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10 Ways to Say No to Patients -- and Still Keep Them Smiling

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Telling Patients No Isn't So Easy

"The art of leadership is saying no, not saying yes," said former British prime minister Tony Blair. "It is very easy to say yes."

Primary care physicians (PCPs) know this all too well.

"Studies, medical societies, and position papers are unanimous in their condemnation of inappropriate antibiotic prescriptions for an uncomplicated URI, but not a single voice tells us HOW to do that," complained Dike Drummond, MD, a family doctor in the Seattle area, in his blog *The Happy MD*.[1]

Indeed, a survey of 150 members of a state medical society (it was unnamed)—with over half of the participating doctors reporting that their compensation was linked to patient satisfaction ratings—found that almost half believed that pressure to obtain better scores promoted inappropriate care, including unnecessary antibiotic and opioid prescriptions, tests, procedures, and hospital admissions.[2]

A study of 192 PCPs sought to estimate the effect of patient requests for medications on physician prescribing behavior.[3] Participants viewed two video-based scenarios: one of an undiagnosed "patient" with symptoms strongly suggesting sciatica, the other of a "patient" with already diagnosed chronic knee osteoarthritis (OA). Half of the patients with sciatica symptoms requested oxycodone; half requested something to help with pain. Half of the knee OA patients requested celecoxib; half made a general request for pain medication.

The results showed that more physicians gave oxycodone to those patients who requested it, compared with 1% of those making no specific request.[3] "In both scenarios, activated patient requests for a medication substantially affected physician-prescribing decisions, despite the drawbacks of the requested medications," the researchers concluded.[3]

"The prioritization of the subjective experience of pain has been reinforced by the modern practice of regularly assessing patient satisfaction," Anna Lembke, MD, a psychiatrist at Stanford University Medical Center, observed in the *New England Journal of Medicine*.[4] Patient rating websites have become very popular and may have a large influence, and doctors who don't accede to patient requests may be rated poorly, ultimately affecting their reimbursement and job security.

But it isn't just patients seeking narcotics for pain or antibiotics for viral infections who are putting doctors in the awkward, discomfiting, sometimes untenable position of saying "no." Some patients demand expensive imaging tests that aren't indicated. Others want diet pills when they aren't overweight. Some want drugs that they see advertised on TV whether or not they are indicated and with no idea of the cost, which may be substantial. Some want appointments that aren't necessary and can't easily be accommodated in a doctor's busy schedule.

How do you tell such patients "no" in a nice way that minimizes your risk of being trashed online, receiving a low score on a patient survey, or inciting the patient to switch physicians? Let's take a look.

Couch a No in an Explanation

Straightforwardly telling a patient, "No, you can't have that drug, test, study, or appointment," maximizes the odds that the news will not go over well. There's a more diplomatic, less confrontational way to achieve the same result.

"A patient might say, 'I need an MRI for a brain tumor,'" says internist Matthew Mintz, MD, associate professor of medicine at George Washington University School of Medicine, who has a private practice. "I don't reply, 'No, we're not going to get the MRI.' That's not my initial response. I might say, 'Well, an MRI is an option, but let me tell you what I think we should do or what the best option for you is.'"

"When time is an issue, patients know that they have only a few minutes for a visit, so if they want action, they're going to ask for it," Dr Mintz reflects. "My initial reaction might be to say no, but that can set up a conflict. Instead, I try to say no by not saying no—by saying, 'Okay, we can consider your request, but let me tell you what I think.' I find that works 99% of the time."

"At the end of the day, you have to go to sleep and know that you did good medicine," agrees Bradley P. Fox, MD, a family physician in private practice who is on the clinical faculty at Gannon University in Erie, Pennsylvania. "How do I approach it? I make sure that any time I say no, it's not just no; it's "No, because …," or "Not exactly."

"Do I cut patients off? Sometimes," Dr Fox admits. "'You do not need an antibiotic because this is viral. Viral illnesses do not get better with antibiotics.' But most of the time I couch it in: 'Here's what we're going to do.' No is not no so much as it is, 'Not now,' or 'No, because …' It wasn't a no, but it was no."

