

HANDLING THE

Well-Informed

Patient

Armed with articles from the Internet and the latest treatments touted on television, patients who know a lot—or who only think they do—can present challenges in the office.

Tips for staying efficient and still keeping patients.

By Julie Sturgeon

ONE INDIANAPOLIS NEUROLOGIST ADMITS HE TAKES a less-than-politically-correct way of handling smarty-pants patients: He hangs up his cell phone to give himself time to regain control of his emotions, later blaming the glitch on a dead-air spot. “That’s nothing. I’ve seen him throw charts after dealing with some of his more stubborn patients,” his wife offers.

Although he requested anonymity—“I know my secret could turn off patients and colleagues,” says this neurologist—fellow physicians are hardly shocked at these behind-these-scenes reactions. Everyone in this profession suffers from similar patient woes.

Since the [U.S. Food and Drug Administration \(FDA\)](#) lifted its ban on direct-to-consumer advertising in 1985, spending levels for this avenue have leaped from \$17 million to \$2 billion in 1998, says Steve Francesco, the president and CEO of [Francesco International](#) in South Orange, New Jersey. “Basically, advertisers found they could pressure doctors to write prescriptions if the consumers pointed out the advertising they had seen. This is not to say that the doctors wrote prescriptions incorrectly. Rather, the advertising called attention to products, because they were either new or in some way relevant to the patient, and the doctor had to listen to this interest,” he points out.

Nancy Elder, a family medicine physician at the University of Cincinnati-Wyoming Practice Center, certainly sees her share of patients with a minor toenail

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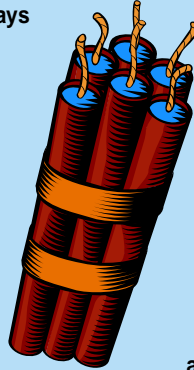
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“If subconsciously you resent that the patient, instead of bringing you the problem expecting you to be the all-wise person, has consulted other resources, you must get over it. Starting with that assumption gets you in trouble all the time with your better-informed patients. Once you admit you feel that way, you can go on to give good patient care.”

—Barbara Korsch, MD, a professor at Keck School of Medicine at the University of Southern California and a pediatrician at Children’s Hospital of Los Angeles.

Why Patients Explode

Patients in the 21st century perceive the health-care scene as a system rather than individuals, says Kevin Stone, MD, a solo-practicing orthopaedic surgeon. The result: a natural skepticism of who the doctor works for. “The most common complaints we hear from patients who migrate from other providers are, ‘They didn’t listen to me; they didn’t answer my questions; they didn’t spend enough time,’” he points out.



The cost is higher than merely lost dollars.

According to research by Ann Humphries, the president of the Columbia, South Carolina-based business communication company **Eticon**, 53 percent of patients say they would retaliate rudely if they perceive the doctor as being rude herself.

Here’s how to avoid unknowingly setting off a chain reaction of office rage:

Look Beyond the History.

Chances are good your patient’s previous medical provider responded to treatment suggestions with a curt, “no” and shut the door. “Next time, the patient comes back full force with the attitude ‘I won’t stand for that crap anymore,’” says physician communication coach Jacque Ater. “They bypass proactive and appropriately assertive and get right into the ring.” To avoid standing in as the next sparring dummy, gather as much information on forms about your new patients before you walk into the exam room.

Accept Homework.

You can and should flatter a patient’s acumen in bringing new material to your attention. But if you part ways leaving future research on Mr. Jones’ shoulders without promising to look

into a few avenues yourself, he feels dismissed. “It signals the doctor already passed judgment and I’m wasting my time,” Ater points out. Beware the temptation to say, “Great! Give me a buzz in a couple of weeks when you find out a bit more,” in a jovial tone.

Look Them in the Eyes.

When you fuss in your pockets for a prescription pad or jot down unrelated treatments during the patient’s explanation of Aunt Sue’s sore throat treatment, the patient becomes anxious. “And remember, sometimes as human beings, we start pounding our fists because deep down, we are so far from feeling we’re right,” says Ater.

Take Your Time.

Despite the clock, your speaking pace may indicate “too rushed to care.” (Quicker paces also confuse

the listener and sound dismissive.)

