Effective Patient-Physician Communication:

Strengthening Relationships, Improving Patient Safety, Limiting Medical Liability
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Written by: Jane Ruddell, JD
Activity Description
This six-credit CME course provides practical tips and insights for physicians and other healthcare providers to improve both the way they communicate with their patients to enhance their patients' clinical experience and to increase awareness of the impact the human dimension of communication has on medical error, patient safety, quality of care and the incidence of professional liability claims.

Target Audience
The target audience for this CME activity is physicians of all specialties.

Needs Assessment
The educational needs of the Target Audience were decided as a result of summary evaluation data from previous continuing medical education activities and final regulations released in December 2004 for PA Act 13 of 2002, which require risk management/patient safety continuing medical education activities for physician licensure.
Course Objectives

At the conclusion of this activity, the participant will:
1. Develop an awareness of the prevalence of patients’ low health literacy skills and how they impede communication and impact patient health.
2. Implement tools that help to identify and compensate for patient’s low health literacy.
3. Examine the importance of effective communication as it relates to patient satisfaction, patient safety and avoidance of professional liability claims.
4. Identify common communication pitfalls, four good communication habits and other communication insights to improve shared decision making and the effectiveness of patient interviews.
5. Recognize and avoid some common pitfalls in team communications within institutional settings and care “handoffs” that lead to poor patient safety.
6. Summarize the regulatory and ethical requirements for disclosure of medical error.
7. Recognize the importance of emotion, early intervention, apology and mediation techniques and processes in handling the aftermath of adverse events and claims resolution.

Author Disclosure

Authors must disclose all associations with proprietary entities that may have a direct relationship to the subject matter of their manuscript. This course was written by Jane Ruddell, JD. The author has returned a disclosure form stating that she is president of HealthCare Resolutions, which receives royalties from the sale of courses.

AOA Category 2-B

This activity has also been approved for 6 hours of AOA Category 2-B CME credit.
CONTINUING MEDICAL EDUCATION COMMITTEE

Gail Barker MBA, PhD – has a financial interest or affiliation with Ultra Clinics.

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Lita G. Saunders, HRM reviewed the course for continuing medical education accreditation through the University of Arizona College of Medicine at the Arizona Health Sciences Center. She is from University Physicians Hospital at Kino in Tucson, AZ.

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INTRODUCTION

Did you know that:

- Up to 90% of communication is non-verbal?
- Approximately 44% of the adult elderly population is functionally illiterate or minimally literate?
- Less than 10% of medical treatment decisions involve a fully informed patient?
- Poor communication is the reason most people sue for medical malpractice?
- Physicians believe that 89% of patients understand the side effects of medication, yet only 57% of patients claim to understand? [1]

Communication. It is a part of virtually every dimension of human experience. Communication is defined as “a process by which information is exchanged between individuals through a common system of symbols, signs, or behavior.” The archaic meaning of "communicate" means “to share.” [2]

Communication is at the heart of every patient-physician relationship. Sometimes the communication is good; too often it is not. Study after study has documented that poor communication skills lead to communication gaps, misunderstandings, and other unintended problems in physicians' relationships with their patients. In health care, the effectiveness of communication between physician and patient often defines the quality of the relationship and dramatically impacts the quality of the care itself.

It is easy to say that delivering high quality care and ensuring patient safety are the goals of every health care provider. It is also easy to point to a plethora of recent regulations, policies, clinical pathways, best practices, benchmarks, programs, processes, consultants and cutting edge technology — all focused on these universal goals. Professionals in health care generally work extremely hard to improve the quality of care and level of patient safety delivered in their offices and institutions. And, most physicians do not need to be reminded that their medical practice should be "patient centered" or that effective patient-physician communication is important.

However, as the healthcare sector has gotten more complex, technical and fragmented, and as physicians feel financial and other pressures that force them to make unwanted changes in their practice, such as spending less time with patients, care has become more centered around the needs of the system itself, rather than around those of its patients. [3]

Further, in this age of high specialization and rapid technological advancements, many time deprived professionals focus so much on keeping up with the “science” of the profession that they tend to neglect the more elusive “human dynamic” inherent in the therapeutic relationship between physician and patient. Yet, it is in this relationship — this human connection — where much of the “art” of medicine resides and where the true quality of the care delivered can often be measured.

This guide is intended to increase the awareness of physicians and other healthcare professionals about the profound impact that effective patient-physician communication has on patient safety, quality of care and reducing medical errors and liability claims.
The guide also will review challenges to effective communication, such as low health literacy and language barriers and provide tips to overcome them. It also will provide practical insights into improving physician communication with patients and caregiver team members. The positive role that honesty, openness, and apologies can play in delivering bad news and having other difficult conversations will also be reviewed. The relatively new concept of using mediation to assist physicians in communicating and as an effective risk management and patient safety tool will be introduced.

Research-related material is presented as an overview of recent literature and studies concerning the topics covered in this guide. The guide is also intended to serve as an information resource and provides references and contact information to facilitate further study.

References


CHAPTER 1

IMPACT OF COMMUNICATION ON QUALITY OF PATIENT CARE, PATIENT SAFETY, AND PREVENTION OF MALPRACTICE CLAIMS

Effective patient-physician communication is becoming increasingly recognized as a critical component of quality care and patient safety. An impressive body of research and a growing number of conferences and professional publications are focusing on the subject. The American College of Physicians Foundation, for example, hosted an annual National Health Communications Conference devoted entirely to the topic since 2002[1] and the Association of American Medical Colleges (AAMC) has long recognized the importance of effective communication in teaching medical students how to become good doctors. “Changes in the healthcare system, an increasingly diverse U.S. population, and the boom in patient access to health care information are making the communications skills of doctors a major priority for the public,” said AAMC President Emeritus Jordan J. Cohen, MD in 1999. [2]

AAMC’s 1999 report Contemporary Issues in Medicine: Communication in Medicine[3] asserted that a large, diverse body of scientific study linked “effective communication” with “increases in physician and patient satisfaction, adherence to treatment plans, more appropriate medical decisions and better health outcomes.”[4] In public opinion research conducted by AAMC and Public Opinion Strategies in 1998, 85% of those surveyed stated that the most important factors patients look for in choosing a doctor are whether he or she “communicates well” and demonstrates a “caring attitude.” Training, education, and experience were far less important. [5] Awakening to the importance of effective communication with patients, approximately 52% of the 144 medical schools surveyed in 1998 by the AAMC included some combination of discussion, observation, and practice to teach communication skills. [6]

One outgrowth of the AAMC’s work in this area was the identification in the report of the following communications-related goals for medical students:[7]

- Develop an appreciation of the interpersonal and situational dynamics of medical encounters.
- Become oriented to the communication tasks of a physician.
- Begin to build a base of skills and strategies associated with these tasks.
- Begin to learn to deal with difficult topics and situations encountered in clinical practice.
- Develop a base of skills and strategies for working with family members and with physician colleagues and other members of the healthcare team.

Starting with the 2004-2005 academic year, medical students across the nation must pass an examination on their communication and interpersonal skills as part of their certification requirements. [8] Similarly, that same year, the National Board of Osteopathic Medical Examiners started assessing patient-physician communication and the patient-physician relationship as part of its Comprehensive Osteopathic Medical Licensure Examination. [9] Through its Medical College Admission Test (MCAT) Communication Skills Project, the AAMC is also assessing whether measuring the communication skills of medical school applicants is feasible. [10] This development
reflects the growing commitment to professionalism and humanism in medical educa-
tion and the need to balance the strong emphasis on scientific and technical academic
performance with more visible evidence of medical education’s equal interest in
humanistic attributes. [11]

Increased focus on training medical students in communication skills appears to be
having a positive effect. A 2003 study of medical students who received comprehensive
training in patient-physician communications [12] found that the training significantly
improved the students’ ability to understand and address their patients’ needs. The
study’s investigators found that the training also improved students’ ability to work with
patients during an office visit on developing a mutually agreeable treatment plan, devel-
oping and initiating an effective doctor-patient relationship, and bringing the visit to a
meaningful close.

The study, reported in the September 3, 2003, issue of The Journal of the American
Medical Association, compared the performance of 155 students enrolled in a special
communications curriculum offered by 3 medical schools with that of 138 randomly
selected students not receiving such instruction. The study measured 21 skills related
to the following 5 key patient areas:

- assessment of patient’s problem and situation
- patient education and counseling
- negotiation and shared decision-making
- relationship development and maintenance
- organization and time management

While, because they receive training, medical students may be better communicators
when they graduate, older physicians in practice today may not have the benefit of for-
mal communications training. Consequently, they may not realize that they are not as
effective as they could be in talking with their patients. One study of the discharge plan-
ning process that measured the level of understanding between physicians and their
patients found significant gaps between what physicians believed patients understood
and what patients actually understood about their follow up treatment plans. [13]

One indication that a physician may be a poor communicator is whether he or she is an
impatient listener — and it seems many are. In one study, [14] 72 patient encounters with
the physicians of an internal medicine group practice were tape recorded over a set
period. The recordings showed that the mean time before a doctor interrupted the patient
was only 18 seconds into the patient’s opening narrative. Most often the doctor actually
stopped the patient’s narrative after the patient stated just one concern. Once inter-
rupted, the patients never finished their opening stories. Y et, patients who were allowed
to continue their narrative without interruption took only less than 90 seconds to finish.

