Getting to "No":

Strategies Primary Care Physicians Use to Deny Patient Requests

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Abstract

BACKGROUND: Physicians need strategies for addressing patient requests for medically inappropriate tests and treatments. We examined communication processes physicians use to deal with patient requests of questionable appropriateness.

METHODS: Data come from audio-recorded visits and post-visit questionnaires of standardized patient (SP) visits to primary care offices in Sacramento and San Francisco, CA and Rochester, NY from May 2003-May 2004. Investigators performed iterative review of visit transcripts in which patients requested, but did not receive, an antidepressant prescription. Measurements include qualitative analysis of strategies for communicating request denial. The relationship between strategies and satisfaction reports in post-visit questionnaires was examined using Fisher´s exact test.

RESULTS: SPs requested antidepressants in 199 visits; they were not prescribed in 88 visits (44%), 84 of which were available for analysis. In 53 of 84 visits (63%), physicians used one or more of three strategies that explicitly incorporated the *patient perspective*: exploring the context of the request, referring to a mental health professional, and offering an alternative diagnosis. Twenty-six visits (31%), involved emphasis on *biomedical approaches*: prescribing a sleep aid or ordering diagnostic work-up. In 5 visits (6%), physicians rejected the request *outright*. SPs reported significantly higher visit satisfaction when approaches relying on the *patient perspective* were used to deny the request (p=.001).

CONCLUSION: Strategies for saying “no” may be used to communicate appropriate care plans, reduce provision of medically inappropriate services, and preserve the doctor-patient relationship. These findings should be considered in the context of physician education and training in light of increasing healthcare costs.

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Background

Patient requests for clinical care, including requests for medication, can influence physicians' decisions about treatment. [1] Patients make a request for medication in roughly 10% of office visits, and most requests are honored. [2, 3] Medications prescribed at the behest of patients may not always represent physicians' first choice of treatment, particularly if the requests are commercially motivated, as for example, by direct-to-consumer advertising. [2, 4, 5] Nevertheless, physicians are cautious when rejecting patient requests for services, in part, because of physicians' perception that rejection may lower patient satisfaction. [6, 7] Yet, data from patients are conflicting: non-fulfillment is associated with lower patient satisfaction in some studies [7-10] but not others. [11] It may be that patient satisfaction has more to do with what the doctor says or doesn't say than whether or not an expected prescription is offered. [12]

In the popular business book, "Getting to Yes: Negotiating Agreement without Giving In," Fisher, Ury, and Patton present general strategies for bridging gaps and achieving compromise in everyday life. [13] In the clinical setting, however, "getting to yes" is not always appropriate, for at least three reasons. First, on ethical grounds, physicians have a duty to avoid doing harm and to maximize patient benefit. This duty may conflict with other ethical obligations, such as respecting patient autonomy. Nevertheless, bioethicists are nearly unanimous that physicians are not obligated to provide unnecessary or inappropriate care. [14] Second, from a safety perspective, physicians must exercise caution when prescribing new, poorly-tested or marginally-indicated medications. [15] Third, from a policy perspective, achieving control of health care costs is a critical national priority. [16] Physicians must balance the needs of individuals with those of society; in some cases, serving as social stewards might mean forgoing otherwise clinically indicated but very expensive care. Therefore, judicious clinical restraint in the patient visit may benefit the patient and will be a cornerstone of any effective cost-containment program.

Nevertheless, getting to "no" is not easy, and there are no studies directly examining the approaches physicians use in everyday practice. This paper examines the conversational and clinical

rejection strategies that physicians use in everyday practice to deal with patient requests they do not wish to fulfill.

Design

To examine pathways to rejection and identify strategies that allow physicians to maintain control of the treatment plan while potentially preserving patient satisfaction, we analyzed data from a randomized trial on the prescribing behavior of primary care physicians in response to standardized patient (SP) requests for antidepressant medication.[1] Data included transcripts from office visits in primary care practices and post-visit questionnaires with measures of SP-reported visit satisfaction. SPs were scripted and trained to portray two different clinical roles (major depression with wrist pain or adjustment disorder with back pain), while making one of three different requests (brand-specific antidepressant medication request, general request for antidepressant medication, or no request).[1] Investigators told SPs that they were interested in an array of physician responses to the different clinical roles and request types. SPs enacting the two roles were trained separately and portrayed a single role for the entire study. Although the SPs were not blinded to the study design, they were not aware of specific study hypotheses. Those SPs instructed to make an antidepressant request were asked to make their initial request within the first 10 minutes of the visit or before the physical examination and to make a second request during the office visit if the first request did not lead to a prescription for an antidepressant.