Open a Discussion

When a patient makes a specific request that you're not willing to accede to, you can diffuse potential conflict by taking a moment to understand the "why" behind the patient's request.

"First, head for the real issue: What are they afraid of?" says William Sonneberg, MD, a family physician in Titusville, Pennsylvania. "It's not that they want that product. Probably they don't want that product. But they have something they're worried about. You have to peel that back—peel away the advertising, if that's where they got the idea—and head toward the main issue."

"It requires persuasion," Dr Sonneberg adds. "If they want an antibiotic, you have to wonder why and seek to understand it. A lot of times patients will say, 'My husband had bronchitis. I have it too.' And you have to say, 'Yes, an antibiotic is commonly prescribed for that, but it's a mistake.' You have to tell patients that if it's that contagious, it probably is viral—that 95% of bronchitis is viral and really should not be treated with an antibiotic."

Dr Mintz occasionally gets a request for vitamin B12 for obesity management. "I do believe in the use of pharmaceuticals for obesity management," he says. "But there are both prescription and nonprescription drugs that patients use or ask for that are not effective. B12 is the best example. B12 is the most abused prescription substance in the medical community. It does absolutely nothing, but a lot of medical obesity clinics offer B12 shots at steep markup."

When Dr Mintz explores why a patient wants B12, he often hears, "'I'm taking this supplement that I saw on TV that says it'll burn my fat, and I don't have to do anything,'" he says. "I tell the patient, 'There's nothing that will burn your fat and you don't have to do anything else. If there were a miracle cure out there, don't you think I would give it to you?' It's debunking some of the stuff that they've heard or seen on TV."

"A lot of times, people come in and ask about the new anticoagulants, which are always advertised on TV," says John Mandrola, MD, a cardiac electrophysiologist at Baptist Medical Associates in Louisville, Kentucky. "I think there is a balance between warfarin and those drugs; we have a conversation about that, and usually it works out just fine."

"Giving an explanation opens a discussion," Dr Fox says. "The biggest problem with a yes/no answer is that it closes

the door. By closing the door to a discussion, it opens the door for patients to walk into an emergency room, call the insurance company, or call the hospital because they weren't happy."

Be Willing to Negotiate

Negotiating with a patient isn't the same as, say, a legal negotiation. At the end, the patient doesn't "win" the negotiation despite your professional judgment. But your willingness to engage with the patient makes ultimately going against the patient's wishes much more palatable than a flat-out no because the patient feels that he or she has been heard by you, which is often what patients want.

"By starting a discussion, you can have patients do the negotiation, and presuming you're a decent doctor, at the end of the negotiation, your response is usually going to be the best one," Dr Fox explains.

"In general, when most patients ask for something specific, it's not that they 100% want that, it's just that they believe it's the right choice," Dr Mintz observes. "Often what I'll do is a two-stage process. First, I say, 'Well, we could do what you want, but let me tell you why we shouldn't.' I have a good practice of never really saying no. Plus it's not a no, and you then give them nothing. You offer treatment options. 'You've tried the over-the-counter remedies. They're not making you feel better. Let me offer some treatment options that aren't antibiotics and tell you how we can get you feeling better so that you can go on your trip.'"

"It's offering a rational explanation of why what they're asking for isn't really the right choice and then proposing appropriate alternatives," Dr Mintz says.

Be a Cheerleader

As the saying goes, you get more flies with honey than you do with vinegar. Turn a hard no into a soft one by offering positive reinforcement to patients.

"There are times when you're actually a cheering section," Dr Fox says. "Tell the patient, 'You're really doing a good job. You may not see it that way today, but you've actually come a long way from when this whole thing started, and what you're doing now is absolutely right." Reinforce that what patients are doing is right and that they don't need more drugs or whatever it is they want."

"One of the things we face all the time is the person who absolutely has to be seen right now," Dr Fox points out. "How do you convince them that they don't need to be seen while making them feel as though you're taking them very seriously, when most people feel if you don't want to see them, you don't believe that they're sick? How do you tell the person who wants the appointment today that they don't need you for the third time in a month?"

