Communication: A Risk Management Tool

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Introduction

In most malpractice suits, the chief factor that motivates patients to pursue a claim is not technical incompetence but a disappointing outcome coupled with dissatisfaction with their clinician's communication and interaction behavior [1–8]. To reduce the risk of malpractice complaints, it is critical for clinicians to understand what patients and families expect of them and develop practices that satisfy these expectations.

Patient Expectations and the Clinician's Role

Patients expect clinicians to attend to both the technical and human aspects of medical care [9–12]. For heuristic purposes, we have clustered these expectations around four roles: *scientist, artisan, companion,* and *advocate.*

Scientist

The successful scientist obtains grants to investigate phenomena, reviews the literature, conducts the investigation, interprets the results, answers key questions (hypotheses), and conveys the findings to others in a comprehensible manner. Similarly, the clinician is given a "grant" (payment) to investigate the symptoms, etiologies, and remedies for a patient's condition. Patients expect the clinician to practice with scientific rigor—to perform a careful examination using up-to-date and proven methods to accurately answer the clinical questions at hand.

Although most patients are unable to assess a clinician's technical competence or performance, they form an impression about competence based on the quality of the interaction. They notice if the clinician conducts the interview in an organized manner, elicits the important details during the history, provides clear answers to questions, and reviews alternative treatments. They notice if the clinician fails to consider all of the data before reaching a conclusion and are mistrustful of diagnoses and explanations that leave out pieces of their experience.

Artisan

When watching a skilled artisan, one notices the coordinated efficiency with which materials are handled and shaped. The artisan's skill is reflected in her actions as much as in the resulting artifact. A clinician's artisanship is most apparent when she is performing the physical examination or a procedure. Artisanship is evident in the way a clinician examines the ears of a sick toddler, sutures a wound, or performs a sigmoidoscopy or pelvic exam in a tense patient. Patients and family onlookers assess the clinician's artisanship during this time. A rushed, distracted, or irritated practitioner undermines confidence and can raise doubts about the quality of care being given, especially in the event of an unexpected or disappointing outcome.

Companion

Patients feel anxious and abandoned when they do not sense an ongoing connection with the clinician and a commitment that the clinician will "go through this" episode of care with them. This anxiety arises not only when the clinician is unavailable but also when the clinician appears unable to empathize with the patient's concerns about the illness and treatment. Failing to appreciate the depth and urgency of a patient's concern can give rise to the belief that the clinician has failed to adequately address an important aspect of care.

Patients may also feel abandoned when call systems and call partners do not respond adequately, when office staff are curt or indifferent, and when they do not know who is responsible for coordination of care and follow-up after a referral. The perception of having been abandoned is common in patients who sue clinicians [4,5,8]. In one study, the obstetricians more likely to be sued were reported by patients to be remote, arrogant, and uninterested [6].

Advocate

Patients are increasingly fearful that the current health care system puts profits ahead of patients [13]. As they become aware of financial and other influences that may affect their care, they are uncertain if their clinician is looking out for their interests. To be seen as an advocate in this climate, the clinician must pass two tests. The first is the "family member test:"

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Patient's mother: *Doctor, are you telling me that if she was your own daughter you would not be ordering a CT scan after she was knocked on the head that hard?*
Doctor: *Exactly. I would not want to put my daughter through that sometimes frightening experience knowing that the chances of it yielding useful information are low. A plan that is just as safe, and more comfortable for your daughter, is to proceed along the lines I just described and to call the office if you notice any of the signs I have written here.*

The second test is of the clinician's willingness to press for care deemed necessary or likely to be helpful. Clinicians who pass this test might offer to call a busy specialist and ask if he can see a patient sooner. They will also appeal denials of services rather than accept the refusal of a health plan or patient care review committee. Failure to appeal denials that jeopardize patient health has resulted in successful malpractice actions against clinicians. In cases where denials are justifiable, clinicians need to respond empathetically while emphasizing that they would not hesitate to press for care that was truly medically necessary.

Doctor: *I understand that you would feel more comfortable going back to the cardiologist you saw before changing health plans and I am sorry that this is worrying you. On the other hand, I think that the cardiologists in this network are very good and that you will find you are well taken care of.*

When Patients' Expectations Are Unreasonable

It is important to help the patient anticipate what lies ahead in the diagnostic and treatment process so that the unexpected does not immediately trigger the assumption that a mistake was made. This includes providing information about medication side effects, the amount of discomfort that might be experienced, and the range of treatment outcomes that are possible. The majority of unexpected outcomes are caused by biologic variability, not errors or negligence. These outcomes are not truly "unexpected" but merely lower-probability occurrences that the clinician may not have mentioned to the patient [14,15]. Because patients tend to underestimate the degree of biological differences between people and disease presentations and responses, they expect that diagnoses and treatment responses are much more predictable than is actually the case. Informing patients about such variabilities and creating a mutually agreed upon treatment plan in which the patient recognizes and accepts the attendant risks and uncertainties are the chief strategies through which "unreasonable" expectations may be handled.

