to another physician;
- they were confused by oral instructions for medication use;
- a language barrier, hearing impairment, fear, mental confusion or illiteracy impeded
  their ability to understand;
- they received conflicting advice from multiple treating physicians;
- they didn't have insurance for medication, or coverage for diagnostic tests, surgery
  or additional office visits.

Physicians' role in noncompliance

A physician's words, actions, inattention or silence can contribute to a patient's

noncompliant behavior. For example, when a patient is advised during an initial office visit to stop smoking or alter eating habits, but the subject is not mentioned again, the patient might conclude that the doctor does not still consider the advice significant. "He knows I still smoke, but he hasn't mentioned it for two years, so he doesn't consider it much of a problem."

Physicians can contribute to a patient's failure or refusal to comply with medical advice in other ways. If their doctor spends too little time to explain the significance of a medical finding, recommended treatment, alternatives, and the expected outcome of treatment, patients may infer these are not important issues. Some doctors impart almost all of their medical advice orally to patients, sometimes in language too technical for the average patient to absorb. Physicians can discourage patients from asking questions by showing impatience, belittling patients' complaints, or by offering unrealistic advice. Telling an obese patient to "cut back on your calories" might be sound advice, but could be impractical unless the patient is told *how* to reduce calories. Similarly, it may be a futile exercise to advise patients to "stop smoking" or to "drink less," without considering the patient-specific factors that prevent their immediate compliance.

Noncompliance and litigation

Litigation experience demonstrates that noncompliant patients are liability risks. These patients may pursue a claim if they believe and can prove their noncompliance resulted from a physician's unclear, inadequate or omitted advice. For example, a patient who suffers a serious medication side effect and fails to seek treatment may claim he was not informed of the side effect or that it could be related to the medication. Similarly, a patient who is injured due to vigorous activity following a surgery may claim the physician was negligent for telling him to "take it easy," rather than giving more specific advice, such as "don't raise your arms above your shoulders for at least 3 days." Employers of patients (or the patients themselves) who are released to work with instructions limiting them to "light duty" may not interpret that instruction the same way the doctor does.

Litigation experience also demonstrates that patients who are wilfully noncompliant have not shared their doctor's advice or warnings with family members. Thus, when a patient's noncompliance results in his or her death, survivors may blame the physician for failing to give the patient clear instructions. MIEC has settled a number of costly claims and lawsuits because doctors failed to document advice they gave to patients who in turn were noncompliant and caused or contributed to their injury or death.

Charting protects the doctor

After they have sustained an injury or an exacerbation of a medical condition, some noncompliant patients are quick to fault the doctor, or anyone but themselves.

Documenting a patient's noncompliance is an effective way for doctors to protect themselves from liability. A sufficiently-detailed, timely handwritten progress note ordinarily affords protection. In cases in which the doctor had multiple conversations about the effects of a patient's noncompliance, a dictated note that includes details of exam findings, discussions and recommendations is beneficial.

In addition to timely documentation, these additional steps shield physicians from malpractice claims by noncompliant patients or their survivors:

Give clear instructions:

Patients often need **written** information to help them understand a medical problem, its treatment and sequelae. Newly-diagnosed conditions such as hypertension, diabetes, hyperthyroidism and cancer, to cite a few, entail many aspects a patient may not appreciate after only an initial oral explanation. Physicians are encouraged to supplement oral explanations, instructions, and recommendations with written information, so that patients and their family can re-read and re-review it as often as they need to. Dispense written information for medications: specify the name of the drug, what it is for, how it should be taken, significant side effects that should be reported to the doctor, precautions while taking the drug and what the patient should do if he or she misses a dose.

Schedule appointments practically:

Rather than set aside the same amount of time for every patient, allocate appointment slots according to patients' needs. For more efficient scheduling, some practices schedule elderly patients at the end of the day, so that if more time is needed with them the rest of the schedule is not delayed. Patients who are not employed and do not have household responsibilities can be more flexible than those on a fixed schedule.

Some practices set aside blocks of time before 8:30 am and after 5:00 pm to accommodate patients whose work schedule makes mid-day appointments difficult. Patients who may have to take off from work without pay to see the doctor are more likely to go to the emergency department or an urgent care center for routine care their own physician could have provided. Many practices keep open two free time slots each day to accommodate urgent drop-ins or make up for unexpectedly long appointments. A scheduling policy based on patients' medical problems reduces haste and assures most patients will have adequate time with the doctor.

Recognize communication barriers:

Encourage elderly, non-English-speaking, hearing-impaired or patients who have difficulty comprehending advice to bring a family member with them. Make sure interpreters are truly bilingual. If you have a large number of patients who speak a common foreign language, find out if the local hospital has a qualified interpreter who can assist by phone or in person. Community organizations and local colleges may have volunteers who can assist. Consider a commercial translation service, such as the toll free AT & T Language Line which can connect you to interpreters in 140 languages. Document the name and relationship of any individual who interprets for your patients.

Stress the degree of urgency:

Tell patients how urgent a recommendation is to obtain a diagnostic test, see another
doctor, or to follow specific medical advice. Document the fact that you stressed the urgency. Patients can prevail in malpractice litigation if they prove that although the doctor gave appropriate advice, he or she did not mention the potentially serious effects of delay or did not stress the urgency.