"My nurse will say to a patient, 'Dr Fox saw you 3 days ago. Chances are, things haven't changed that much since then. If you truly want to be seen today, we can bring you in. But it might be better if...'—and at that point you make them feel good about what they've done; you put a positive spin on it," Dr Fox says. "A lot of times, you can keep them from walking back in the door when it's not necessary."

Use a Good Cop/Bad Cop Routine

Having your nurse or physician assistant tell a patient no on your behalf can be the icebreaker that leaves patients with a positive experience even though their initial request is ultimately denied.

"I sometimes will have the nurse give the absolute no answer, and then I do the good cop/bad cop routine by walking in and doing the negotiation, while the patient still doesn't have the bottom line yet," Dr Fox says.

"Oftentimes the nurse will say to the patient, 'Dr Fox won't give you that drug.' And then the nurse will walk out and say

to me, 'Yeah, they're not happy.' I'll walk in and say, 'Well, Carol seems to think that you're not happy because I won't prescribe the medication you requested. What's going on?' Now the conversation is open. It gives me a chance to say, 'Okay, well, this isn't really what you need, but here's what I will give you.' So it's a good cop/bad cop routine, but you still wind up with the same final result."

Show Patients Empathy

Patients go to see the doctor for a variety of emotional and complex reasons. One of them is to be acknowledged, respected, and understood. This is often more important than having their request for a specific medication or test fulfilled.

"If I give a patient my undivided attention, and I sit down in the chair and meet them eye to eye and face to face and I listen, and then I give them my best advice, I think that counts as something," says Dr Mandrola. "It may sound Pollyanna-ish, but I believe it. I believe that if we meet our patients and we listen and have empathy, it works. Sure, I've had a few bad reviews on Vitals.com because I was late or rushed or whatever, but for the most part, listening and having empathy makes a difference in how patients respond to you."

Dr Mandrola not only sees patients with heart rhythm problems, he has heart rhythm problems himself. "One of the things I do is say, 'I've had this,'" he tells patients. "'I know it sucks. But here's what I would try.' I try to acknowledge to patients that I understand that they have this problem. It doesn't work 100% of the time, but in general, I don't usually feel pressured by patients to do things that I don't feel comfortable with."

"Most people are reasonable enough to understand that if you give them the real reason why you're doing things the way you're doing them, they'll grasp the explanation," Dr Fox believes. "It's the process, not the actual final results, in getting what you need to do."

"At the end of the day, it's all about letting patients believe that they've at least won some dignity," Dr Fox says. "The 'no' answer takes away their dignity. It takes away their feeling of self-worth and pride. You need to make them feel as though they still have that when they leave the office."

Match Your Response to the Patient

When Charles Davant, III, MD, a family physician in Blowing Rock, North Carolina, has to tell a patient no—for example, when a patient requests an antibiotic for a viral infection—he considers a number of factors about the patient as a unique individual in his practice.

"First, it depends on how well I know the patient," he says. "And it depends on the patient's level of education. There are a few people we see where we know they'll be in the office three times if they don't get an antibiotic. And there are other patients who are here and are pretty sure they don't need an antibiotic, but they just want to make sure. So educational level plays a role."

Framing a response to the patient with a view to who the patient is as an individual isn't just important for PCPs. Take cardiac electrophysiology (EP).

"Atrial fibrillation (Afib) gets put into a silo of a disease, like a gall bladder problem or appendicitis," Dr Mandrola says. "Patients have this view that I've got a problem, and I want a fix. A lot of times, though, taking care of Afib is more about managing the problem and aligning whatever treatment is best for that patient with what their goals are. With Afib, it has to be personalized, and what's right for you might not be right for me. My job is balancing that. Many patients want the doctor to decide, but in EP many treatments are preference-sensitive."

Deflect the Blame

There are times when you need to say "no" to a patient that are not solely your decision. But because you're the only

one in the room with the patient, it's okay to deflect the blame to the absent party to make life easier on yourself.