Another study [15] found that, in practice, less that 10% of medical decisions were made
with the participation of a fully informed patient. That study defined a “fully informed”
patient as one to whom the doctor has provided the pros and cons of the test, proce-
dure or medication regimen, informed them of their options and any side effects, and
helped them reach an individualized decision about treatment. According to principal
investigator, Wendy Levinson, M.D., “These findings [in the study] raise quality-of-care
concerns, since there is mounting evidence that inadequate patient involvement may
interfere with a patient’s acceptance of treatment and adherence to medical regimens.” [16]
Poor communication can impede patient compliance, understanding, and information exchange. For example, poor physician interpersonal skills can result in patients becoming less forthcoming with information and more reticent to listen to and comply with the doctor’s instructions. In contrast, physicians with proficient interpersonal abilities are able to more effectively gather patient data and communicate with patients, usually resulting in more accurate diagnoses and a greater probability of patient compliance with treatment.\(^\text{[17]}\)

According to the Institute of Medicine, effective communication also plays a key role in the movement to improve patient safety. Its 1999 report *To Err is Human, Building a Safer Health System*\(^\text{[16]}\) turned a national spotlight on patient safety concerns, spawning a wave of commissions, committees, authorities, legislation, regulations, requirements, programs and a myriad of so-called experts in patient safety. Many of the resulting initiatives have focused on systems and breakdowns in processes — from simple to complex — and have incorporated data collection, trending, performance indicators, statistical analysis and other objective, scientific approaches to understanding medical errors. A number of these initiatives also promoted institutional cultures that encourage reporting, identifying, and correcting medical and human errors without penalizing the individuals involved.\(^\text{[19]}\)

More recently, however, the focus on patient safety has broadened to encompass learning from the patients themselves. An increasing number of physicians and institutional providers are turning to patient satisfaction surveys, as a tool to better measure the effectiveness of their clinical care sometimes in response to demands by payers.\(^\text{[20]}\) The Center for Medicare and Medicaid Services (CMS), working with hospital and industry groups, spent over 3\(\frac{1}{2}\) years to develop a 27-question patient survey that would permit patients to access and compare results reported by participating hospitals.\(^\text{[21]}\) The survey was completed in 2006 and hospitals are expected to begin reporting their survey results beginning in 2007.\(^\text{[22]}\)

As healthcare attorney and consultant James W. Saxton wrote:

> As physicians and hospitals experience growing pressure to increase the quality of their outcomes, enhance the safety of their patients and lower the cost of their care, analysts expect greater attention and scrutiny to be given to the accountability function of patient satisfaction scores, and to ways in which patient satisfaction measurement can be further integrated into an overall measure of clinical quality.\(^\text{[23]}\)

Commercial payers such as Independence Blue Cross (IBC) in Philadelphia, use patient satisfaction surveys as a quality measure. In its QIPS (quality incentive payment system) program, IBC factors subscriber satisfaction with provider care into its compensation formulas.\(^\text{[24]}\)

Patient satisfaction and compliance with treatment plans are, in turn, largely influenced by the quality of the communication between patient and doctor.\(^\text{[25]}\) In developing its patient satisfaction survey CMS held 16 focus groups of recently discharged patients in major cities across the country. The consensus of these patients was that high quality physician and nurse communication is, “the most important aspect of quality care.”\(^\text{[26]}\)

I. Steven Udvarhelyi, MD, IBC’s senior vice president and chief medical officer, directly links patient satisfaction, and therefore quality of care, to overall effectiveness of communication between patient and physician. “Satisfying the patients and addressing their
concerns is an outcome in and of itself... The patient is the best judge of whether his/her needs are being met."

Apart from satisfaction surveys, more and more institutions are being encouraged by patient safety organizations to seek patient input and involvement in patient safety initiatives. There is growing recognition that patients and families hold valuable information, inaccessible through any other means, and that listening to them can be extremely helpful in identifying and avoiding possible medical errors. For example, the Johns Hopkins Hospital has received national recognition for excellence in patient safety related to patient and family communication involvement and other patient safety initiatives. The Johns Hopkins Children’s Center patient safety program goals include empowering families to assume equal partnership in their child’s care.

The emerging use of patient input to evaluate quality of care is a more holistic approach to assessing clinical quality, reflecting a broader shift in thinking — from the core technical clinical aspects of medical practice to the patient-centered care being taught today — about how quality should be measured.

Consistent with the theme that good patient-physician communication leads to increased patient satisfaction, higher levels of patient satisfaction have been correlated with lower medical liability claims experience. A retrospective longitudinal study of 645 general and specialist physicians practicing in a large medical group found that the number of lawsuits was significantly related to the total numbers of unsolicited letters from patients complaining about the physicians. Those physicians who were sued (even when data was adjusted for volume of the clinical activity) had been the subject of far more complaints. In fact, 9% of the physicians studied were responsible for 50% of the complaints, which fell into four categories: (1) communication, (2) care and treatment concerns, (3) access and availability, and (4) the “humaneness” and respectfulness of the physician.

The resulting article, “Patient Complaints and Malpractice Risk,” published in the June 12, 2002 issue of The Journal of the American Medical Association, begins with a recitation of the “conventional wisdom” about why physicians are sued, including factors associated with the physicians’ caseloads, unpredictable circumstances, an especially litigious population or even simple “bad luck.” The authors then go on to refute that “wisdom”:

Research has forced reconsideration of these traditional explanations of claims experience. Risk seems not to be predicted by patient characteristics, illness complexity, or even physicians’ technical skills. Instead, risk appears related to patients’ dissatisfaction with their physician’s ability to establish rapport, provide access, administer care and treatment consistent with expectations, and communicate effectively.

Among the research studies cited by the authors, the perhaps most frequently cited is “Physician-patient communication,” published in The Journal of the American Medical Association in 1997. Researchers studied the communication behaviors of physicians with multiple medical liability claims filed against them, as opposed to those of physicians with no claims. After analyzing audiotapes of 10 routine office visits for each physician, they found that the physicians who had no claims against them “used more statements of orientation (educating patients about what to expect and the flow of the visit), laughed and used humor more, validated the patient’s emotions and tended to use more facilitation (soliciting patients’ opinions, checking understanding, and encouraging..."
The physicians without claims also spent an average of 3.3 minutes longer with each patient than did the physicians who had claims against them. Patients of those doctors with claims, conversely, reported feeling rushed, feeling ignored and receiving inadequate explanations or advice.

The authors concluded:

*Patient dissatisfaction is critical. The combination of a bad outcome and patient dissatisfaction is a recipe for litigation. When faced with a bad outcome, patients and families are more likely to sue a physician if they feel the physician was not caring and compassionate. Breakdowns in communication between physicians and patients lead to patient anger and dissatisfaction and possible litigation. Conversely, effective communication enhances patient satisfaction and health outcomes.*[^38^]

Even in high-risk disciplines a physician’s interpersonal skills deficits may result in increased claims. For example, specific factors contributing to a family’s decision to sue following perinatal injuries included the belief that the physicians did not listen to them (13%), did not talk openly (32%), attempted to mislead them (48%), or did not warn them about long-term neurodevelopment problems (70%). The researchers of that study observed: “Even when physicians provide technically adequate care, families expect answers to questions and want to feel as though they have been consulted concerning important medical decisions. If these expectations are not met, even patients who have not experienced adverse outcomes will become angry and express dissatisfaction with care.”[^39^]

While avoiding medical liability litigation is not — and should not — be the primary reason to improve patient-physician communication, research shows that effective communication nonetheless reduces the likelihood that patients and their families will sue. Physicians who focus on defensive medicine as the most effective deterrent to medical liability claims may be overlooking a more important way to deter a claim, namely improving their communication skills and acting with care and concern. “[A] relationship that bespeaks thoughtful professionalism and a humanistic approach many times solves more problems, melts more hostilities and eliminates more suits than almost any other single recommendation.”[^40^]

In summary, improved communication can play a central role in improving patient safety, enhancing the opportunity for better patient compliance and quality of care, and reducing medical liability claims. Understanding that better communication skills can be learned is the starting point for physicians who wish to communicate more effectively with their patients.

**References**

4. AAMC, Note 3, at 5.


6. AAMC, Note 3, at 7.

7. AAMC, Note 3, at 13-8.


11. Id.


CHAPTER 2
THE PROBLEM OF LOW HEALTH LITERACY:
IT’S BIGGER THAN YOU THINK

There are a number of challenges facing physicians who wish to improve the quality of their communications with their patients. One of the most profound is low health literacy. What is health literacy? The generally accepted meaning is “the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.” Nearly 50% of all American adults — approximately 90 million — have low health literacy and have trouble understanding and acting on health information, including information given to them by their physicians.

The costs to these individuals, and society as a whole, are inestimable considering that low health literacy is a profound impediment to delivering and receiving quality care. The Surgeon General has called health literacy the “currency of success” to better our national health.

Health literacy is fundamental to quality care, and relates to safety, patient-centered care, disease prevention and patient self-management.


Sizing the Issue – National Literacy Studies

Part — but by no means all — of the problem of low health literacy stems from the prevalence of general illiteracy or low literacy, meaning the ability to read, in the adult population at large. Studies show that 21% of adults in America cannot read the front page of a newspaper and 48% cannot read a bus schedule.

Two major literacy assessments of adults residing in the United States shed light on the scope of the issue. In 1992, the US Department of Education National Center for Education Statistics (NCES) conducted a baseline National Adult Literacy Survey (NALS) to measure the general literacy skills of 26,000 randomly selected adults. Participants were asked to complete several literacy tasks organized into five ascending levels of difficulty. Level 5, the most advanced, represented less than 5% of the adult population and 47% of adults scored in the two lowest levels. More than 20% of Americans had only the lowest Level 1 skills, while another 27% fell into Level 2.