Obtain an informed refusal:

Patients have the right to decline a physician's advice for tests or treatment. The doctor is best protected if he or she documents that patients were informed of the consequences of their decision to refuse recommendations for treatment, medication,

tests or referral. Document the discussion.

Be a good listener:

The amount of time physicians can practically spend with patients seems to diminish every year. Because the doctor's responsibility to obtain information and act upon it remains the same, regardless of time pressures, physicians must make the best use of their time and listen well to what the patient says. Patients, too, are mindful that a doctor's time is limited, and they may not want to cause friction by asking too many questions, or taking too much of the doctor's time. Patients can sense when the doctor is in a hurry or is impatient with them. Physicians are encouraged to avoid body language that signals impatience or inattention. Communication experts advise that when discussing serious matters with patients, the physician should sit at eye level, rather than stand or hover in a doorway. If the patient does not seem to understand plainly-worded information, consider sending the patient a letter that summarizes your findings and recommendations. Such a letter can be an expanded reiteration of a progress note.

Encourage questions:

Many patients are reluctant to "bother" the doctor with questions and need "permission" to telephone the office if something troubles them. Others won't volunteer information. "If he thought it was important, he would have asked about it," these patients typically contend. Doctors who ask, "is there anything else you'd like to tell me," and who encourage their patients to speak freely learn more than colleagues who assume that a patient's silence is evidence that all is well.

Document noncompliance:

Ask your staff to note failed appointments in patients' charts. Use a reminder system to contact selected patients whose missed appointments put them at risk. Often, what appears to be noncompliance is a simple oversight.

When all else fails...

Accommodating patients who habitually fail to follow advice may seem admirable, but
ironically such acquiescent behavior has been used against physicians who are sued by the patient or the patient's family. In some cases, when doctors continue to provide treatment that is not effective or is not the treatment other physicians would have chosen because of the patient's noncompliance, the argument is made that the patient was noncompliant with the doctor's knowledge and permission.

When reasonable efforts fail to convince the noncompliant patient to keep appointments, follow advice, take medications, or see a referral physician, after a final warning the prudent course of action may be to consider discharging these patients from the practice. The threat of losing their doctor may encourage some patients to be more compliant with the doctor's advice.

MIEC's *Managing Your Practice Advisory #2*, "How to discharge a patient from your practice," offers advice and includes sample discharge letters.

How to reach MIEC

Home Office Claims

Oakland, CA
510/428-9411 (Bay Area)
Outside 510: 800/227-4527
Fax: 510/654-4634

Hawaii Claims Office

Honolulu, HI
Phone: 808/545-7231
Fax: 808/531-5224

Idaho Claims Office

Boise, ID
Phone: 208/344-6378
Fax: 208/344-7192

Loss Prevention Department

Oakland, CA
510/428-9411 (Bay Area)
Outside 510: 800/227-4527
Fax: 510/420-7066

E-mail:
lossprevention@miec.com

Resources from MIEC's Loss Prevention Department

Answers to professional liability questions. The Loss Prevention Department responds to a wide range of general questions about malpractice liability, and obtains legal advice for policyholders when indicated. *Sample questions:* How long must a physician keep medical records? How does a doctor properly withdraw from a patient's care? What is the best method to obtain informed consent and how should consent be documented? (*Direct questions about specific patients to an MIEC claims representative*.)

Medical Records text. MIEC's booklet, *Medical Record Documentation for Patient Safety and Physician Defensibility*, offers practical advice for maintaining defensible medical records and avoiding documentation deficiencies that can compromise a medical defense. The book includes useful chart forms, answers to questions about medical records, and a self-assessment form to review documentation quality. The book is free to MIEC policyholders and offers Category I continuing medical education credits.

Chart forms and templates. MIEC's *Chart Forms and Templates for a Medical Practice*, offered free to MIEC policyholders, is a packet that includes ready-to-use forms and templates that help physicians and staff organize medical charts, find data easily, and document important information that protects patients and physicians. Camera-ready forms can be reproduced for office use. The entire library of forms is contained on an included PC computer disk.

REQUEST A PUBLICATION

Extensive resource library. Policyholders can request sample medical record chart and consent forms; patient education materials; articles on medical-legal topics; lists of resources for practice guidelines; vendors of electronic and voice recognition medical records systems; and more.

On-site loss prevention survey. MIEC's loss prevention specialists conduct complimentary individual or group practice surveys in which record-keeping, office procedures and practice policies are analyzed. Surveyors meet separately with physicians and their office staff to discuss liability issues relevant to the practice and specialty, and offer practical advice for reducing liability exposure. A written report summarizes the survey findings and provides constructive suggestions for improvements.

Newsletters and alerts: MIEC publishes the *Claims Alert; Special Report; We Get Letters...; New Law Alert*; and *Managing Your Practice* newsletter series, and other publications that offer helpful and timely solutions to practice problems and answers to policyholders' questions. Contact the Loss Prevention Department or visit our Internet website for a list of titles and ordering information.

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