

# Healthcare **Communication** Review

On Building Health Partnerships: Food-for-Thought, Practical Tips, Resources

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## DIFFICULT HEALTHCARE RELATIONSHIPS & ENCOUNTERS

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## Difficult Healthcare Relationships: Choices to Make

The potential for difficulties in doctor-patient relationships, as in any other, are many. They may stem from a clash of personalities, from stressful situations or, despite good intentions, from misunderstandings. Sometimes there is little that can be done to prevent or resolve a difficult relationship. This is especially true when the doctor and/or the patient have no real interest in doing so. Sad to say, that is sometimes the case. In that instance, it may be best to simply end the relationship. That being said, there may be times when a relationship is best served by not rushing to judgment about the other's willingness to change, to start over, or to mend fences.

What might make someone do an about face? What might make them stop, listen, discuss and, perhaps, turn a difficult encounter into a stepping stone towards a better, stronger relationship? In general, a three-step approach (useful to both doctors and patients) can go a long way towards minimizing and resolving the difficulties that arise in their relationships. This approach calls for self-searching, for understanding others and for communication.

The first step, self-searching, involves asking ourselves if, and how, we might be contributing to the problem at hand. What are we doing and why? The second step involves learning how and why others, in this case, doctors, may be contributing to the problem. Having gained these insights, the final step involves communicating – to both build understanding and work to resolve difficulties.

Typically, doctors are expected to take the lead here, and they should. But what if they don't? What if patients are unhappy with the way things are going but don't want to change doctors – or don't have the option of doing so? Should they just grin and bear it – remaining passive, as they typically did in the past? Or should they take the lead in trying to work things out?

It is often easier, of course, to forgo all this – to give up on a particular relationship and seek another in its place. Why, then, would patients choose to bother? Many don't. Sometimes there is no doubt that finding another doctor without first trying to resolve the matter at hand may be the right thing to do – but not always. What if the offending doctor is one that the patient, for the most part, had liked as a doctor? Should an offense outweigh all that is liked about that doctor? What guarantees are there that a new one will *always* respond as the patient wants? And what will the patient do if problems arise with the new doctor as well – keep moving from one to another? Many relationships appear to experience discord at some point. People don't always behave as one might expect them to. That being the case, wouldn't it be better for patients to work through difficulties as they arise – or at least to give it a try before moving on?□

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*From the Editor*

Relationships can sometimes be difficult. This is as true for the relationships we form with our doctors and other members of our healthcare team as it is for those we form with family and friends. The question is not so much whether we can escape difficulties altogether, they are almost as certain as are death and taxes. Instead, we might ask: how can we minimize their occurrence and, when they do occur, resolve them? That, however, raises the question of *who* is responsible for repairing healthcare relationships when they go downhill – doctors, patients or both?

There is good reason to think that physicians and other healthcare professionals bear the full burden of building and maintaining effective healthcare relationships with their patients. Even though patients now have the final word when it comes to decisionmaking and so share some of the power in these relationships, they often feel intimidated and insecure when it comes to playing an active, assertive role in their care. At the same time, doctors, with their medical knowledge and historical aura of authority, often have a tremendous psychological advantage over their patients.

Perhaps it is for just these reasons that instructions for maintaining and repairing difficult relationships are earmarked for professionals, with none offered to patients – at least none that could be found by this writer. For our part, however, we believe that physicians bear great responsibility for building and maintaining healthcare relationships, but not necessarily all of it. It is our belief that those who take full advantage of their rights as patients share some of that responsibility. Within these pages, therefore, articles offer patients food-for-thought on, and practical tips for, minimizing and repairing difficulties in those relationships. Use them in good health.

*Judith A. Greenfield*

**Project Update**

***Award of Distinction***

We are pleased to announce that the Summer/Fall 2004 issue of this publication, on the topic of finding, using and being patient advocates, has received an **Award of Distinction**, bestowed by *The Communicator Awards*, for exceeding industry standards for communicating a message or idea. That issue is currently posted on our web site at **www.healthcp.org**.