NCES updated that research in 2003, conducting a National Assessment of Adult Literacy (NAAL) to measure progress against the 1992 NALS and also to assess skills more definitively in specific populations. NAAL studied U.S. residents’ ability to meet literacy demands at home, in the workplace and in the community by performing prose, document and quantitative tasks. In the 2003 study, NCES recognized the growing importance of health literacy by including a section designed to measure this subset of general literacy.
The complex NAAL study examined literacy among populations grouped by age, race/ethnicity, gender, educational attainment and employment status. Overall, compared to the 1992 study there were only slight decreases in the percentage of adults who scored in the Below Basic category, no change in those who scored in the Basic category, slight increases in those with Intermediate level skills and a small decrease in the number who scored in the Proficient category.[5]

Literacy problems are especially common among the elderly. In the NAAL assessment, although the literacy level of adults over 50 increased in 2003 over 1992, this group still had the lowest average literacy level in 2003 and accounted for the largest percentage of adults with Below Basic scores. Of all older adults surveyed, 23%, 27% and 34% scored in the Below Basic category for prose, document and quantitative literacy respectively.[6] In another 2003 study[3] approximately 44% of adults aged 65 and older scored in the lowest of the five 1992 NASL skill levels. There is a strong inverse relationship between increasing age and decreasing or low literacy, partly because reading, vision and other communications skills often decline with age.[3]

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### NAAL Literacy Scoring[5]

<table>
<thead>
<tr>
<th>Level of definition</th>
<th>Sample tasks typical of level</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Below Basic</strong></td>
<td>searching a short, simple test to find out what a patient is allowed to drink before a medical test</td>
</tr>
<tr>
<td></td>
<td>signing a form</td>
</tr>
<tr>
<td></td>
<td>adding the amounts on a bank deposit slip</td>
</tr>
<tr>
<td><strong>Basic</strong></td>
<td>finding in a pamphlet for prospective jurors an explanation of how people were selected for the jury pool</td>
</tr>
<tr>
<td></td>
<td>using a television guide to find out what programs are on at a specific time</td>
</tr>
<tr>
<td></td>
<td>comparing ticket prices for two events</td>
</tr>
<tr>
<td><strong>Intermediate</strong></td>
<td>consulting reference materials to determine which foods contain a particular vitamin</td>
</tr>
<tr>
<td></td>
<td>identifying a specific location on a map</td>
</tr>
<tr>
<td></td>
<td>calculating the total cost of ordering specific office supplies from a catalog</td>
</tr>
<tr>
<td><strong>Proficient</strong></td>
<td>comparing viewpoints in two editorials</td>
</tr>
<tr>
<td></td>
<td>interpreting a table about blood pressure, age and physical activity</td>
</tr>
<tr>
<td></td>
<td>computing and comparing the cost per ounce of food items</td>
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</tbody>
</table>

**Low Health Literacy**

Health literacy is not measurable simply by looking at general literacy. The NAAL measured reading ability only, which is inadequate for assessing health literacy. In the Institute of Medicine’s (IOM) April 2004 report, *Health Literacy: A Prescription to End Confusion*,[^1] “health literacy... includes a variety of components beyond reading and writing, including numeracy, listening, speaking, and cultural and conceptual knowledge.”[^7] IOM further identified distinct causes of low health literacy, some or all of which may be “co-morbid” in any given patient:

- Limited reading ability
- Lack of background knowledge in health sciences or biology
- Lack of familiarity with medical language or medical materials or documents
- Cultural differences in approaches to health and health care[^8]

There is also an emerging awareness that health numeracy, which has long been overshadowed by health literacy, warrants independent study and development.[^9] Health numeracy is “the degree to which individuals have the capacity to access, process, interpret, communicate and act on numerical, quantitative, graphical, biostatistical and probabilistic health information needed to make effective health decisions.”[^10] In other words it is the ability to understand the mathematics and statistics of health. This issue is especially important for patients who must make difficult treatment decisions involving statistical risks and benefits.

In a broad sense the healthcare delivery system itself can be considered a cause of low health literacy. Patients are faced with a system characterized by complicated bureaucracies and often daunting and confusing processes for finding and obtaining health services. Patients who see multiple specialists are subjected to a “silo” approach to treatment, with each specialist concerned primarily — if not only — with the disorder of his or her specialty. These specialists do not always connect or coordinate their findings with those of the other specialists. Primary care providers have little time to effectively oversee, manage and communicate fully with these multiple physicians, and even if they did, most payors would not compensate them for this service. The system often means that no medical professional has a comprehensive, holistic perspective on the patient’s overall state. This leaves confused patients and their families struggling to gather and digest complex information, keep track of competing treatment plans and coordinate their overall care themselves.

In some circumstances, the health literacy of even a generally literate patient may approach that of an NAAL *Below Basic* reading-level patient, with the literate patient’s ability to understand health concepts and health information compromised by the vocabulary and form in which health information is presented. More than 300 studies show that the content of health-related materials generally far exceeds the average reading ability of American adults.[^11]

Even highly educated individuals report difficulty with understanding the vocabulary and technical terms used by medical institutions and physicians. Consider a mother with a Ph.D. who was trying to decipher instructions on a Pepto-Bismol bottle.[^12] The child’s pediatrician had told the mother to give the child Pepto-Bismol but gave no further instructions. The bottle’s instructions read:

- **Age 9 to 12**: 1 Tbsp. or 15 ml
- **Age 6 to 9**: 2 Tsp. or 10 ml
The mother called another physician friend for help because she didn’t know to give her 9-year old child 10 ml or 15 ml. This highly intelligent and sophisticated woman was concerned that she might overmedicate her child because the instructions — which appeared straightforward — were confusing.

In another example, cited by the Institute of Medicine in its April 2004 Report, a patient information sheet contained the following: “Patients should be monitored for extra ocular CMV infections and retinitis in the opposite eye.” How many patients could decipher that? [13]

Physicians themselves may have difficulty understanding vocabulary across specialties. For example, a very prominent neurologist once stated that he could not fully understand the explanation he received from an orthopedist about his shoulder injury. [14]

**How Does Low Health Literacy Impact Health?**

Studies measuring health literacy have typically focused on one or two specific attributes, such as understanding prescription labels. As noted earlier, the importance of measuring health literacy much more broadly was built into the NAAL study design. NAAL’s health literacy component is the first national assessment tool designed specifically to measure adults’ ability to read and understand health information, such as medication information, medical instructions, insurance forms and prevention and wellness information. While the statistics on health literacy were not included in the first installment of NCES’s 2003 NAAL report, the topic is listed as one of several for future reports.

The U.S. Department of Health and Human Services (HHS) examines health literacy from three perspectives:[16]:

1. **Clinical** — literacy related to clinical encounters and other interactions between a healthcare provider and patient, such as office forms, dosing instructions, instructions for self-management of chronic disease.

2. **Prevention** — literacy related to activities aimed at healthy lifestyles, preventing disease and identifying symptoms of health problems.

3. **Navigation of Healthcare System** — literacy related to understanding how the healthcare system works, such as understanding covered and non-covered benefits, determining eligibility for Medicaid and giving informed consent.

To put these abstract perspectives into more concrete terms, consider a study relating to aspects of navigating the health system and clinical encounters. The study measured the comprehension of patients with low health literacy and found:

- 60% could not understand a standard informed consent form
- 26% did not understand when their next appointment was scheduled
- 42% did not understand directions on a pill bottle for taking medication on an empty stomach
- 43% did not understand the rights and responsibilities section of a Medicaid application

Another study found that many colorectal patients did not understand the meanings of words clinicians use every day, such as “bowel,” “colon,” “screening test,” “tumor,” “lesion,” “polyp” or “blood in stool.” [18]
Prescription warning labels and instructions for taking medication are particularly problematic. In a study of 253 hospital patients with low health literacy[^19]:

- 85% did not understand the direction “Take with Food”
- 61% did not understand the direction “Take with plenty of water”
- 81% did not understand the direction “Do not take with dairy products”

In another study, the number of patients reading at or below a 6th grade level who correctly interpreted eight commonly used prescription warning labels ranged from a low of 0% to a high of only 78%.[^20]

And, again the elderly fall into a special category. Like others, low health literacy for them is attributable only in part to their general low literacy and the complexity of the healthcare delivery system itself. Their larger and more complicated health needs, coupled with diminished capacities, compound the potential for misunderstanding, misdiagnosis, poor compliance and mistreatment in healthcare settings.[^3]

To make matters worse, older adults have more chronic diseases than younger patients and most suffer from one or more co-morbidities.

- Approximately 80% of 65 year olds with hypertension have co-morbidities and physical limitations.
- Over 95% of 65 year olds with congestive heart failure or stroke have co-morbidities.[^21]

These and other studies demonstrate that low health literacy carries with it significant health implications. Low health literacy drastically affects patients’ ability to take responsibility for their own health which is exacerbated by changes in the way health care is delivered. Advancements in medical treatments often require patients to do more in the course of their treatment regimens, such as diabetics who monitor their own blood sugar and self-administer insulin. Patients who struggle to read and understand written instructions for their own care will be less able to follow them correctly.

According to the 2003 report issued by the United States Department of Health and Human Services, patients with low health literacy report poorer health than patients with high literacy.[^15] They are more likely to see the doctor only after their disease or condition is advanced, are more likely to be hospitalized, are less likely to use health screenings and are more likely to have low adherence to treatment plans.[^24] The attendant financial costs of low health literacy can be staggering, with one estimate of the annual costs approaching $73 billion.[^22]

Of course, it is difficult to tease out the precise adverse implications of low health literacy on health status apart from other contributing circumstances, such as limited education or poverty. This can make the problem seem intractable, and the search for a solution more daunting. Even the Federal Department of Health and Human Services has struggled with what to do at a health policy level, beyond recommending more study. It concluded its 2003 investigation of health literacy by asserting that “much more needs to be known about the causal pathways between education and health and the more specific role of literacy, as well as the discrete contributions of health literacy.”[^25].

In the meantime, the next section offers some practical ideas about what you can do on a day-to-day basis to help your patients with low health literacy.
Clues to Identifying Patients with Low Health Literacy

Identifying health literacy deficits during clinical visits is a challenge. Your experience might suggest that your patients from certain population groups, such as the elderly, low income, unemployed, poorly educated, cultural, ethnic and language minorities are at greater risk for struggling with low health literacy than others. While you may be right, looking for individual behavioral clues is a more reliable way to determine whether a particular patient is struggling with low health literacy.