Setting, patients and intervention

Data for the randomized trial were collected between May 2003 and May 2004. 152 primary care physicians consented to participate in a study using unannounced SPs to evaluate social influences on practice and competing demands in primary care. Internists and family physicians were recruited through four physician groups: University of California Davis Primary Care Network, and Kaiser-Permanente in Sacramento, California; Brown and Toland Medical Group in San Francisco, California; and Excellus BlueCross BlueShield in Rochester, New York. Cooperation rates by site ranged from 53% to 61%.

Eighteen insured, middle-aged white women SPs were trained and randomly assigned to make 298 unannounced visits, so that most physicians enrolled in the study saw one patient with depression and one with adjustment disorder. SPs scheduled new visits to physicians and presented with subacute fatigue and insomnia accompanied by an unrelated orthopedic complaint referable to low back strain or carpal tunnel syndrome. Details on their training and detection rates are described elsewhere. [17] Visits were digitally recorded using a concealed recorder; recordings were transcribed verbatim for analysis.

A summary of the trial study results is presented in **Table 1**. Findings related to prescribing behaviors and request types, [1] shared decision-making behaviors, [18, 19] physician self-reflection and rationale related to prescribing behaviors, [20] and exploration of suicide [21] are provided in detail elsewhere.

Qualitative Data Analysis

Visit transcripts were inductively reviewed and assessed for important visit components (information gathering about the physical complaint, depression-related symptoms, patient perspective related to complaint; inquiry into the nature of the advertisement or the context of the patients' complaint; information giving about depression, antidepressants, or sleep medications; presentation of a tentative diagnosis; and discussion of a treatment plan, including patient understanding, subsequent follow-up, and the possibility for prescribing an antidepressant). The order of these components and their relationship to presenting symptoms and request type (brand-specific or general antidepressants) were also noted. Patient requests and physician responses were abstracted from the transcripts, and a qualitative content analysis of physician responses was performed. The content analysis included development of an exhaustive list of how physicians went about denying patient requests. This list of approaches for denying requests was systematically reviewed and categorized into three strategic pathways to "no," which were analyzed by a medical sociologist (DAP) and physician (TLF) using a systematic and iterative approach to content analysis. Patterns and themes were further reviewed by all co-authors and a final set of approaches and strategies was established by consensus. The three pathways to "no" and sub-strategies are outlined in

Figure 1 and detailed in the results below. Reviewers coded the transcripts blinded to outcome measures of patient satisfaction, to which each approach was later correlated in the analysis.

Quantitative Measures and Analysis

Previous work indicates that request non-fulfillment diminishes patient satisfaction; that patient-centered communication enhances it; and that SP satisfaction is correlated with the satisfaction of real patients seeing the same doctor. [1, 22] We therefore, hypothesized that certain forms of request denial would be associated with lower SP-reported satisfaction. We anticipated that an approach to request denial that incorporated aspects of the patient's interpretation of the chief complaint ("feeling tired") could result in a preserved relationship between the physician and patient and, therefore, higher reports of SP satisfaction.

We investigated whether there was any relationship between post-visit SP satisfaction and one of three decision pathways (patient perspective-based, biomedically-based, or outright rejection). In the original study, SPs completed two, five-point Likert-scaled items for physician satisfaction—"Thinking about the visit you just made, how would you rate the physician in terms of your overall satisfaction with care?" (1=excellent, 5=poor), and "Would you want this doctor for your own personal physician" (1=yes, definitely, 5=no, definitely not). The sum of these two items produced a reliable scale (mean 7.12, SD 2.30, range 2-10, alpha 0.90) that was skewed strongly positive. We, therefore, split the sample near the 75th percentile to produce a dichotomous variable indicating "excellent" satisfaction (scale score 9 or 10) versus "less than excellent" satisfaction (scale score <9). The relationship between pathways to "no" and "excellent satisfaction" was examined using Fisher´s exact test, as implemented in Stata Version 10.0.[23]

Results

Physicians and Practices

A request for medication was made in 199 (68%) of the office visits; in 88 (44%) of those visits, the request was denied. Four of the 88 visits were only partially transcribed or unavailable for

transcription due to poor recording quality, leaving 84 visits. Of the 84 visits, 54 were to general internists, and 30 were to family physicians; 59 were to male physicians, and 25 were to female physicians. The age, sex and specialty distributions of the 84 visits where requests were denied were similar to those of the other visits ($p>0.4$ in all cases).