“And a lot of times you are running crazy, so you unconsciously want to sound declarative and definitive to prevent a patient from wasting your time,” she explains. In other words, avoid paying so much attention to schedules that you risk depersonalizing the patient. Watch out for “Now, you’ll go to rehab on Friday, the social worker will see you 10 minutes before that appointment, and I’ll be back tonight on rounds to check your status. OK? Good.”

Shut Up.

Former emergency medicine doctor Pete Farmer, MD says that doctors usually interrupt patients after 18 seconds. This, too, provokes anxiety and further ties the patient’s tongue in expressing his concerns adequately. ■

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“We tend to make decisions based on pleasing our patients, what the drug reps tell us, and what samples they leave in our closets.”

—Nancy Elder, a family physician at the University of Cincinnati-Wyoming Practice Center. She says many physicians yield to patient requests for prescriptions.

cialist Angelo Agro of New Jersey, told the American Medical Association in June, “The patient is at best incompletely informed and at worst, deluded.” The AMA committee agreed the ads can undermine doctors’ credibility, and proposed a resolution to lobby for language stating that doctors may recommend other treatment options in these pitches.

But progress brings another challenge: Internet connection. Surveys show that older Americans in particular don’t want to miss out on this information gold mine—and two-thirds of those who search for health information on line talk about it with their doctors, reveals the [National Library of Medicine](#). The number of MEDLINE searches alone jumped from 7 million in 1997 to 120 million currently, with one-third of those conducted by consumers.

Couple it with the new paradigm that preaches patients as customers, and these ingredients produce a sophisticated but know-it-all patient. Elder breaks hers into two categories: the basically healthy whose worry leads them to pursue inappropriate investigations or expensive hyped prescriptions, and the chronically ill who rely on the Internet to build a support community of “What is your doctor doing?”

“Unfortunately, I don’t see physicians as open to identifying where the communication breakdowns occur,” says Jacque Ater, a Rochester, New York, communications coach who founded [CommunicATER](#) to work with both patients and physicians. “They’re afraid to open the flood gates to a litany of complaints if they create a practice philosophy based on good communication and partnership.” Yet empathic skills create the same end result, she notes: One physician client habitually backed up

fungus who request Sporonax and women who need to shed 10 pounds who demand Meridia. Her eye-rolling favorite: the requests for Celebrex, to help achieve tai chi moves like the lady in the commercial. “And they see their friends get it because to be perfectly

honest, doctors don’t often make good medical decisions,” Elder contends. “We tend to make decisions based on pleasing our patients, what the drug reps tell us, and what samples they leave in our closets.”

Others, like ear, nose, and throat spe-

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her waiting room by spending 75 minutes chatting with each patient.

Here is how some doctors have found the happy balance:

Free your mind

Today's patients bring a higher degree of suspicion and mistrust of health care



Dr. Weinstein

in general, says Dan Weinstein, MD, who specializes in brain injury rehabilitation at McGee Rehabilitation Hospital in Philadelphia. "It takes

greater effort on behalf of the health-care provider to establish a trusting relationship that, two decades ago, was simply assumed," he adds.

The starting point stares you in the mirror each morning, says Barbara Korsch, MD, a professor at Keck School of Medicine at the University of Southern California and a practicing pediatrician at Children's Hospital of Los Angeles.

"Physician, know thyself" permeates every message in her teachings and books on patient-doctor relationships. "If subconsciously you resent that the patient, instead of bringing you the problem expecting you to be the all-wise person, has consulted other resources, you must get over it. Starting with that assumption gets you in trouble all the time with your better-informed patients," Korsch says.

"Once you admit you feel that way, you can go on to give good patient care. If you try to pretend doctors don't have feelings, it will only get in your way."

You needn't lie on the analytic couch to discover which patients get to you.

Korsch holds group discussions with young interns under her wing, but individual doctors can achieve the same results by scanning the day's patient list. When your heart sinks at a particular name, stop a moment to figure out what

triggers this dread. "Once you turn it from being annoyed to curiosity about yourself and your patient, it becomes interesting instead of an irritation," she explains. "We're supposed to be scientists, so use intellectual curiosity as a resource." Korsch has even confided her dismay to that patient, saying, "I found myself worrying when you leave because I often feel I haven't met your needs. Do you ever have that feeling?"