Many patients are reluctant to volunteer that they read poorly or cannot read at all. A patient’s inability to read often causes him or her to feel shame or embarrassment; he or she may be unwilling to ask questions for fear “of looking dumb.” Physicians and their staffs should be alert to signs that the patient might be challenged. The following examples are potential “red flags” that a patient may be struggling with low health literacy:

- incomplete or inaccurate patient registration forms
- frequently missed appointments
- noncompliance with medication regimens
- lack of follow through with lab tests, radiological tests or referrals to specialists
- saying “I forgot my glasses” when asked to read or write or saying “I’ll take this home to discuss with my children/spouse.”
- inability to name medications he or she is taking
- inability to explain what the medication is for
- inability to explain dosage or how to take medication
- identification of medications by looking at or describing size, shape and color rather than names

Another approach is to use a screening tool. Most of the analytic tools recently developed to measure print literacy take 3 to 12 minutes to administer, and longer to score and interpret, making them too wieldy for most office practices. However, several researchers have preliminarily concluded that a single literacy screen (SILS), which asks a question about needing help with reading instructions from a director of pharmacy, is a reasonably effective means of identifying patients who may need help reading health care information.

What You Can Do to Help Your Patients with Low Health Literacy

Once you have identified your patients with low health literacy, you can take these several simple steps to help them understand the health information and treatment instructions you are giving them.
**During the Patient Visit**

When meeting with your patients in person use the steps below as a guideline to help all patients, but especially those with low health literacy, understand the diagnosis and treatment.

1. **Introduce Yourself** – It is important for you and your staff to orally introduce yourselves by name and role each time you see the patient, unless and until you are positive they can recall who you are. Nametags and personalized white coats will not suffice. Although they do help names are often hidden or flipped or too small to be read.

2. **Slow Down** – There is a saying “slow down to save time,” which is helpful to keep in mind when working with patients with low literacy. Making eye contact is one way to check comprehension.

3. **Use Simple Language** – When talking with your patient, speak slowly and use simple, everyday language as if you were speaking to a family member. Most medical professionals have a fondness for communicating in technical terms and easily forget that the medical “language” so familiar to them is a foreign language, perhaps even Vulcan, to most patients and families. Suggestions for simplifying written information discussed in the next section can also be useful in your conversations.

4. **Show or draw pictures or diagrams** – The adage “a picture is worth a thousand words” can be very helpful. Visual images improve the patient’s comprehension and ability to recall. Draw a simple picture that the patient can take home or use simple, pre-printed diagrams.

5. **Give information in bite-sized pieces** – Cover only one or two concepts at a time and repeat the information once or twice. Offer a notepad for the patient to write or draw reminders.

6. **Use the “teach-back” method to check comprehension** – Read, or have a staff member read, written instructions aloud and underline key points you want the patient to remember. Don’t simply ask if patients “understand” ... they may say they do when they really don’t. Instead, ask the patient to repeat back what you have told them; say “I want to make sure I’ve explained this well”, and “Tell me what you will do and how you will do it when you’re at home.”

7. **Help patients avoid feeling ashamed** – Encourage your patients to ask questions, and tell them upfront you don’t mind repeating information to be sure they understand. Offer to help them with their paperwork. Reassure them that many people have difficulty understanding healthcare information, even you, and that you and your staff are ready to help.

8. **Suggest bringing a friend or relative to office visits** – This approach is recommended particularly if the treatment or condition is complex.

9. **Educate staff** – Make your staff aware of how pervasive low health literacy is and train them to watch for the red flags. Office staff should offer help in filling out forms or reading information in a polite, discreet, cheerful and confidential manner. They should also be sensitized to the shame and embarrassment many patients feel and be taught to avoid embarrassing anyone.
Written Materials

As noted earlier much patient-focused health materials is written at reading level ranges requiring high school, college or graduate degrees, making them likely to be beyond the reading level of patients with even average literacy much less, low literacy.

Pay close attention to written materials you rely on to convey information, whether it is developed by you or is widely published health information. Readability and comprehension level are big issues. Straightforward, easy-to-understand writing to describe technical, medical, and scientific concepts is largely missing in our increasingly complex society. In fact, the issue has caught the attention of, among others, the Harvard School of Public Health, which has established the Health Literacy Studies (HLS) research program in its Department of Society, Human Development and Health. HLS takes the position that today's healthcare system has become one giant literacy test that too many patients are failing. While HLS believes that part of the solution lies in improving the "student's" reading skills through educational initiatives, it also questions why accessing and receiving health care must be such a hard task in the first place. The gap between reading ability and health literacy needs to be narrowed.

In health care, that gap not only hinders your patient's ability to comprehend and comply; it can also cost you plenty. One example is the so-called "$3.6 Million Consent Form" used by a hospital in Florida for an experimental research study in which a research subject was injured and filed a lawsuit. As related by Mark Hochhauser, a readability consultant who specializes in language and medical research, the court found that the hospital did not have the patient's "informed consent" to participate in the study because the consent form was too complicated, dense, and incomprehensible.

As a rule, the readability level of informed consent forms typically exceeds the documented average reading level of most patients. So review of these documents should be a priority. But, in truth, you need to review all your office forms, standard patient instructions and other health or treatment information, such as pamphlets and booklets published by medical information providers and vendors to see if any are contributing to a fog of technical terms or jargon.

Written materials should be written at the 6th grade level or lower, particularly if most of your patients are at risk for low literacy. Don’t worry about offending highly educated patients — evidence indicates that all patients, not just those with limited literacy skills, prefer easy-to-read materials over more complex ones.

There are professional resources to help you draft materials at an acceptable grade level, including word processing systems. However, a simple and more direct way of checking your health information materials is to have several laypeople, including sixth or seventh grade students, read it for you. Another simple approach is to pretend that you or the author are describing a medical term or condition to an elementary school student. You would choose simple, lay terms rather than the medical terms or jargon commonly used by clinicians when speaking with or writing for adult patients.

Readability is generally a function of three factors: (1) language, (2) organization, and (3) layout and design.

Language includes vocabulary, or word choice, as well as sentence length, sentence structure and tone. Sentences should be short, simple and direct. With respect to word choice, the universal rule is to use plain language and avoid jargon. Some examples of common medical jargon and more understandable alternative, "plain language" terms are set forth on the following page:
Because format and style are also very important to the readability of written materials, we also have the following suggestions when writing or reviewing written materials you would like to use with your patients:

<table>
<thead>
<tr>
<th>Instead of writing:</th>
<th>Write this:</th>
</tr>
</thead>
<tbody>
<tr>
<td>analgesic</td>
<td>drug used for pain</td>
</tr>
<tr>
<td>antihistamine</td>
<td>drug used for allergies</td>
</tr>
<tr>
<td>anti-inflammatory</td>
<td>reduces swelling and irritation</td>
</tr>
<tr>
<td>benign</td>
<td>not cancer</td>
</tr>
<tr>
<td>biopsy</td>
<td>removal of small amount of tissue (or lung, breast, etc.) for testing</td>
</tr>
<tr>
<td>carcinogenic</td>
<td>causing cancer</td>
</tr>
<tr>
<td>cardiac insufficiency</td>
<td>heart failure</td>
</tr>
<tr>
<td>cardiologist</td>
<td>heart doctor</td>
</tr>
<tr>
<td>chemotherapy</td>
<td>drugs for cancer</td>
</tr>
<tr>
<td>colonoscopy</td>
<td>internal exam of the bowel using a tube</td>
</tr>
<tr>
<td>demyelination</td>
<td>loss of protective coating for nerve fibers</td>
</tr>
<tr>
<td>dermatologist</td>
<td>skin doctor</td>
</tr>
<tr>
<td>embolism</td>
<td>blood flow blockage</td>
</tr>
<tr>
<td>endoscopy</td>
<td>internal exam of an organ using a tube</td>
</tr>
<tr>
<td>febrile</td>
<td>has a fever</td>
</tr>
<tr>
<td>feces</td>
<td>bowel movement</td>
</tr>
<tr>
<td>femur</td>
<td>thigh bone</td>
</tr>
<tr>
<td>gastroenterologist</td>
<td>stomach doctor</td>
</tr>
<tr>
<td>hypertension</td>
<td>high blood pressure</td>
</tr>
<tr>
<td>incontinent</td>
<td>can’t control urine or bowel movements</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Instead of saying:</th>
<th>Say this:</th>
</tr>
</thead>
<tbody>
<tr>
<td>inoperable</td>
<td>can’t be cured by an operation</td>
</tr>
<tr>
<td>lipids</td>
<td>fat in blood</td>
</tr>
<tr>
<td>malignant</td>
<td>cancerous</td>
</tr>
<tr>
<td>metastasized</td>
<td>cancer has spread to ……</td>
</tr>
<tr>
<td>monitor</td>
<td>keep track of, keep an eye on</td>
</tr>
<tr>
<td>myocardial infarction</td>
<td>heart attack</td>
</tr>
<tr>
<td>neurologist</td>
<td>brain doctor</td>
</tr>
<tr>
<td>noninvasive</td>
<td>without surgery, needles or cutting skin</td>
</tr>
<tr>
<td>oncologist</td>
<td>cancer doctor</td>
</tr>
<tr>
<td>oral</td>
<td>by mouth</td>
</tr>
<tr>
<td>palliative</td>
<td>relieve pain but won’t cure</td>
</tr>
<tr>
<td>radiology</td>
<td>X-ray department</td>
</tr>
<tr>
<td>referral</td>
<td>send you to another doctor</td>
</tr>
<tr>
<td>toxic</td>
<td>poisonous</td>
</tr>
<tr>
<td>ventilator</td>
<td>breathing machine</td>
</tr>
</tbody>
</table>
**Typeface** [33, 34]

- Pretty as they might look, quirky, unusual, or fancy fonts make materials harder to read.
- Among the plain vanilla fonts, serif (the small thin extension of type at the bottom of the letters) typefaces, such as Times New Roman or Garamond, make text on paper easier to read because they lead the eye from one letter to the next. However, the opposite appears to be the case for digital (Internet) display; sans-serif fonts such as Arial or Helvetica have been recommended for screen readers.