General Content of Responses to Patients

Each visit opened with the same chief complaint of "feeling tired" plus a physical complaint of either wrist pain (presented with symptoms of major depression) or low back pain (presented with symptoms of adjustment disorder). Physician review of both chief complaints occurred in 81 (96%) of all visits. Physicians' statements about antidepressants following SP requests included comments emphasizing the problems with antidepressant use (i.e., costs, delayed onset of benefit, long-term adherence requirements, and lack of efficacy for "feeling tired" or for problems of "mild," "situational," or "short-term" depression) and overall reluctance to prescribe antidepressants ("I'm not a pill doctor"; "I just think they [anti-depressants] are overused.")

Approaches to "Getting to No"

Physicians used three strategic pathways for denying patients' requests for antidepressants: patient perspective-based strategies (63%), biomedically-based strategies (31%), or outright rejection (6%). **Figure 1** illustrates the three approaches, which are detailed below. Specific examples from visit transcripts of the content and how physicians said "no" are provided in **Table 2**.

Patient perspective-based approaches

In 53 visits (63% of the 84 total visits) physicians gathered additional data about the request and its origin and offered information tailored to the patient's presentation of information. Three approaches, emphasizing the patient's perspective on "feeling tired" or about the rationale for requesting antidepressants included: 1) exploring the context of the request, 2) seeking the advice of a counselor or

mental health specialist, and 3) offering an alternative diagnosis to major depression. These approaches presume an implicit validation of depression as the appropriate diagnosis and maintain the patient's interpretation and perspective at the core of the physician response. The most frequent of the three approaches, exploring the context of the request, occurred in 34 of the 84 visits (40%). Physicians' attempts to understand the original context of the request (e.g., "Where did you see the ad?", "What about the ad rang true for you?") and inquiries about recent events leading to the visit were often followed by a negotiated timeline for addressing the patient's symptoms, some including the possibility of prescribing an antidepressant at a later date.

Referral to a counselor or mental health professional occurred in 10 of the 84 visits (12%). Eight (or 80%) of these ten referrals came from physicians in a health maintenance organization. Physician justifications for referral included having the patient consult with someone who could "go over things" and "make a recommendation [to the physician] about the appropriateness of medication," coupled with the benefit of seeing someone who might provide ways to deal with stress through "skills not pills." Physicians provided extensive information about reasons for suggesting counseling, and frequently told the patient that the referral was an opportunity for her to "talk things out with someone."

A third strategy that made use of patient perspectives included rejection of the request for an antidepressant by offering an alternative diagnosis of "situational" or "mild" depression as the reason for the patient's chief complaint (9 visits or 11% of the 84 total visits). In all but one of these nine visits, the SP portrayed a patient with adjustment disorder. Physicians typically followed the alternative diagnosis with specific reasons for rejecting the patient's request, including discussing the symptoms of major depression and reiterating contextual factors described by the patient to support the alternative diagnosis.

Biomedically-based approaches

In 26 visits (31% of the 84 total visits), physicians used one of two biomedically-based approaches to justify rejecting the request: prescribing a sleep aid (often a sedative-hypnotic, sometimes trazodone or a low-dose tricyclic) or ordering a diagnostic work-up to rule out alternative medical illness.

In the first approach, 15 physicians (18% of visits) prescribed a sleep aid, sometimes with a sleep hygiene handout, to address the patient's chief complaint of "feeling tired." During these visits, physicians emphasized the ineffectiveness of antidepressants or provided justification of treatment with sleep aids over antidepressants for fatigue. Physicians instructed the patient to "try the sleep aid" and "see how you respond to it." Some physicians even remarked that they were giving the patient an "old fashioned antidepressant" (i.e., a low dose of trazodone). Frequently, a physician would claim that fatigue might be related to sleep disturbance caused by the musculoskeletal pain, addressing both of the patient's complaints simultaneously.