Second, admit your vulnerabilities. Korsch, for instance, knows she doesn't emotionally handle children with leukemia well. She also overreacts to intellectual limitations "because I grew up in an environment where if you couldn't be smart and learn things, it was all over." Remember, the more information you have about yourself, the more easily you conquer this communication hurdle.

But what's good for the doctor means crawling into the patient's mindset as well. Pete Farmer, MD, a Southern California business coach and former emergency physician (he served as the senior medical officer for the Apollo 13 recovery), recently developed what he calls a patient communication index to assist colleagues. Patients prioritize 12 groups of adjectives in the order that best describes them, and within minutes, the computer file it generates clues their physician on how to best address their needs. For example, one patient's preference may be to cut to the chase, while another prefers the doctor use visuals to explain medication doses, disease progression, etc. Feedback shows the reports pinpoint the patient perfectly 88 to 95 percent of the time.

Farmer encourages physicians to share the personality test results with their patients. "It's a real-life way to say 'I care' and start a dialogue," he says.

Dallas-based cosmetic surgeon Jim Gilmer, MD, carefully filters his initial pa-

tient discussions to discover if this person has had multiple surgeries, is unhappy about anything in his or her life, or takes psychotherapeutic drugs. "The staff will talk about a patient when we think there's a problem—not because we're mad at this person, but we don't want her to cause herself and us grief," he says. Ater suggests probing to see why the patient chose you—did managed care dictate the decision or was he displeased with another practice? Identifying these gaps early prevents stumbling over them when you least need the confrontation.

Master the art of conversation

"I've walked a long mile with doctors in all different specialties, and they weren't pulled to medicine because they were strong communicators," Ater says.

"They're certainly interested in finding answers, but the actual listening, paying attention, reading non-verbal cues—uh-uh." She recommends committing to open communication in the mission statement, then including that phrase in welcome letters, on the back of appointment cards, even framed on the receptionist's wall. The repetition keeps the physician focused as much as the patient.

Those who balk at this formal step fear a time backlash in the exam room. However, the average length of an office visit climbed two minutes between 1989 and 1998 to 18 minutes, according to surveys by the [National Center for Health Statistics](#). The AMA's similar studies show the rise by one minute, to approximately 21 minutes. Researchers surmise the change stems from doctors treating more complex cases during office visits, and increased attention to preventive care.

Korsch's experience shows the amount of time a patient uses to ask about a new treatment or disease state isn't as long as the doctor anticipates. "They haven't memorized a whole page off the

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Internet,” she says. “They’re apt to deliver a very brief—and sometimes misleading—synopsis.” Elder often finds that spending a few extra minutes on prescription education and discussing alternatives in a first appointment heads off a frustrating round of confrontations over the years.

During her days as a speech language pathologist, Ater didn’t hesitate to say gently, “I know you want some of my time, and I want to work this out with you. But it’s 11 am and I have four other people waiting to see me at this moment. Let’s find an alternative.” When a physician’s time truly is crunched, Ater recommends either to book a double session for a future date or suggest the patient bring a book and wait until the end of the doctor’s day to address the topic.

It’s not time but temperance at issue for Weinstein. His patients rarely spill their intentions at his request, so he perfected the art of asking the same question in five slightly different ways:

- ✓ **Why are you here?**
- ✓ **What do you hope to accomplish?**
- ✓ **Is there anything special you want to ask me about?**
- ✓ **What brought you to my office today?**
- ✓ **Do you have any questions I can answer?**

He’s also learned the real meat of the appointment occurs in the 30-second wrap up when he asks, “Is there anything else you were hoping to achieve while you were here?” “Finally, out comes the list of five medications, two therapies, and three insurance forms they’d like me to complete,” he laughs. Weinstein now allots five minutes for this phase.

Once mano a mano with a patient who presents a file of diverse articles, Gilmore asks that person to prioritize her expectations from this particular visit. Elder also takes time to probe the

patient’s experience with the treatment she mentions. “I whip out my Palm Pilot right there and say, ‘I can’t remember all that I’ve read. Let’s look at the references together,’” she says. With this tool, she points out things like average cost compared to an alternative treatment’s cost, or looks at side effect profiles and drug interactions. “Somehow having this authority, even if it’s just an electronic file, helps me convince some difficult patients.”