**Type Size** [33]

- Type size, along with type weight, spacing and contrast can be more important to readability than typeface. Use at least 12 point type. Larger type, such as 14 point or 16 point, may be better when you anticipate a large population of visually impaired readers.

**Type Weight and Contrast** [33]

- Studies suggest that using dark letters in a medium weight or semi-bold type on a light background is the most effective presentation. You might think using dark letters in a bold typeface against a light background would be even better. But, that’s been found to be annoying, the written equivalent of being continually yelled at.

**Capital Letters** [34]

- Use uppercase and lowercase text. Capital letters are all the same height, and often of similar widths. Visually impaired and normally sighted readers all use the different shapes of lower case letters to help work out which letters they are reading — using just capitals removes these useful shape clues and makes a document harder to read.

**Design and Layout** [33, 35]

- Layouts should be simple and clear.
- Stick with the same system throughout a document for headings and sub-headings and numbering systems.
- Wide margins around pages of text make reading easier by drawing the eye into the page, not off it.
- Don’t clutter the page with too much text or too many pictures.
- Make sure any pictures or illustrations you select are simple, easy to recognize and clearly identified. They should illuminate the text, not muddy the waters. To avoid unnecessary controversy, select age and culturally appropriate pictures.
- Use headings to attract your readers’ attention to important information. They help readers find their way through a document and locate important points.
- Write short sections that break up the material into easily understood segments. Short sections look easier to read and understand; a long section — even if it has the same exact content as a group of shorter sections — looks more forbidding and is harder to navigate.
• Try to use bulleted lists, as opposed to blocks of text in paragraphs. Bullets highlight information in a visually clear way and help readers focus on important material.

• Poorly designed and printed material impedes visually impaired people.

• Complicated language impedes people with literacy problems.

• Unexplained technical jargon impedes everyone.

Language and Cultural Considerations

As discussed above, reading ability is not the only issue when addressing health literacy: Culture gives meaning to health communications, so health literacy must be understood and addressed in the context of culture and language. The increasing diversity of American society presents new communication challenges for physicians, especially those working in non-English speaking or culturally and ethnically diverse communities and those who are themselves foreign born.

Language Barriers

According to the 2000 U.S. Census, over 30 million people, or over 11% of the total population, were born in other countries. About 21 million of these immigrants exhibit Limited English Proficiency or LEP, which means the limited ability to speak, understand, read or write English. Additionally, nearly 47 million, or 18% of the population, speak a language other than English at home. Resources to help these populations learn English as a second language (ESL) already scarce appear to be lagging farther and farther behind changing demographics. For example, between 2001 and 2004 enrollment in federally funded programs located in Pennsylvania and New Jersey grew by only 5 percent and one program, Even Start, will see drastic funding cuts from $225 million in 2005 to $70 million in 2007. To make matters worse, one in four people who want to learn English can’t because of time constraints, child care, and money or transportation deficits. In their responses to a Robert Wood Johnson 2001 survey, 73% of healthcare providers said that a patient’s understanding of treatment advice was the most compromised aspect of care due to language barriers and 71% said language issues complicated their patients’ ability to explain symptoms and concerns. These language barriers readily translate into problems in the exchange of important medical information, which in turn, threatens the quality of healthcare services.

A host of information exchanges are at risk when patients and physicians speak different languages, such as:

• Inadequate informed consent
• Misunderstanding physician’s instructions
• Poor adherence to treatment plans
• Missed appointments
• Exacerbated time pressures
• Incomplete medical histories

Negative health consequences are often the direct result. Like patients with low health literacy, non-English speaking patients often defer needed medical care, are less likely to be given a follow-up appointment after an emergency room visit, have fewer primary care visits and receive fewer preventive services than English speaking patients.
Forty-seven studies conducted from the years 1985 to 2003 indicated that language barriers are associated with:

- longer time spent in clinical visits
- fewer clinical visits
- less understanding of physician’s explanations
- more lab tests
- more ER visits
- less follow-up
- less satisfaction with health services

It is easy to appreciate how readily medical information can get “lost in translation.” Take, for example, the case of the 45 year-old Hispanic immigrant who was under treatment for high blood pressure. He went to an emergency room complaining of dizziness and was found to have dangerously low blood pressure. He said he had been taking the two medications his doctor prescribed a week ago exactly as directed on the bottles. They said, “once a day.” The only problem: “once” in Spanish means 11 meaning the patient took over 5 times what had been prescribed. Thankfully, a Spanish-speaking physician in the emergency room was able to figure it all out and the patient was appropriately treated.

In another example, simple instructions for treating a child’s ear infection with a liquid oral antibiotic were translated by a lay interpreter as simply “para los oídos” — “for the ears.” This left the mother thinking she should administer the oral medication into her child’s ear rather than by mouth.

It is particularly challenging when English cannot easily be translated into the patients’ vocabulary. For example, there is no word – or even concept- for “cancer” in the Hmong language. Some inexperienced interpreters have described radiation treatment as putting “a fire in you,” prompting Hmong refugees to refuse treatment.

Complicating the problem is the growing number of foreign-born physicians and health care workers. According to the American Immigration Law Foundation, the number of United States immigrant hospital employees grew by 32 percent in the 1990s. Not only can language barriers associated with these individuals hamper care, they create customer service problems, frustrating patients and caregivers alike. When a patient complains or asks for a referral to another clinician because they can’t communicate, both care and the bottom line suffer. In response to the expanding scope of this concern, the number of firms to help foreign born physicians and other clinicians improve their English is also mushrooming.

**Access to Resources**

Under Title VI of the Civil Rights Act of 1964 and Executive Order 13166, patients with LEP have a right to a trained interpreter and any provider receiving federal funding aside from Medicare Part B must comply. Further, federal regulations, agency guidance documents and a 2000 Executive Order impose an affirmative obligation on recipients of federal funding to reduce language barriers.

Over 60 medical professional and healthcare organizations have endorsed a Language Access in Health Care Statement of Principles, which calls for societal support to meet the cultural competence needs of providers and LEP populations.
Trained language interpreters have formal education in interpreting and abide by a professional code of ethics that includes confidentiality, impartiality, accuracy and completeness. The best medical interpreters are not only fluent in two or more languages; they are also familiar with medical terminology and have experience in health care. Although there are several accredited training programs for medical interpreters, there is no national certification. When a trained interpreter is not available, clinicians often turn to the patient's family members or friends who speak the patient's language. This practice carries its own set of problems. Family members may unconsciously screen information or try to “protect” the patient. Further, untrained translators are more likely to make errors that lead to clinical consequences than are professionals or trained interpreters. A study conducted by researchers for the University of Virginia confirmed that using trained over untrained interpreters significantly improved communication and medical care for patients with Limited English Proficiency (LEP).

**Biased Care**

Cultural, racial and ethnic divisions can result in biased care, even if unintentional on the part of the caregiver. Researchers have identified a disparity between the care that racial and ethnic minority patients receive compared to white patients. A study of therapeutic relationships and the interpersonal settings in which patients are diagnosed, given treatment, referred for diagnostic procedures, etc., revealed that these situations are better for white patients. When interacting with African-American patients, for example, physicians were observed to exhibit “less nonverbal attention, empathy, courtesy, and information giving”, to adopt a more “narrowly biomedical” communication style, to spend a lower proportion of time intervals providing health education, chatting and answering questions, to be more verbally dominant and to exhibit more “negative emotional tone” than with white patients. Not surprisingly, African-American patients asked fewer questions, provided less information and showed a more negative emotional tone during exchanges with their doctors. When the physician and patient are of the same race or ethnicity, called race/ethnic “concordance,” these issues are less apparent.

**Cultural Barriers**

Equally important to language and racial barriers, but more difficult to identify, are the significant cultural gaps between groups that impede effective communication. In her 1997 book “The Spirit Catches You and You Fall Down,” author Anne Fadiman chronicles the severe cultural rift between a refugee Hmong family and a small California hospital which was treating a Hmong couple’s daughter for severe epilepsy. Each side of this divide had strongly and deeply held values and beliefs that clashed with one another, leading to a string of frustrating treatment failures and negative experiences despite everyone’s very best intentions.

Cultural sensitivity can be essential to delivering quality medical care. For example, cultural beliefs may affect how patients take their medications. Many Southeast Asians, including the Hmong, view Western medicine as being too “strong” and, on their own, reduce their dosage. West African women come from a culture that places extremely high value on privacy and discretion, making them reluctant to discuss personal matters with medical staff and concerned that they might be seen at the clinic by other Africans. Understanding non-verbal cues is equally important.
For example, when a Southeast Asian patient does not look her doctor in the eye it is intended as a sign of respect. Vietnamese consider the head to be the seat of the soul, which should not be touched without permission. Physicians who know these traits will be better able to demonstrate respect and support the therapeutic relationship.

Integrating cultural and linguistic competencies into medical practice is challenging due to limited resources, multiple competing demands and other pressures of practice. However, learning about cultural sensitivities to the extent feasible not only promotes better communication and health outcomes, it fosters a stronger more respectful clinician patient relationship.
References


6. Id.


8. IOM, Note 7, at 6.


11. IOM Note 7, at 10.


13. IOM., Note 7, at 2.


19. HHS, Note 15, at 44.


22. A variety of organizations have quantified the costs of low health literacy, with a variety of estimates, all in the billions.