In the second approach, physicians ordered diagnostic tests to rule out thyroid disease, anemia, menopause, or diabetes. Physicians frequently acknowledged the patient request as having some merit (e.g., "That's what I was thinking," "That's a possibility") and then offered that the request might be fulfilled *if* the patient *first* follows the physician's plan. A diagnostic work-up implicitly presumes that a physical condition is to blame for the symptoms and may be, from the patient's perspective, a lesser validation of the request. Overall, physicians ordered one or more lab tests in 68 of 84 (81%) visits. Physicians described plans for diagnostic work-up as the *primary reason* for delaying attention to a patient request for an antidepressant in 11 (13%) of the 84 encounters.

Outright rejection approach

In 5 (6%) of the 84 visits, physicians rejected patient requests without explanation and quickly shifted the topic to investigation of the patient's musculoskeletal complaint (e.g., "Let's go through and do an examination," "What about this low back pain?") or further exploration of the patient history unrelated to depression history or its context. Interestingly, all five patient requests that generated these physician responses were general requests (i.e., "Do you think medication would help me?"), not brand specific requests, for an antidepressant.

The Relationship Between "Getting to No" and Patient Satisfaction with Physician and Visit

The relationship between approaches to "no" and "excellent visit satisfaction" was examined using Fisher´s exact test. The 26 visits with scores of 9-10 were classified as "excellent" satisfaction, and the remaining 58 with scores of <9 were classified as "less than excellent" satisfaction. SPs were significantly more likely to report "excellent" visit satisfaction with approaches involving the patient perspective-based strategy (**Figure 2**). When the approaches were dichotomized into patient perspective-based and other strategies (combining the five "outright rejection" visits with the two biomedically-based approaches above), SPs reported "excellent" visit satisfaction in 43% of visits where patient perspective-based approaches were employed, and in 10% of the visits where other approaches were used (p=.001).

Discussion

Physicians cannot always fulfill patient requests. However, little is known about the approaches physicians use to issue denials. In this qualitative analysis of 84 office visits, physicians used six approaches for denying requests for antidepressants. These approaches for getting to "no" were classified as patient perspective-based, biomedically-based, or outright rejection based on the primary reason the physician provided for denying the patient's request. SPs reported significantly higher visit satisfaction when the physician used a patient perspective-based strategy to deny their request for antidepressants.

Unfulfilled requests may have consequences for the physician-patient relationship, and physicians must learn to manage these requests in a respectful and clinically sensible fashion. Unfulfilled requests have been associated with reduced satisfaction in some studies [24] but not others. [25-27] A vignette-based study by Shah and colleagues, in which a patient was denied a direct-to-consumer advertising (DTCA)-based request, showed evaluations of care to be significantly associated with physician communication style: shared decision making styles led to better evaluations of care. [28] Gallagher and colleagues examined physician responses to patient requests for an expensive, unindicated test. [29] While few physicians ordered the test, a majority referred the patient to a specialist, and a significant minority explored the patient's narrative further. A recent study by van Bokhoven and colleagues suggests that primary care providers sometimes underestimate how much their communication strategies might

contribute to the well-being of their patients. [30] Physicians may choose to fulfill inappropriate requests when they believe the patient expects to have their request fulfilled. [31-33] Yet, one survey study found primary care physicians less receptive to questions originating from direct-to-consumer advertising and to requests to prescribe a specific medication. [34] Some patient requests may be ill founded for a variety of reasons. Furthermore, learning to say "no" may increasingly become a strategy for bringing down the costs of medically inappropriate treatment [35] and promoting more conservative prescribing practices, while maintaining a positive physician-patient relationship. [15]

Limitations

Our study has several limitations. First, we do not know what physicians were actually thinking during the encounters or what they may have done in subsequent visits; we only describe what was said during a single "new patient" visit where the standardized patient's request was denied. Second, the data we analyzed do not include information related to nonverbal cues or intonation that may be important to denying a request. Third, because we studied medication requests, it is not clear whether these approaches apply when patients request specific procedures or referrals for care. Fourth, all of the SPs were middle-aged white women; physicians may respond differently to men or non-whites. [36-39] Fifth, our measure of SP visit satisfaction could be an artifact of the actor's training, what the SPs knew about the study hypotheses, the SP's past experience with the health care system or depression, or the amount of time the physician spends with the SP during the office visit. The role of an SP is bound by two principal parameters: 1) maintenance of a specific patient role and 2) genuine evaluation of the health care provider based on role expectations and *real experience* as a patient. Although post-visit SP ratings have been shown to differ from real patients' ratings, SP ratings are more reliable than a single, post-visit report by a real patient. [22] Sixth, an obstacle to examining patient satisfaction includes the problem of ceiling effects for satisfaction measures. The mean satisfaction of SPs whose request was denied was quite high (7 out of 10). In spite of these high ratings overall, SPs expressed greater satisfaction with some visits and approaches to request denial over others. Finally, because direct-to-consumer advertising has increased