***Project Advisors***

We are delighted that the following healthcare professionals have agreed to serve as advisors to the Project. Patients who would like to serve as advisors are encouraged to contact us.

**Barry Bub, MD** is a physician, psychotherapist, educator and author of *Communication Skills that Heal*, Radcliffe Medical Press, Fall 2005.

**Sheldon Marc Feldman, MD, FACS** practices at Beth Israel Medical Center, in New York City, where he is Chief of both its Appel-Venet Comprehensive Breast Service and its Division of Breast Surgery

**Neil Prose, MD** is Director of Pediatric Dermatology at Duke University Medical Center. He also teaches courses and seminars, on doctor-patient communication, for medical students, residents and practicing physicians.

**Kathryn R. Reed, CMPE** is a member of the executive staff of the Mid-Hudson Family Health Institute and also serves as Executive Director of the Catskill Hudson Area Health Education Center, located in Highland, NY.

## The 21<sup>st</sup> Century Patient: Coming of Age

Times are changing. So are patients and the way we interact with our doctors. Where before we were expected to be passive and “patient,” now we are urged to be active and assertive – to claim our rights to know and decide. This is a good thing because, as patients, we have much to contribute when it comes to the process of figuring out what is wrong and deciding what to do about it. Not only do we have important knowledge and insights, but we also have the greatest stake in the matter. It is we, after all, who will bear the consequences of healthcare decisions. Yes, it is very good that patients are becoming assertive.

That being said, it is important to ask *how* we can assert ourselves without creating discord in the relationship – without preventable creating difficulties. A look at where we’ve been and where we’re going may help answer this question.

For centuries, the prevailing view was that normally competent adults become vulnerable and childlike when afflicted with an illness, leaving them unable to understand anything about their medical condition or what to do about it. In that respect, the doctor-patient relationship mirrored the parent-child relationship. Because doctors were primarily men, it was called a paternalistic relationship. Around twenty to thirty years ago, that view began to change. Patients and their advocates were arguing that illness did not automatically render them incompetent to make decisions and that, given the potentially harmful effects of new, life saving treatments, they should be given the opportunity to give their informed consent. This view now prevails and patients have begun making the not-so-easy transition from being submissive to being assertive.

Some may approach this new role timidly, by prefacing their comments with something along the lines of, “*I know I’m not an expert, but...*” It’s almost as if they are apologizing for speaking up. This approach can help pave the way by sending the message that the intent is to contribute to, rather than challenge, the discussion, but it also tells doctors that we are not so confident in what we are saying, making it easier for them to dismiss it. Others may decide to stand tall, to say what they have to say respectfully, without hostility, but also without apology. This approach sends the message that we have confidence in ourselves and expect to be heard – that we expect to be given the respect that we deserve. This approach seems just right! Yet those of us who follow this path may find that doctors sometimes take what we are saying the wrong way. How can this be?

One explanation has to do with the attitudes, biases and past experiences that influence what we say and how we hear things. This is as true of doctors as it is of anyone – despite their goal of maintaining objectivity. The way doctors take what their patients say, therefore, may have nothing to do with the actual patients themselves. For instance, doctors may take requests for a particular medication as a challenge of their expertise – an interpretation that may have less to do with the patients actually making the requests than it does with the current climate. That is, in this age of patients’ rights, doctors are often thought of as the bad guys. And they know it.

A variety of reasons, some inspired by doctors themselves, may account for this view. One reason, however, is the shift (backed by patient advocates) of the doctor-patient relationship to a business model in which patients are consumers and doctors are providers. This model, marked by a “Buyer Beware” warning, encourages distrust. It also encourages some patients to, in effect, to find other doctors if the ones they have will not do, or give them, what they want.

One outcome of this unfriendly climate is that even respectfully offered opinions and requests may push buttons that others have created, leading doctors to misinterpret our intentions and, perhaps, to feel challenged and angry. A lesson to be learned from this, then, is that we may need to pave the way after all. The question is, *how*? To apologize still defeats our purpose and sends a wrong message. It is important that, as patients, we present ourselves as equals and experts in our own right. We should present ourselves, and be seen, as partners whose views and questions deserve consideration, not automatic dismissal. And therein lies a two-part answer to how we might pave the way for respectful, harmonious relationships and encounters.