Four examples:
§§ Source
$73 billion ACP-ASIM Observer, Feb. 2003
$32-$58 billion Center on an Aging Society
Medical Expenditure Panel Survey
$50 billion Maternity Care Coalition


25. IOM, Note 7, at 242.


30. IOM, Note 7, at 12.


36. IOM, Note 7, at 10.69.


38. Id.


42. Id.


46. Morse, A. Language access: giving immigrants a hand in navigating the health care system. NCIS State Health Notes 2002; 23: 1-5.


49. . Id.


53. Id.


55. Id.


60. Id.

61. Id.


64. Id. p.15

65. Frelick, Note 63, at 15.

66. Id.
CHAPTER 3

GUIDING PRINCIPLES FOR MORE EFFECTIVE COMMUNICATION WITH YOUR PATIENT

Shared Decision Making: The Four Habits

The essence of an effective interview lies in effectively communicating your technical expertise and enhancing the odds that your patients will understand, comply with, and receive the intended benefits of their treatment plan. It also supports the fundamental objective of physicians and patients becoming partners in care, in what has become commonly known as “patient-centered care” or “shared decision making.” As the authors of one research study opined, physicians should think about ways to help their patients make more informed decisions. “Uninvolved and uninformed patients are less likely to accept the doctor’s choice of treatment and less likely to do what they need to do to make the treatment work.”

The national discourse on shared decision making intends to address this concern. The goal of creating a new dynamic between modern physicians and their patients has been described as creating a “true partnership between professionals and patients in which each contributes equally to decisions about treatment and care.”

In shared decision making, because the patient is treated as an equal partner in shaping his or her treatment plan, the physician incorporates the patient’s preferences and values into the medical plan as best he or she can. As such, shared decision making enhances the likelihood that the patient will adhere to a treatment plan once he or she and the physician have agreed on it. For example, if a physician believes a patient may not consistently take a medication three times a day, and a once-a-day alternative exists, offering the patient the once-a-day alternative improves the odds of the treatment plan being followed.

Shared Decision Making Checklist

• Suggest that patients prepare a list of question and concerns before office visits.
• Set an Agenda — Agree on what you and the patient hope to accomplish in the patient visit
• Partnership — Involve the patient by asking questions, listening, responding
• Assessment of patient’s preferences, abilities, ideas
• Explain options and alternative approaches and solicit the patient’s reaction to them
• Facilitate patient’s reflection on the impact of alternatives on goals and lifestyle
• Negotiate a decision on treatment
• Establish the Plan reminding the patient it is tailored specifically to him or her
• Monitor and address patient’s changing needs by checking on how the plan is working

An approach, termed the four “habits” of good physician conduct for every patient interaction, serves as a guide for shared decision making. The four habits are:

1. Invest in the beginning of the patient session
2. Elicit the patient’s perspective
3. Demonstrate empathy
4. Invest in the end of the patient session

Each of these habits is central to improved patient-physician communication and better patient care.

**Habit 1 – Invest in the beginning of the patient visit**

Setting a positive tone for the patient visit is done in the opening minutes. It is here that you create rapport and begin to build trust and confidence with the patient. Some behaviors to help in this process include:

- Meet new patients in your office, if practicable, before they are shown the exam room. Interview them before asking them to undress, if the exam requires that and, again, if practicable.
- Ask how the new patient prefers to be addressed. Some people do not like being called by their first name and you should not assume that it is all right to use it without the patient’s permission.
- When you introduce yourself address the person with full formal name first, then ask how he or she would prefer to be addressed such as: “Hello, I’m Dr. Dorite, one of the partners in this practice. You are Mr. Herbert Rockly, is that right? We haven’t met before, so I don’t know how you prefer to be addressed.” “Herb is fine.” “OK, Herb. Thank you.”
- Make eye contact.
- For established or returning patients, briefly refresh your memory from the chart before you enter the room. Little will make your patient feel more like a number, body part or widget on an assembly line than watching you bury your head in the chart, too preoccupied to greet them as a person. Simply knowing who your patient is will demonstrate your interest and inspire the patient’s confidence that you are prepared and “on the ball.”
- Apologize if the patient had to wait and make it clear you realize his or her time is valuable.
- Chat conversationally at first. Recall something from the last visit or, better yet, something personal to signal the patient that you know who you are talking to. It may help to write a note in the margin of the patient’s chart — look at it before you enter the room — that references something personal and ask him or her about it. For example, “How is Matt's college search going?” or “How is Rosie’s soccer team doing?”
- Sit down and talk to the patient at eye level. Looming over the patient sets a domineering tone.
- Try to “read” the patient’s state of mind, or mood. Is he or she anxious, worried, or cheerful?
• Sit close enough to the patient to be able to touch him or her. But “read” your patient to see if non-exam touching is appropriate. Any doubt should be resolved in favor of not touching, particularly if the patient is the opposite gender.

• Negotiate a consensual agenda – the problems you and the patient will address and the order in which they will be addressed.

• Avoid physical barriers, such as desks or exam tables, between you and the patient.

• Pay attention to physical setting and climate. If the patient is gowned, offer a blanket, heat cold instruments before touching them to the patient’s body or turn up the heat or air-conditioning, as appropriate. Remember that you are fully clothed, and, with a white coat, are wearing at least a couple of layers of clothing compared to an undressed patient’s thin gown. If you are comfortable, it may likely mean that your patient is not.

• Be sensitive to the patient’s sense of vulnerability. Simply being a patient is likely to make many individuals feel exposed, awkward, embarrassed and vulnerable. You may need to adjust your expectations for your patient’s capacity to absorb information and answer questions responsively. To drive home this point, the United Health Foundation (UHF) developed informational material for physicians using the attention-grabbing claim that people lose their ability to “hear” by 68% when they are naked. While UHF may be engaging in hyperbole, the point is nonetheless on target.

• Use orienting statements; patients like to know what to expect. Examples are:
  • “First I will examine you and then you will have some tests in the outpatient radiology unit.”
  • “Okay, we’re finished. Everything looks fine. Let me help you sit up.”
  • “You will feel some pressure. It shouldn’t be uncomfortable but let me know if it is.”

**Habit 2 – Elicit the patient’s perspective**

When moving into the “medical” aspects of the conversation, start with open-ended questions such as “How are you feeling today?” or “When you made this appointment, what were you hoping we would accomplish today?” It is important to get the right information. Effective questioning at the beginning of the visit can help minimize the patient’s “Oh, by the way...” afterthought so common at the end of patient visits.

Allow the patient an opportunity to tell a story by using facilitating statements or questions, such as: “Go on, tell me more.” “I see, and that started when?” Facilitating statements may also include asking patients their opinion about the treatment and their medical problems: “What do you think might be causing this to happen?” “What do you think about taking these pills?” Use nods and other nonverbal cues to encourage the patient to keep talking. Use phrases like “go on,” “please continue,” “and?” and “tell me more” to encourage your patient to tell you what he/she is experiencing. It is important to listen actively and reflectively. Avoid cutting your patient off, but do ask questions to clarify what the patient has said. The challenge is to hear the patient’s narrative and elicit symptoms – continually trying to achieve the proper balance.

Recall the study observing the average doctor’s tendency to interrupt the patient only 18 seconds into his narrative. Be mindful of this pitfall to better avoid it.
Think of the interview as a collaboration between you and the patient. Use follow-up questions that incorporate the information you just heard as a means to validate that you in fact heard correctly. Ask, for example, “So how long have you been having these headaches?” or “It sounds like you have been feeling this pain in your knee for about two weeks. Is that about right?” Help the patient clarify symptoms, especially those such as diarrhea, dizziness, weakness, or fatigue. Such vague and nonspecific symptoms may mean entirely different things to patient and physician. Accordingly, ask questions to pin your patient down on these: “When you say you get light headed what exactly do you mean? Please give me an example.” “How many times did you go to the bathroom yesterday? What did your stool look like?” “Do you feel dizzy all the time or just when you do certain things like stand up or bend over?”

Ask your patient for examples of how his or her symptoms impacted his or her life. For example, “What do you mean when you say you are tired?” This is important to make sure that you and your patient are thinking about the same symptom in the same way. If the patient’s responses are not illuminating, ask leading questions such as, “Are you going to bed before 9:00 p.m.?” “Have you stopped playing tennis?” etc. It is important to be absolutely clear in order to avoid misdiagnosis. Give the patient your complete attention. An increasing number of patients are turning to Complementary and Alternative Medicines and Modalities (CAM) such as herbal remedies, nutritional supplements or acupuncture in lieu of, or as a complement to traditional Western medicine. Ask about the patients use and thoughts about the efficiency of any CAM. When physicians neglect to ask their patients about these practices, they risk missing important information and could adversely impact the therapeutic relationship.

Well-chosen questions play an important role in eliciting the most helpful information from patients. For additional tips and insights into questioning techniques see Appendix 2.

**Habit 3 – Demonstrate empathy**

Empathy, understanding and validating a patient’s feelings, are extremely important components of an effective patient-physician interaction. As Sir William Osler advised medical practitioners in 1904, “It is as important to know what kind of man has the disease as to know what kind of disease has the man.” And it still is. Empathy is not always a natural part of a physician’s make-up. And, ironically, despite the laudatory humanitarian mission of medical education, the nature of that education itself may serve to drum good instincts right out of an aspiring physician. Using the Jefferson Scale of Physician Empathy, an empirical study conducted in 2004 revealed a decline in the level of empathy in medical students between the beginning and end of their third year. Previous studies had reported that 75% of medical students become more cynical about the profession as they progressed, and that they lost humanitarianism, enthusiasm and idealism along the way.

These trends make it all the more important for physicians to consciously develop the ability to respond empathetically to their patients. Showing empathy demonstrates your caring and concern, and thus promotes the patient’s trust in you. In the medical interview process empathy has been characterized in this way:

*Empathy is a type of understanding. It’s not an emotional state of feeling sympathetic or sorry for someone. ... In medical interviewing, being empathic means listening to the total communication - words, feeling,
and gestures - and letting the patient know that you are really hearing what he or she is saying. The empathic physician is also the scientific physician because understanding is at the core of objectivity.\textsuperscript{[12]}  

Note the two part aspect of empathy described in this characterization: 1. Listening and understanding, and 2. Communicating that understanding back to the patient.