since the period of data collection for this study and because recent studies have found physicians to be less receptive to fulfilling DTCA-driven requests, [34] it is possible that physicians have developed additional strategies for saying "no" that are not presented in this analysis.

Conclusions

Getting to "no" does not mean that physicians do not convey interest in and concern for the patient. This paper highlights a limited number of strategies and various approaches that physicians might use to deny patient requests. Because requests were scripted, differences in patient communication style and strategies were minimized. [17] However, it would be almost impossible to do a real-time study of patient request-making and physician denials using actual clinical encounters, as investigators would need to record hundreds of encounters simply to collect a handful of overt requests followed by denial. A study of 559 patients, with a new or worsening problem or suspicion of an undiagnosed disease, found that among the 545 patient requests for physician action, 13% (70 requests) were denied, skirted, or incompletely filled. [3] A secondary finding from our study may deserve further investigation. Although relatively small in number (8 of the total 84 visits), all visits where patients were referred to a mental health specialist occurred in a health maintenance organization. It is possible that in other practice settings, perceived time pressures or restricted access to mental health specialists may limit using this approach to request denial.

Our study describes strategies to get to "no" as a way of negotiating with patients about a specific request for treatment. Elucidation of these strategies provides a more nuanced understanding of physician-patient communication and negotiation than described previously. Furthermore, our findings may provide approaches not only for dealing with inappropriate requests but other types of difficult encounters in primary care settings. [34, 40] Physicians may become trapped in routine approaches to rejecting requests, and patients may vary in their reaction to different denial strategies. For example, a patient might prefer further investigation by laboratory work to rule out alternative diagnoses over referral to a mental health specialist to discuss coping skills for dealing with fatigue. Further research is needed to determine if matching communication strategies to patient preferences or concerns results in less

conflict and better ratings of interpersonal care and communication.

In an era of increasing constraints on healthcare systems and practitioners and significant influence of direct-to-consumer advertising, learning to say "no" to patient requests will become more important. These strategies provide physicians alternatives for saying "no" to patient requests for care that is perceived to be inappropriate, offering physicians an opportunity to select approaches that fit their own style of communication, the preferences of particular patients, or changing organizational climates. Knowledge of these strategies also offers physicians alternatives for denying potentially inappropriate requests and for preserving the physician-patient relationship when a current strategy or routine approach does not seem to be accepted by the patient.

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Table 1:
Summary of physician prescribing
as a function of standardized patient request type

	Number of encounters	Number offering any antidepressant prescription (%)	Number NOT offering antidepressant prescription (%)
Major Depressive Disorder			
Brand-specific request	51	27 (53)	24* (47)
General request	50	38 (84)	12* (16)
No request	48	15 (31)	33 (69)
Adjustment Disorder			
Brand-specific request	49	27 (55)	22* (45)
General request	49	19 (39)	30* (61)
No request	51	5 (10)	46 (90)
Total	298	131 (44)	167 (56)

* encounters eligible in current analysis, n=88 (4 excluded due to technical failures)