First, we consider what we want to be – active, assertive consumers or active, assertive partners. If it is the latter, we pave the way by letting our doctors know that our interest is in exploring things with them, not in telling them what to do. Or our interest is in understanding, not in challenging. In other words, we explain instead of apologizing. True, this may not always have the desired effect but, even if that is the case, at least we will know that we have done our part. Another way of looking at this is to continue the parent-child comparison for the doctor-patient relationship. By becoming partners with our doctors, we will have made the transition from patient as child (paternalistic model) to patient as adult (collaborative model) – bypassing or discarding patient as defiant teenager (business model). We will have come of age.□

***It is important to ask how we can assert ourselves without creating discord.***

## Doctors: What Drives Their Engines?

As little as 20 to 30 years ago patients' complaints might typically have been that their doctors were detached, arrogant and wouldn't tell them what was going on. Today, patients are more likely to criticize doctors for not listening – either interrupting them, “...*I don't want him to hear half my sentence. I want him to hear the whole thing,*” or dismissing them, “*If I'm worried about it because I feel [a] problem exists...I definitely want it to be taken seriously.*”<sup>1</sup> The frequency of these complaints makes one wonder. Why would doctors not tell and not listen, for instance? A partial answer can be found by a look at some of the forces that have driven them over the years. We begin with Hippocrates.

From the time of Hippocrates, in the fifth century B.C. through the late 1800s, medical knowledge had little substance and doctors didn't know if cures were the result of effective treatment or something else. What doctors did know was that, under these circumstances, their power to heal patients would stem more from their ability to inspire confidence than from their medical abilities. They were therefore advised by their mentors to set themselves apart from their patients and to use their social and cultural status, along with their medical training, to establish their dominance. The tactics for doing so, varied.

Hippocrates, for instance, urged doctors to reveal “...nothing of the patient's future or present condition,” and to engage in conversation with patients only so far as it encouraged patients' acceptance of prescribed cures.<sup>2</sup> Much later, in the 17<sup>th</sup> and 18<sup>th</sup> centuries, some doctors spoke out about the value in educating patients. Even so, these same doctors believed that patients wanted to be deceived and saw manipulation and deceit as the best way of getting patients to follow their instructions. Around the same time, one suggestion for creating an air of authority involved “[A]rriving in ‘roadsters with their green saddle-cloths...[with] four footmen in similar livery, and spouting a little Latin’.”<sup>3</sup> So it was that centuries of being arrogant and keeping patients in the dark was justified by a genuine concern for the patient's good.

All that began to change in the late 1960s and early 1970s when it was learned that participants in scientific studies were routinely deceived. This provided the impetus for ethical and legal questions of informed consent.<sup>4</sup> Around

the same time, advances in science and medical technology enabled doctors to extend lives that would otherwise have ended – leaving some with such a low quality of life that it was the subject of much contention. Terri Schiavo is a more recent and very notable example.

As a result of the uproar generated by these and other types of events, today's physicians know they may not impose treatments on patients – that patients must give their *informed* consent before treatments can begin. And that requires them to tell their patients what is going on, what their choices are and to explain the risks and benefits of each. But change is hard for anyone – especially when asked to discard more than 2000 years worth of teachings. Under those circumstances, it's not surprising that we often see changes in form but not substance. That is, some physicians may go through the motions of acting differently but, when looked at closely, we might see that little has changed.

Many reasons account for this, with historical influences topping the list. The fact that most medical schools now offer at least one course on communicating differently with patients has been an encouraging start. Yet, even when medical schools emphasize “patient-centered” care, as is the case with the University of Western Ontario's Department of Family Medicine, those teachings are often lost when students shift from learning in the classroom to learning in hospital settings. Why? The answer, according to one of its classroom professors, is that hospital-based faculty, often of the old school, instruct students in old-style behaviors.<sup>5</sup>

Meanwhile, modern constraints related to science and time also conspire to thwart even well intentioned physicians from responding, as they might wish, to patients. Early scientific and technological advances allowed doctors to see and hear patients' symptoms for themselves. With tools such as stethoscopes and ophthalmoscopes, for instance, they no longer needed to rely on patients' reports of their symptoms.<sup>6</sup> As scientific discoveries progressed, so too did the importance of objective knowledge – knowledge grounded in proven facts and, ideally, free of bias. Previously missing, vital aspects of medicine were now in place!