Note also the key element of that characterization: in the patient-physician context, empathy is typically considered a cognitive construct, rather than an affective one.\textsuperscript{[16, 17]} The implication of that premise is that empathy is not an either-you-have-it-or-you-don’t personal quality; to the contrary, it is a teachable and learnable skill.\textsuperscript{[16]}

Empathy, moreover, is considered a testable skill. The research study “Empathy: Definition, Components, Measurement, and Relationship to Gender and Specialty,” published in the September 2002 issue of The American Journal of Psychiatry\textsuperscript{[16]} relates how the validity and reliability of the Jefferson Scale of Physician Empathy was confirmed by the testing of 704 physicians affiliated with the Jefferson Health System in the Philadelphia, Pennsylvania region. An explanation of the specifics of the study is beyond the scope of this publication, but the results set forth in the Side Box are interesting enough to warrant mention.

### WHO HAS EMPATHY?

Of the 704 physicians who took the Jefferson Scale of Physician Empathy:

- Women’s scores were higher than men’s to a nearly significant degree.
- (Controlling for gender) psychiatrists, internists, pediatricians, emergency medicine specialists, and family practitioners all had about the same degree of empathy.
- (Again, controlling for gender), the mean empathy score for psychiatrists, internists, etc. was significantly higher than for anesthesiologists, orthopedic surgeons, neurosurgeons, radiologists, cardiovascular surgeons, OB/GYNs, and general surgeons.


Mindful, then, that physician empathy is a behavior, more than an emotional state, actions that manifest empathy include making empathic statements:

- “It sounds like you were really scared [when your chest was hurting and you couldn’t get relief from the nitro pills]. I would have been, too.”
- “You have a lot on your plate right now. That must be hard.”
- “That must have been really upsetting.”

It is important to verbally include the patient as the other “half” of the “team” responsible for improving his or her health. Comments that indicate worry or concern such as “If we’re having this problem, your blood pressure is too high,” as opposed to “you are having this problem” suggest you are approaching the patient’s problems as a team, rather than criticizing or judging the patient.\textsuperscript{[8]} So considering using statements like “I know it may be difficult for you, but we need to work together to tackle this problem.”
Finally, when a symptom may be important to the patient because it impacts quality of life, but is medically neutral, validate the patient's experience: “It must be uncomfortable or difficult to live with, but it is not something that requires me to treat you.”

Beyond those recommendations, the best advice for demonstrating empathy may be to simply turn off your autopilot and listen carefully to everything your patients tell you. According to the noted researchers whose study, “A Study of Patient Clues and Physician Responses in Primary Care and Surgical Settings,” appeared in the August 23, 2000, issue of The Journal of the American Medical Association:

In routine office visits patients’ clues offer opportunities for understanding patients’ lives and emotions. We define a clue [emphasis in original] as a direct or indirect comment that provides information about any aspect of a patient's life circumstances or feelings. These clues offer a glimpse into the inner world of patients and create an opportunity for empathy and personal connection. [18]

The study itself involved the audiotaping and videotaping of 116 randomly selected routine office visits to primary care physicians (54) and surgeons (62). The researchers found that in more than half the visits the patients offered at least one clue, with the mean number of clues being 26. Further, in more than half of those visits with clues, the physicians were clueless. The surgeons responded to emotional clues 38% of the time; the primary care doctors, 23% of the time. [18]

The particular content of a patient clue can be as varied as the patients themselves, and a significant portion of the article consists of excerpts from the taped conversations. But the authors do suggest the following in the way of general guidance:

Patients can offer clues about themselves when they are talking about events in their lives or their own feelings, seeking to receive an emotional response from the physician. The researchers termed these emotional clues. But they assert that patients also offer clues in the course of small talk, such as brief remarks about sports or the weather. These social clues are more subtle, but the researchers illustrate by example how they can also yield valuable insight, if you pay good attention. [19]

They also opine that ignoring patient clues is not the only counterproductive response a physician can give. They noted, in fact, four types of physician responses to emotional clues that are more likely to create enmity than empathy. These responses, called “missed opportunities,” are:

1. inadequate acknowledgement;
2. inappropriate humor;
3. denial (that the patient actually feels or should feel the stated emotion); and
4. termination, explicitly refusing to continue the discussion. [20]

Habit 4 – Invest in the end of the patient visit

The end of the patient visit is a critical time to engage in shared decision making. This is the time you:
• validate symptoms and check the accuracy of reported symptoms and what you heard;
• tell your patient what you are concerned about and why;
• deliver diagnostic information;
• offer rationales for treatment;
• check feasibility of treatment plans with the patient;
• provide education, materials, and treatment instructions; and
• make sure that you have covered what is needed to ensure patient cooperation and compliance and that the patient has understood you.

Continue to keep communication a two-way street by involving the patient in the wrap up. Ask:

• “What questions do you still have?”
• “Did you get what you needed today?”
• “Is there anything else we need to discuss?” a couple of times, to elicit all the concerns.
• Ask the patient to review out loud what you have told him or her, and always invite your patient to call you with any follow-up questions.

AND, finally, but just as important:

• Avoid standing up too soon as if you were trying to escape. Try to appear like you are prepared to stay as long as it takes, even if your schedule is jammed and you are already behind.

Other Aspects of Successful Patient Encounters

Embedded in the discussion of the Four Habits are three elements of successful patient-physician communication that merit more extended discussion.

• Don’t race through the visit.
• Don’t destroy your empathetic words with unwelcoming body language.
• Don’t leave your sense of humor at the examining room door.

Time

Despite popular opinion, time is still on your side. There is a common perception among physicians that the pressures HMOs and other payers place on their practices require higher productivity, more patient visits, and less time for the kind of fully involved, patient-centered conversations and shared decision making you have just been urged to do. However, studies show that this perception is often misplaced. In two studies, patients who were allowed to talk without interruption for as long as they liked spoke for an average of only one minute and 40 seconds in one study, and a mean of one minute and 32 seconds and a median time of 59 seconds in the other. Contrast these studies with the one that reported that the average doctor interrupted the patient only 18 seconds into his or her narrative.
Even just an extra minute or two can make all the difference. Doubling or tripling the time you spend with patients is neither necessary nor even desirable. Recall the 3.3 extra minutes the primary care physicians without malpractice claims spent with patients, compared to physicians with malpractice claims (mean, 18.3 vs. 15.0 minutes). In the classic 1997 *JAMA* study of the behaviors of physicians who were sued, as compared to those who were not, patients of physicians with prior malpractice claims reported “feeling rushed, feeling ignored, receiving inadequate explanations or advice, and spending less time during routine visits than patients of physicians with no prior claims.” Looking at that way, spending an extra 1 or 2 minutes per patient may be a prudent investment of time, even if it adds up to a longer day.

But the 2000 study (by the same lead investigator) of patient clues and physician responses discussed above suggests you may not have to. The physicians in that study who responded positively to their patients’ clues actually spent less time with their patients. “Visits with missed opportunities tended to be longer than visits with a positive response. Physicians in both primary care and surgery can improve their ability to respond to patient clues even in the context of their busy clinical practices.”

**Non-Verbal Messages**

Non-verbal behavior plays a significant role in medical care, and often reveals emotions, moods, desires and worries better than words. Clothing and appearance, facial expressions, eye contact, nodding, gestures, posture, speech rate, pitch and tone of voice all deliver strong messages regardless of what words are used. In fact, studies show that up to 90% of all communication is non-verbal.

Most physicians understand the importance of dressing professionally — the White Coat can cover a multitude of sartorial sins. But many do not appreciate or pay enough attention to the impact their body language, tone of voice and facial expressions have on their patients. Surprisingly, given its importance to the therapeutic relationship, non-verbal behavior has received little attention in medical communication literature, and many physicians are unaware of its importance. A recent review of the few studies on the subject revealed wide variation in physicians’ ability to judge their patients’ emotions accurately. Physicians both misread cues of patient distress and also thought patients were more negative and less satisfied than they actually were. Physicians also exhibited nonverbal conduct that tended to dehumanize the patient and significantly and negatively affected the way the patient felt both about the physician and their experience. The non-verbal communication had a more powerful influence than the technical competence and quality of the medical care the patients received.

By way of example, consider what message is being conveyed when:

- the physician talks to the patient and family with his or her hand on the door.
- the physician sits with crossed arms and closed body posture.
- the specialist enters the exam room for a consult and heads straight to the chart, does not introduce himself or herself or look at the patient, and launches directly into a medical question.

New technologies, such as computers in exam rooms, are modern marvels, but they have their pitfalls. They can draw the physician to a terminal to check information rather than concentrating fully on the patient, exacerbating the lack of human connection in the interview.
Humor

An often overlooked way to connect with patients is humor. Appropriate humor puts patients at ease and, as such, it can be a valuable mode of communication. One research study found that a patient's perception that his or her physician has a sense of humor positively related to that patient's trust, compliance and satisfaction. In addition, a sense of humor was one of the prominent characteristics of physicians who experienced no medical malpractice claims in the 1997 *JAMA* study of claims and no-claims physicians. Naturally, be careful to use it judiciously; being a clown or acting too cavalierly will not inspire trust or confidence and may backfire.

Examples of Interview Styles

To help illustrate what has been covered the following scripts adapted from actual internal medicine interviews contrast “less effective” and “more effective” interviewing styles:

**Less Effective:**

**Physician:** What seems to be the matter?

**Patient:** I am having trouble losing weight.

**Physician:** I can see...you’re about 50 lbs. overweight.

**Patient:** Yes, I know. That is why I came to you for help. I think there is something wrong with my thyroid.

**Physician:** Are you severely fatigued, losing your hair, or constipated?

**Patient:** No, I am not.

**Physician:** Well then. How about menstrual irregularities, changes in your fingernails, or the appearance of a goiter?