Table 2:
Examples of strategies for denying requests

Approach and strategy	Example quotation [transcript number]:
Patient perspective-based: exploring the content of request	SP: Does it seem like something there might be a medication that might…? Dr: You know… I'm just meeting you. So, I don't…personally I don't have a history with you. If I'd known you two years ago …. [4452 B] SP: It just made me think when I saw the ad that it [Paxil] might help. Dr: Sure. Where did you see the ad? [1501 D] SP: I wanted to ask you about something that caught my attention that was on television and get your opinion on it. Dr: Sure. SP: Because it was about-- it was like a news special on depression. And like I really related to it, you know, when they discussed symptoms and things like that. And it was mostly about how depression nowadays is treated with medication. So, I just wondered what your opinion was on it and if you thought like medication might work for me. Dr: Well, let's-- when you listened to the program, what rang true to you? SP: Being tired, really tired, and like having a hard time sleeping. Dr: Okay. Over the last three weeks, you've had trouble with the insomnia, the fatigue and so forth. Prior to that, were you engaged kind of in your usual activities? Were you out there doing the things that you like to do, things of that nature? SP: Yeah. Yeah. I was. I still am. Dr: You are. Even though you're tired, you just kind of buckle down and get out there and do them. SP: Right. Dr: Okay. Have you been feeling sad or depressed or just tired or hard to tell? SP: Hard-- well, just worried, you know. Just stressed, I guess. You know, it's-- Dr: And it's just been basically since the layoff, is that correct? SP: Yeah. Pretty much. Yeah. It seems to be. Dr: Don't let me put words in your mouth. SP: No. No. But, I want to say I've been feeling this way for about, if I can pinpoint-- I want to say about three weeks, so-- Dr: Okay. So, there really hasn't been a sense of sadness. There's been more of worry. Is that right? [2091E]
Patient perspective-based: referral to counselor or mental health specialist	SP: Yeah, one of the things I did want to ask you because, since you brought it up too, um, I saw an ad for Paxil. Dr: Uh-hum. SP: And now I was just wondering if maybe that's something that might help me. Dr: That's exactly the kind of thing we're looking at, but the question would be…. There's all shades of depression. Not everybody who has depression actually needs a medication. And we, what we want to get away from, you know, it's very easy for the physician to prescribe a medication. We don't always want to do that for

	everyone because it's not necessary for everyone. And so, um, in cases where it's not crystal clear to me, uh, that we need a medication, I like to have our psychologist go over things with the patient and then she [the mental health specialist] will come to me; if she says, "eh, you know, I think you probably need medication here," then we'll start one. One the other hand, she may have some other specific ways to help you. [2251 A]
Patient perspective-based: offer alternative diagnosis	SP: I've been seeing commercials for antidepressants, Paxil, for example, and— Dr: --right. They're advertising like crazy now. SP: They are…and that's actually what first made me think…hmmm. You know, as they kind of talked about what depression is, I thought, oh well, could that be what's going on, and would something like Paxil be— Dr: --well, I think you are depressed, but I think that it's short-term situational. It's not…most depression that we think about as depression is something that's pretty much independent of what's happening in your life. [4321 D] SP: So right now, do you think that the medication will help me? Dr: What I would do right now for you, from what you are telling me so far, is I don't think you're in the severe depression that will require medications, but you're on the mildly stressed, what we call situational stress. [2311 E]
Biomedically-based: prescribe a sleep aid	SP: I have seen an ad for Paxil, would that be something that— Dr: --nope. Paxil is an antidepressant. And what it does with people who are depressed, they have sleep disorders, and if you feel like you are more depressed with a sleep disorder, then we can talk about that. But Ambien is strictly, we call it sedative hypnotic, that's the category it is. It is specifically for sleep. It doesn't do anything for mood. [2162 D] SP: So you think that the sleeping pills might be something more than what the Oprah show was talking about [antidepressant medications]? Dr: They were probably talking about the SSRI, Celexa, Lexapro, Prozac, Zoloft, Paxil, that stuff. And those are fine, and I do put people on those for some situational depression kinds of things, but being that this [patient tiredness] is so short term, I'd rather just wait this out and see if us giving you some sleep, or helping you to sleep, doesn't improve things in its own right versus doing the antidepressant. [3261 E] SP: But actually one of the reasons I wanted to come in is I saw this ad for Paxil-- Dr: Uh huh. SP: --which I wanted to ask you about because I just haven't really been feeling like myself and-- Dr: Uh huh. SP: --some of the symptoms, I guess the way it was presented just kind of sounded like me a little bit. Dr: Okay. Usually, Paxil is presented as an anti-anxiety, so social phobia, social