See *Doctors*, pg. 5

*From the time of Hippocrates... through the late 1800s, doctors knew that their power to heal patients would stem from their ability to inspire confidence... [so] they were urged to reveal “...nothing of the patient's future or present condition...”*

**Doctors, continued from pg. 4**

With objective knowledge about diseases and the development of technologies to treat them, doctors are doing just that – focusing on treating *diseases* (as opposed to treating sick *persons*). With objective knowledge at hand, the tendency to distrust and dismiss unproven, possibly biased, subjective knowledge grew. Medicine was soon seen as having two distinct parts: the science of medicine (a systematic and objective basis for understanding the human body and its afflictions) and the art of medicine (being able to subjectively understand, and effectively communicate with, patients).<sup>7</sup> Scientifically obtained, objective knowledge is valued so much that even patients tend to put great store in it. While they might prefer doctors who have personal skills, many patients would argue that those abilities are not needed for the task of diagnosing and treating ills.

Reliance on objective – or evidence-based – knowledge has had its effect on the way doctors respond to patients. Like the earlier advances that enabled doctors to see and hear symptoms without relying on patients to describe them, the belief that objective knowledge is enough for good doctoring has provided yet another basis for not having to listen to patients. This is one reason why, soon after patients start telling the story of why they came to see the doctor, they are often interrupted by a series of questions – questions that, from a scientific standpoint, doctors expect will provide the answers needed for determining next steps.<sup>8</sup>

Time plays a role here as well. Doctors are often concerned that letting patients say everything they want to say will not only be of little diagnostic value, but will also take more time than they have to give to each patient. The current insurance reimbursement system, where insurance companies negotiate fees for various healthcare services, has particularly affected primary care physicians. Insurers do not pay doctors for listening. As a consequence, primary care doctors must see more patients in a day in order to make ends meet. Seeing more patients in a day means less time to spend with each and, in turn, means less time to listen.

Between modern and historical forces that influence how doctors respond to patients, there seems to be little hope of significant change. But there is hope! Inviting patients to speak, listening to them and acknowledging their concerns, not only can have profound effects, but have been shown to minimally, if at all, increase time spent.<sup>9</sup> Fortunately, there are increasing numbers of physicians and other healthcare professionals who are showing that subjective information is also vital for the successful treatment of patients. Furthermore, they are showing that skills associated with the “art” of medicine – listening to and appreciating what patients are going through, for instance– can be taught.

***Today’s physicians know they may not impose treatments on patients – that patients must give their informed consent before treatments can begin... But change is hard for anyone – especially when asked to discard more than 2000 years worth of teachings.***

So who will teach them? Mostly it’s been a number of groups, such as the American Academy on Physician and Patient, [www.physicianpatient.org](http://www.physicianpatient.org), who work with practicing physicians as well as hospital-based physician educators. But we, as patients, can play a role here as well. By trying to resolve our own difficult situations [see pgs. 6, 8], we can provide doctors with an opportunity to respond differently to us and, through that experience, to hone their skills for communicating with other patients.□

<sup>1</sup> Judith A. Greenfield, *A Health Partnership: A Qualitative Study of Patients, Nurses and Medical Practitioners on Collaborative Decision-Making* (MI: UMI Dissertation Services, 1996), 45.

<sup>2</sup> As reported by Jay Katz, MD in *The Silent World of Doctor and Patient* (NY: The Free Press, 1984), 4

<sup>3</sup> See note 2, pgs 11, 13-16.

<sup>4</sup> Albert R. Jonsen, “The Birth of Bioethics,” *Special Supplement, Hastings Center Report* 23(6):S1-4 (1993).