The key to successfully defusing hostility during any of these stages, Korsch maintains, is to show respect for the patient’s preparation. However, physicians must deliver statements like “I can see you’ve really read a lot about this” or “I really appreciate that nowadays patients do have so much information on their own—it really makes my job easier” with sincerity. Consumers, like children, spot a phony in a heartbeat.

The second trick lies in refocusing the conversation back on the patient. For instance, if a woman were to launch into a recitation of what everyone in the chat room says about fibromyalgia, Korsch would reply, “I sympathize with all these patients who have a hard time getting their doctor to listen because it’s a very vague syndrome and we don’t know enough about it. Today, if you’re agreeable, I’d like to hear more about your personal experience and what you’ve tried so we can work out approaches to help you.”

Korsch adds, “People are very unlikely to resent when you pay attention to them personally.” For the information-toting gentleman, a similar “Gee, you have a lot of knowledge about this. Some of it I’m familiar with and some of it is new to me. But I’m having trouble getting a clear picture of the symptoms bothering you. In the limited time, it might be more useful if we focus on that” calms nicely.

When a physician definitely disagrees with the patient’s suggestion, Ater recommends dealing from a factual standpoint: “I’ve tried this on eight or 10 patients and we hoped it would bring quick relief. Unfortunately, we’re not seeing an impact, and as a result, I can’t be comfortable prescribing this medication.” Phrases like “ethical,” and “my first duty is to you” go far in refocusing on the patient’s best interest. “That person is probably near despair or they’ve tried a trillion other things and this must be the magic bullet,” she says. “So stay as centered as you can. This is really an attack on their disease, but they’re using you as a focal point.”

A physician’s ability to admit “I don’t know” or “I don’t have enough information to make an appropriate decision” about a new Mexican desert cure for cancer weighs equally important. “Many doctors want to flee to their comfort zone and say, ‘No, no, that’s too experimental’ or try to BS their way through,” Ater explains. Instead, when a patient-physician relationship reaches this impasse, physically write out a plan and insist the patient accept some ownership. The conversation sounds like, “With the little I know, quite frankly, I’m not inclined to do much with this avenue. However, let’s take some time—you see what you can find and I’ll look into some professional channels at my disposal. In three weeks, we’ll meet again to talk about possibilities.”

Failing to assign a role, Korsch warns, means chalking up another failure at your expense. “If it’s only your agenda, they walk out of there saying, ‘He never did listen to me,’” she says.

How you physically listen during these negotiations also affects the outcome. The most effective doctors, Ater reports, sit on a rolling stool and lean back into the wall to signal a relaxed attitude. Others invite the patient to abandon the exam table in

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favor of a chair that puts her at the doctor's eye level.

"You are two adults discussing a joint problem. Your goals are the same, so keep in mind that [the patient is] not the adversary," says Korsch.

When in Rome...

Patients aren't the only Americans glued to the Internet. This May, the AMA reported the percentage of on-line physicians who consider the Web a useful resource for drug information, business, and patient education increased significantly. Web use among doctors alone has jumped from 20 percent in 1997 to 70 percent in 2000. Seventy-nine percent of physicians surveyed use it for communication, 51 percent for drug information, and 39 percent as a patient education tool.

Gilmore's Web site becomes a follow-up contact for patients considering cosmetic surgery. After reinforcing the conversation with literature, he points them to the industry links and articles on line to answer additional questions. But Gilmore refuses to throw the ball in the patient's court and walk away—he sends a follow-up e-mail to each patient who supplies an address to invite further questions.

Kevin Stone, MD, an orthopaedic surgeon in San Francisco, relies on his Web page to get a word in edgewise among the sports magazines touting training techniques or medical supplements used by the rich and famously injured. He pumps this space with news on how his clinic treats specific problems, how rehabilitation programs work, surgical techniques, scientific research information, and excerpts from professional presentations. Stone also makes himself accessible to journalists who report on specific topics in order to provide the public with up-to-date information.

"As much extra effort as this new communication style takes right now, I

still prefer this over the all-powerful doctor who speaks with dictums," says Weinstein. "At the same time, I have to continue my practice with a clean conscience, so a small percentage of my patient encounters conclude with me saying 'I don't think it's a particularly good match.'" ■

Julie Sturgeon is a Greenwood, Indiana-based free-lance writer who contributes regularly to Unique Opportunities.