	anxiety, general anxiety and for depression too. [1672D] Dr: Well, for the fatigue, I think the fatigue is purely caused by a lack of sleep and stress. SP: So do you think that the Paxil might help? Dr: Um, no Paxil is an antidepressant. [It] can cause side effects. I think for you right now the main thing is to figure out a way to reduce stress and to sleep better. So I think I'd like to give you a medication like Elavil. Take it half an hour before going to bed. This medicine will make you feel drowsy, sleep better. Once you sleep better, you can recharge at night time right? The next day you feel more energetic. This medicine can cause side effects. Weird dreams, nightmares, too much grogginess, nausea, headaches, but relatively speaking, it is a pretty safe medicine. It's used a lot for so many other conditions. It's a type of old-fashioned antidepressant. [2112D]
Biomedically-based: order diagnostic work-up	SP: …you know, I did want to ask you, because I thought you brought it up…I saw a commercial on TV— Dr: --uh huh— SP: --for Paxil. Dr: Okay. SP: …and that's what got me thinking —I was wondering if maybe you thought that might help. Dr: It might. I would like to draw some blood first just to make sure that the fatigue is only from depression and not from, say severe anemia or a thyroid disorder or diabetes or something like that. [1701 A] SP: What about medication for depression? Dr: Well, why don't we get this stuff done first and then get you back in, 'cause maybe there's something going on metabolically that could be explaining all of this. I will make an appointment for you next week or something, alright? [2102 B]
Outright rejection: deny without explanation	SP: So, do you thing the medicine's going to be what I need right now for that? Dr: No. What about this low back pain? [2132 E] SP: Do you think I need a medication like the one I was mentioning? Dr: (1 second)…let's do through and do an exam and all that and see what we come up with, okay? [4442 E]

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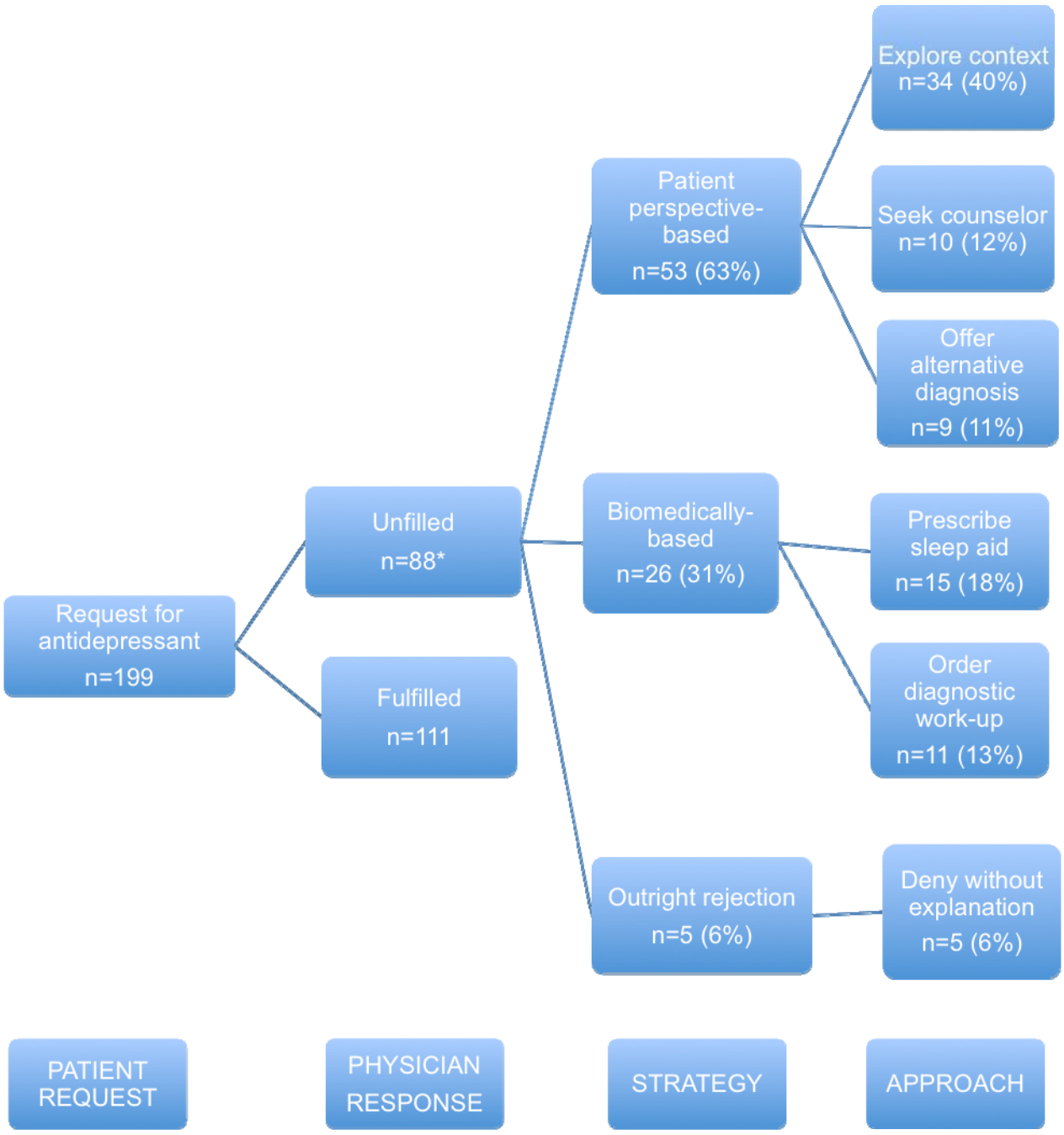