<sup>5</sup> Judy Belle Brown, MSW, PhD, speaking at the AAPP Research and Teaching Forum, *Emerging Trends in Health Communication*, Maritime Institute of Technology, MD, October 11, 2003.

<sup>6</sup> Paul Starr, *The Social Transformation of American Medicine* (NY:Basic Books, 1982), 136.

<sup>7</sup> Eric J. Cassell. *The Nature of Suffering and the Goals of Medicine*. (NY: Oxford University Press, 1991), 21.

<sup>8</sup> H.B. Beckman and R. M. Frankel, “The Effect of Physician Behavior on the Collection of Data,” *Annals of Internal Medicine* 101(1984): 692-696.

<sup>9</sup> See note 8.

*We would love to come speak with your group about this or other doctor-patient matters. For a listing of topics, visit our web site at [www.healthcp.org](http://www.healthcp.org) or call us at 845-687-2328 and ask for a brochure.*

## Difficult Situations: Four Scenarios And Ways to Deal With Them

*Note: When difficulties occur and doctors seem uninterested in changing their ways, patients are faced with a choice: to accept the situation, or not. If not, then they must choose between finding another doctor or first trying to resolve the problem. How much of an effort is made, by those who want to give it a try, is up to each individual. The amount of energy one has for this effort may be one determining factor. The following suggestions for resolving problems offer no guarantees of success and are only some of the routes that might be taken. Readers are encouraged to adapt these approaches to fit their own comfort levels. Scenarios continued on pg. 8.*

**The doctor dismisses your concerns. Perhaps he or she feels your problem is due to your age, to stress, or to being overweight. Even though that may be right, you're worried it might be due to something else.**

### ***To Avoid This Scenario...***

It is often hard to anticipate that a doctor will dismiss your concern. That being the case, your efforts will have to focus on resolving the problem. If, however, you go to a new doctor after having had your concerns dismissed, then steps to avoid being dismissed again might include:

First, prepare for your first visit with the new doctor by listing your symptoms and explaining why you think they may mean your problem is due to something other than your age, weight or stress. Also list, or bring in, your medications (including any dietary supplements). Bring two copies of the lists so both you and your doctor can keep track of things.

Second, begin with explaining to the doctor why you are there – starting with the fact that your concerns were dismissed by another doctor.

*Doctor, I'm here because I've been having (describe symptoms). The other doctor told me it was due to stress/age/weight, but I'm not convinced because...*

*I know she may be right, but she didn't really look into it. That's what I'm hoping you will do – check this out a bit more before you decide it's not due to something else. To help me remember, I've written everything down. Here's a copy for you.*

### ***To Resolve This Scenario...***

To work through this with your doctor, you might explain why you are not convinced the diagnosis is correct and then ask:

*Doctor, if I were not old/overweight/stressed, what would you think these symptoms could mean and how would you check them out?*

Then, negotiate\* with the doctor, including next steps, what results to expect one way or the other, and when, if at all, to try something else. Try to reach agreement on what it would take to convince each of you that the original diagnosis is correct or that your problem is due to something else.

\* For tips on how to negotiate, send an SASE to us at P0 Box 661 Stone Ridge, NY 12484. Or visit [www.healthcp.org](http://www.healthcp.org), click on articles and scroll down to "Doctor-Patient Negotiation."

**Your doctor tells you its time for you to find another doctor – in effect, "firing" you.**

Reasons for being fired vary. Perhaps the doctor feels the patient was too inconsiderate or angry\*. If that describes your case, an apology *should* be given. Along with an explanation, that may help resolve the situation. Avoidance is obvious: if the doctor won't, for instance, write the note, or send you for the test, or give you the medication you want, don't get angry, get curious. Ask: *Doctor, why don't you want to do this?* Then listen, discuss and, perhaps, negotiate.

Other times, patients might be fired after questioning their doctors or rejecting prescribed treatments – for instance, medications. In the ideal world, this should not happen. But it sometimes does. In deciding whether or not to try to repair the relationship, you might take into account the strength of the relationship up to this point. You might also ask if it is repairable and worth the effort to try doing so. If your answer to both questions is 'yes,' then you might try to make it clear that your questions do not mean that you question their expertise.