Take the patient who feels a twinge of pain in his back and whose friends tell him, "You tell your doctor you need an MRI."

"That's actually gotten easier lately as insurance companies have gotten tougher," Dr Davant observes. "When a patient comes in, and they've only had back pain for a week or 10 days, I tell them, 'We can try to get it precertified, but then the insurance company will say, 'You've only had pain for 10 days and it's not radicular. We're not going to cover the MRI until you've had physical therapy and this has been going on longer.' That way, I can tell the patient, 'It's your insurance company. You'll have to do this, this, and this first. Otherwise, you'll have to pay out of pocket.' That way the insurance company is the bad guy, not me."

Sometimes clinical guidelines can play the role of bad guy—as, for instance, when a patient who isn't obese requests diet pills.

"Diet pills are fairly easy," Dr Davant says. "Some guidelines have a cutoff of a BMI of 30 or 35, depending on whether you have comorbidities. I can tell patients, 'You're not fat enough. Go out and gain another 15 pounds.' Specific guidelines are useful, particularly things that you can show people and say, 'That's why your insurance won't pay for it.'"

When Necessary, Be Firm

Most of the time, if you do it diplomatically, patients will take no for an answer. But sometimes they won't. In those instances, put your foot down—but gently.

"You have to really be firm with certain people," Dr Sonneberg admits, thinking of patients who insist on an antibiotic for bronchitis. "You have to take the professorial view. With some patients, you have to act like you're delivering the Sermon on the Mount and do it with authority and conviction. You can't waffle and say, 'Maybe there's a small chance I should do it to protect the patient.' You have to say, 'No, this is a virus.'"

"The analogy I always like to use is, 'If you use an antibiotic for virus, it's much like offering a fire extinguisher to someone who's drowning.' Your heart's in the right place. You try to do good. You're trying to treat something that's bad. But you're treating the wrong thing. A life preserver will not help you in a fire. I tell the patient, 'You need and deserve the right treatment. If I give you an antibiotic, the chances I'll hurt you are very strong.'"

"At that point, I sometimes go through a scare technique. I say, 'The chance that you'll be hurt by that antibiotic is far worse than the virus that we're trying to treat with it. For example, it increases your risk of dying of cardiac arrhythmia threefold. Frankly, I fear that more than I do bronchitis.'"

Patients seeking narcotics for pain under suspicious circumstances may also require a firm denial. "Most of our chronic pain patients have signed pain contracts and know that they're not going to get any early refills," Dr Davant says. "And they've learned that if they come in having 'lost' their medicine, they will be drug-tested right on the spot to see what else is on board."

If a patient is seeking amphetamines, Dr Davant has a policy for that as well. "If people who come in and want amphetamines and things like that—if they make a good case, I would probably give it to them, but only for a couple of weeks; I'm certainly not going to give a month's worth," he says. "But I'll send for their medical records. And I have a very good clinical psychologist whom I send college students to if they think they have attention-deficit disorder, and she puts them through a very nice evaluation, so I've got documentation. If someone comes in, and they've just moved to the area, I can probably get records from their previous doctor in a few days."

Sometimes Dr Davant gives patients a written rather than an electronic script, "because the latter goes straight to the pharmacy. I say, 'The weekend's coming up, and I think you'll be better in a couple of days. If you're not better in 3 or 4

days, go ahead and fill this and try it then.'"

Dr Sonneberg hopes that his expert opinion will be return on investment enough to keep patients content. "Oh, you mean I took all that time off from work, and you're not going to do anything?" he sometimes hears. To which he replies: "You took all this time off from work. You deserve the best treatment—the right treatment. You don't deserve something that's going to hurt you. In your case, with a viral infection, that's what an antibiotic will do. All medicines have side effects. You just have to make sure there's a chance of a benefit."

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Cite this article: Neil Chesanow. 10 Ways to Say No to Patients -- and Still Keep Them Smiling. *Medscape*. Feb 17, 2016.