Figure 1: Strategies and approaches for saying "No" to antidepressant requests

***Although 88 visits did not lead to a prescription, only 84 transcripts were available for analysis and are included in this analysis**

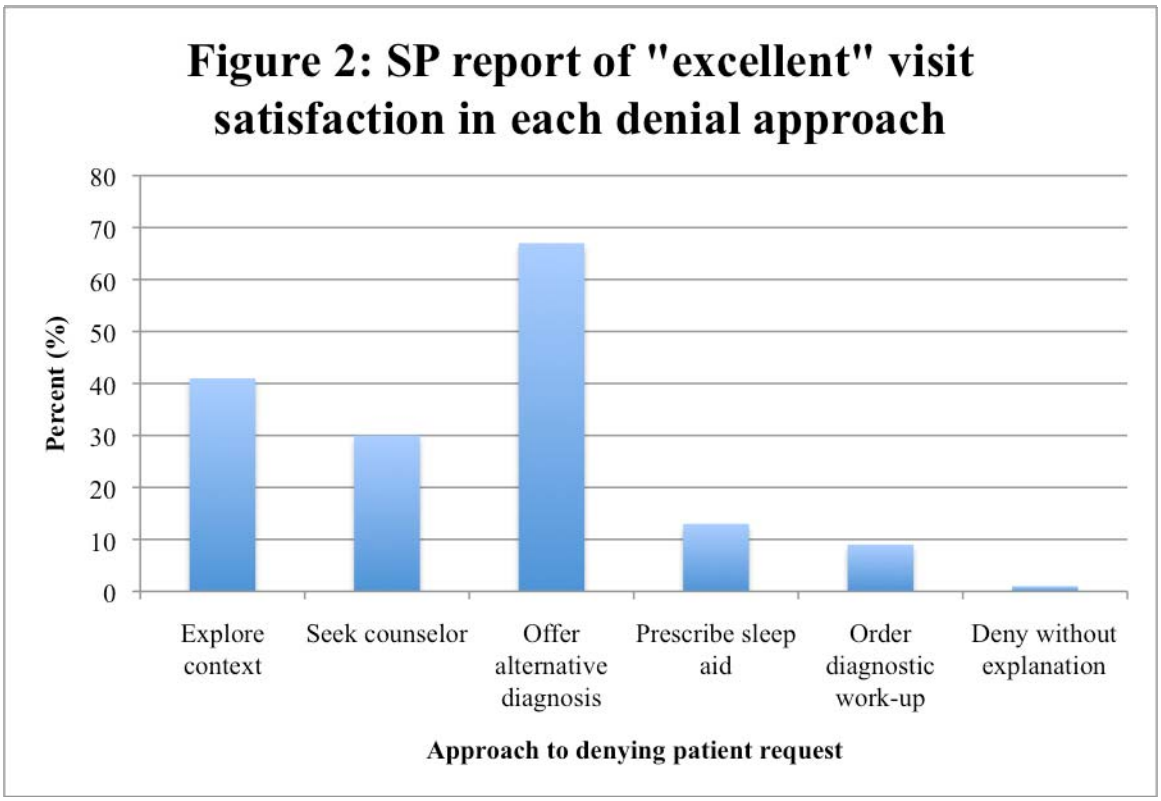
Figure 2: SP report of "excellent" visit satisfaction in each denial approach
Percent (%)
80
70
60
50
40
30
20
10
0
Explore context
Seek counselor
Offer alternative diagnosis
Prescribe sleep aid
Order diagnostic work-up
Deny without explanation
Approach to denying patient request