### ***To Avoid This Scenario...***

You might pave the way by explaining:

*Doctor, when I was taking this drug I felt (describe symptoms). It worried me, so I decided to learn about it and found out (describe). Or, it worried me so I stopped taking it.*

*I really can't live with this so I don't want to take it anymore. What do you suggest? Is there something else I can do or take?*

### ***To Resolve This Scenario...***

You might try to invite discussion by saying:

*Doctor, I've been questioning you because I'm having trouble with the side effects of this medication, not because I don't value what you have to say. I do, which is why I'm here asking you what else I can do or take. If that's the reason you think I should find another doctor, perhaps you might reconsider. Or is there another reason?*

\* Visit [www.healthcp.org](http://www.healthcp.org), click on articles, scroll down and click on "Stories of Reaching Out."

Approaches, continued from pg. 6

**The doctor interrupts you when you're in the middle of explaining the first of several concerns you have. If you don't get to raise your other concerns, you leave feeling frustrated. If you finally raise them at the end of the visit, the doctor gets annoyed.**

***To Avoid This Scenario...***

You might try bringing a list of concerns with you so that the doctor can see, at the beginning of the visit, all the things you want to talk about. Bringing two copies, says Dr. Fred Platt, may help those doctors, who don't like lists, accept them.<sup>1</sup> Two copies allows both patients and doctors to select the most important concern(s) to be addressed at that visit and, given time limits, to manage the time spent on them.

If your doctor does not like patients to bring lists, you might explain:

*Doctor, I have a number of things to ask you about and I don't want to forget them. I know you have to pace yourself during this visit so I brought a copy for you.*

If you don't bring a list and the doctor interrupts you to ask pointed questions about the first concern you raised, you might respond by saying:

*Doctor, before I answer your question I just want to let you know that I have some other things that I need to talk to you about.*

Or, if you don't have other concerns but have more to say about the one you have raised, you might say:

*Doctor, I'm happy to answer your questions but I want you to know that I have more to tell you about this.*

***To Resolve This Scenario...***

If the doctor is annoyed because you raised a new issue at the very end of the visit, you might say:

*Doctor, I understand that you would have wanted me to tell you this at the beginning of our visit and I was planning on doing that. But when we focused on the first problem I forgot about it (or didn't get a chance, until now). What can we do to avoid this next time? Should I bring a list? I can make a copy for you, too.*

**You feel that the doctor is rushing you into making a decision that you are not ready to make.**

***To Avoid This Scenario...***

There definitely are times when important decisions must be made immediately. Emergency, life-threatening situations are some. Other, serious situations, may call for major decisions to be made as soon as possible. Still others may require major decisions, but allow some time for making them. It's not always easy to tell which is which. For this reason, you should first try to find out how important it is to make a quick decision and what "quick" means. You might ask:

*How much time do I have to make this decision? What will happen if I don't make it right away but take the time to learn about it and figure out what I want to do?*

If, after getting answers to those questions, you want to take some time to decide what to do, tell the doctor. You might ask him to respect that and to help you in your efforts to figure out what you want. You might, for instance, ask him to direct you to sources of information and support.

You may feel that you want to get a second opinion before making a decision. While many doctors accept this, it might help to let your doctor know that seeking another opinion doesn't mean you don't value his. You might say:

*Doctor, this is a major, life-changing decision for me and I just can't make it right away. I need to sort through everything. I'm thinking of getting a second opinion and want you to know that it doesn't mean I don't value yours. In fact, I'd like to come back and talk to you about it. I'm counting on you to help me work through this.*

***To Resolve This Scenario...***

You might let the doctor know you are feeling rushed. Try to find out why. Explain your need to take some time. Talk about what he can do to help you decide and, perhaps, reach agreement on a target date for making that decision. You might begin by saying:

*Doctor, I am thankful for your concern, but I'm feeling very rushed. I need time to really understand my options, and how they will affect my life, before deciding. What is likely to happen if I wait? How likely?*

<sup>1</sup> F.W. Platt. "The Dreaded List." *Patient Care*. 31(4): 122. (Feb 28. 1997).