When There Is Disagreement

Patients have other sources of health information and may request tests and treatment that the physician judges to be unindicated. When a clinician denies a patient's request (eg, for a nonformulary drug, a narcotic, a referral to a specialist, a disability authorization), the clinician must explain the basis for her decisions openly, in terms that the patient can comprehend. We encourage clinicians to establish explicit criteria for evaluating patient requests for tests, treatments, or referrals and to identify these criteria in discussions with patients.

From a risk management point of view, it is advisable to demonstrate openness to getting a second opinion. This may be done inexpensively by asking an office mate to review a chart or more intensively by arranging for a second-opinion appointment with another clinician. It is much more difficult to sue two clinicians who have come to the same opinion, and getting these second opinions is far less expensive than defending a single malpractice complaint. Making criteria for decisions explicit and encouraging second opinions when there is disagreement enhances collaboration and reduces mistrust. In addition, the clinician who is open to another professional opinion reduces the risk of being viewed by the patient as arrogant or dismissive, two attributes frequently ascribed to physicians in plaintiff depositions [5].

When "Unexpected" Outcomes Occur

Despite careful attention to the technical and human aspects of care, outcomes that are surprising and upsetting to the patient will occur. For example, consider a patient with stomach pain who does not show all the signs of having an infected appendix; later in the week the appendix ruptures, requiring emergency surgery. The clinician's natural inclination might be to avoid the patient, expecting an awkward and perhaps accusatory conversation. Yet making contact with the patient, the patient's family, and other health care providers at this time can preserve the doctor-patient relationship and head off litigation. The keys to making this interaction constructive are expressing empathy for the patient's distress; offering accurate, non-defensive explanations of why the clinical condition was not recognizable during the initial visit or phone call; and maintaining regular contact with the patient and carefully coordinating care with other clinicians involved. Avoid making misleading statements, such as "I am sorry I missed that infected appendix yesterday." The clinician has not missed a diagnosis when she has reached a reasonable conclusion based on the evidence available.

When There Has Been a Mistake

A number of studies suggest that nondefensive disclosure of mistakes and assurance to the patient that such mistakes will be prevented in the future mitigates against the motivation to sue [2,16]. Guidelines that address the ethics of physician

behavior in dealing with medical mistakes call for fully informing patients when a mistake has been made in almost all cases [16,17]. Yet surveys indicate that such open disclosure to the patient occurs in the minority of situations [16]. In our workshops, clinicians typically report that risk managers counsel against admitting a medical mistake to a patient. Many of our attendees lament that patients have become so litigious that physician defensiveness and guardedness are necessary self-preservation strategies.

We recommend that clinicians quickly get in touch with their risk managers when there has been a mistake with injury to the patient. Together they should develop an approach to the patient that recognizes that monetary compensation is not the sole or even chief motivation for litigation. Patients and families just as often sue to get more information when they feel the clinician has misled them or refused to answer their questions. Another reason given for litigation is to prevent the clinician from repeating the error with another patient. Patients also sue when they feel that the clinician has been arrogant and dismissive; the lawsuit is a means to address this slight and equalize the power balance in the relationship [2,3,5,8,18]. These motivations could be reduced if the clinician is able to recognize and appreciate the patient's perspective and respond constructively.

Risk managers often fear that clinicians will accept responsibility and blame unnecessarily, making it harder to defend them if a claim is later made. Conversely, they worry that the clinician will behave defensively with the patient and family and add to their ire and motivation to retaliate. Maintaining contact with the patient and family rather than avoiding and distancing is the first step at these upsetting times. Constructive behavior includes expressing empathy for the patient's and family's pain and distress, avoiding defensiveness, offering full explanations, and arranging excellent follow-up care paid for by the medical group and/or the malpractice carrier so that no bills go to the patient. The blanket advice that the clinician make no attempt to contact the patient after the injury has too often resulted in missed opportunities to relate honestly and empathetically with an injured patient and family and has resulted in expanded demands for recoveries based more on anger than the need for financial assistance. More than 50% of the cost of adjudicating these claims in litigation goes to legal costs rather than to compensation of the injured patient [19]. Heading off expensive and distressing lawsuits by dealing openly and fairly when mistakes are first recognized could best serve all parties involved.

Conclusion

Technical competence is essential in a medical provider, but it may not reduce the likelihood of a clinician being involved in malpractice litigation. Instead, communication and interaction skills have the most impact on a patient's motivation to litigate in the face of disappointing outcomes and events. Clinicians who are skilled in interacting with their patients can do a great deal to reduce their risk of being sued.

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