**Patient:** No doctor, I haven’t noticed any of those things.

**Physician:** Then I don’t think you suffer from hypothyroidism. My experience with people who claim to have a thyroid problem is that they just eat way too much and do not want to face the truth. A little exercise and fewer trips to Burger King can really go a long way.

**Patient:** Doctor, I really don’t eat that much. I try and diet as best I can. I really think it’s my thyroid. Will you please test for it?

**Physician:** Thyroid testing typically runs about $250.00. If you want to waste your insurance company’s money then let’s go ahead. I will have my nurse call with the results when they are in.

**More Effective:**

**Physician:** What seems to be troubling you?

**Patient:** I am having trouble losing weight even though I’m trying really hard.

**Physician:** How long have you had the extra weight? Can you tell me anything about when and how it happened?

**Patient:** I’ve gained it just in the last 6 months without doing anything differently that I can think of. Despite my best efforts I still can’t lose the weight. I think there is something wrong with my thyroid.
**Physician:** That's a possibility. The symptoms of under active thyroid do include unexplained weight gain. However, people who have that condition usually complain of fatigue, hair loss, and constipation also. Have you experienced any of these?

**Patient:** No doctor, I have not experienced any of those things.

**Physician:** Well, I do think we should check your thyroid. But, I would also like some more detailed information on your diet and exercise habits. I know an excellent nutritionist who can help fine tune your diet. We'll check your thyroid function, and if it is too low we will discuss treatment options.

**Patient:** Thank you for your concern doctor. I could probably use some advice on how to eat better.

**Physician:** Whatever the cause we will work together so you can lose weight safely and effectively.

### Improving the Office Experience

It's the little things that count. Some of the topics discussed in this section may seem trivial or obvious. Yet, it is amazing how often small patient courtesies are ignored in office practices, and how easy it is to create a more welcoming environment for your patients. Running an unfriendly office may predispose you to creating unhappy patients or even a medical malpractice suit before you have even said one word. By the time you get to the patient, he or she may already be feeling irritated, frustrated, annoyed or downright angry about what has just happened or not happened in the waiting room. The issues identified in the next sections are common problems, drawn from many anecdotal experiences, with some simple tips to consider.

#### The Long Wait

There is probably nothing that irritates patients more than being made to wait. Some frustrated professionals have taken to sending physicians bills for the time they waited, in protest over the physician's perceived lack of respect for the patient's time. A patient's experience in your office or facility can dramatically influence his or her perception of whether or not he or she has received high quality care. For example, a study of emergency department patients correlated how long they waited with their perceptions of care. Those who waited more than an hour for treatment rated the thoroughness of their exam as “very good” or “excellent” far less frequently than did patients who waited 15 minutes or less.

However, a simple explanation and apology can do wonders to defuse the anger of the simmering patient. If your office practice routines frequently require patients to wait more than 10 minutes to be seen, consider some of the following:

- Train staff to apologize and explain why the patient is waiting. Ignoring the issue only exacerbates the situation.
- Give patients a realistic time estimate as to when they might actually be seen. Have staff avoid using phrases like: “The doctor will be right with you.” That frequently is code for a long time; patients are catching on. Instead, have your staff say, “I'm sorry you have had to wait. You are the next patient and I expect Dr. Impromptu to be with you in another 10 minutes or so. If it looks like it will be much longer, I will let you know.”
• Place a sign on your reception desk that lets patients know your policy on waiting. For example:

_We know that your time is valuable and we do our best not to keep you waiting. We will let you know if our doctors won’t be able to see you within 15 minutes of you signing in. If you can’t wait, please talk to the receptionist to reschedule your appointment. We are sorry if we inconvenienced you._

• Don’t show patients to an exam room until very shortly before they will actually be seen, not what appears on the schedule. If you are running 20 minutes behind, your patients will be more comfortable in the waiting area. Long waits on exam tables in a flimsy gown with no back support and nothing to do, are uncomfortable for the patient and reflect a lack of respect and consideration by you.

• Apologize and explain why you are late when you enter the room: “I know your time is important and I apologize for making you wait. I had a patient with an emergency that just couldn’t be helped.”

• Thank a patient who had to wait for you. “Thank you for waiting.”

• Provide varied and current magazines in the exam rooms, in addition to the waiting area.

Perhaps the most important thing you can do to cut down on waiting time is to be realistic and honest with yourself about your habits. Are you chronically behind? Do patients complain to you or your staff about waiting? Periodically track how well you keep to your schedule and be realistic. If, instead of 15 minutes per patient, you average 20 minutes, adjust your patient scheduling to accommodate that extra time. You won’t fit in any more patients by ignoring the reality and you will risk alienating the ones you have. An “ideal” schedule that just doesn’t work in reality should be changed.

A very simple, welcoming touch is to have all staff members wear nametags and introduce themselves by name. Receptionists should also state their names when answering the phone. Many patients, especially regular ones, would like to address your receptionist or nurse by name and it’s embarrassing and awkward to ask if the patient has forgotten. Take them off the hook. Also, train your office staff to ask how patients prefer to be addressed and note that prominently on the chart and on contact information forms. Then have staff greet them that way on subsequent visits. Staff should use orienting statements to help the patient anticipate what is coming up in the visit. A little attentiveness and pleasant small talk costs nothing and will put the patient more at ease.

Give your staff written guidelines about expected conduct and attire, and reinforce them with an orientation and periodic refresher sessions. Let staff know that you will be observing them, asking patients for feedback, and including professionalism and etiquette in your performance evaluations. Then do it.

Some suggested guidelines for your staff could include:

1. Act in a polite and professional manner at all times.

2. Dress should be clean and professional. Professional uniforms and white footwear are generally required of all clinical and patient care personnel. Office staff should not wear skin-tight clothing, tights, tube-tops, plunging
necklines, mini-skirts, shorts, blue jeans, or t-shirts with pictures, writing or graphics displays. No flip-flops or stiletto heels.

3. Conversations with other staff about your, or their, personal lives are not permitted in reception area or other patient areas.

4. No personal telephone calls are permitted in, or within earshot of, patient waiting areas or exam rooms.

5. No chewing gum.

6. No eating at your workstation (coffee, tea and soda are allowed).

7. When greeting new patients ask how they prefer to be addressed: “Would you prefer that I call you Mrs. Smith?” and note the information prominently as a reminder for others.

8. When a patient arrives, make eye contact immediately and greet them courteously and by name. Don’t continue writing or talking on the phone while patients are waiting to be greeted or when signing patients in.

**Comfort Counts**

Pay attention to the aesthetics and comfort of the office and exam rooms. Try the following:

- Furnish the waiting area with plenty of comfortable chairs; including at least one love seat or oversized chair for the comfort of your larger patients and visitors.
- Provide books, toys and other distractions for children
- Have a variety of recent (not 2 years old!) magazines available both in the waiting area and exam rooms
- Hang pleasing, colorful pictures or posters
- Have tissues and drinking water available for patients
- Warm your instruments and cover cold metal hardware that comes into contact with patients’ skin where feasible
- Have a blanket or throw and booties available or offered by your staff, especially if the patient is gowned
- Make sure a chair is available in the exam room; it’s hard on the back to sit unsupported on an exam table
- Provide hooks or hangers for patient clothing

**Avoiding Common Pitfalls**

Some typical and common patient experiences may seem like trivial matters to you, but paying attention to your patients’ comfort and showing respect for their time reaps benefits for your relationship. The following suggestions may help you avoid some common pitfalls:

1. **Problem:** One hour wait, no explanation, when patient finally does see the doctor, she does not apologize or explain the reason for the long wait. The doctor rushes through the patient’s exam and doesn’t have time for questions.
**Suggestion:** Be realistic about how long appointments will take and set schedule accordingly. Have office staff members offer to reschedule patients. Have a system where patients can call ahead to see what the amount of wait time will be before arriving. Apologize and explain lateness, respecting of course, other patients’ confidentiality.

2. **Problem:** Patient is told to undress because the doctor will be “right in.” Patient does, and waits for 20 minutes — which feels like 90 minutes — in a frigid exam room. By the time the doctor arrives, the patient’s lips, toes and fingertips are blue.

**Suggestion:** Turn up heat in exam rooms, and have staff offer a blanket and foot socks. Apologize for lateness and cold temperature. Don’t show a patient to the exam room until the doctor is nearly ready to see him/her.

3. **Problem:** As the patient is leaving the exam room, you pass him or her in the hallway and the patient calls out some final question. In so doing, the patient divulges some very personal information.

**Suggestion:** Ask the patient to step into your office or back into the exam room for “afterthought” questions.

4. **Problem:** Parent and child waiting in exam room, physician finally comes in, does a quick check, and attempts to make a get-away before parent can ask questions. The physician stands at the door, hand gripping the door knob, as the parent asks very important questions about the care of the child.

**Suggestion:** Be mindful of body language and patients’ need to feel like you are not rushing through the visit or are anxious to leave. It doesn’t take as long as you think to sit down and answer questions and it may save you grief and time later on.

5. **Problem:** A patient with symptoms that are very concerning or debilitating is trying to schedule an appointment to see you. He or she calls the office repeatedly during the day and either gets a busy signal, the answering service, or is put on hold for so long that he or she is forced to hang up. He or she is unable to reach you that day.

**Suggestion:** Set up an answering machine for a nurse or staff member to triage and return calls the same day, even if only to advise them when the physician can return the call him or herself.

6. **Problem:** A patient arrives and signs in after other patients are already in the waiting area, but is called and shown to an exam room before the others.

**Suggestion:** Have your office staff members apologize to the patients who were already waiting and, if feasible, explain why the patient seemed to be taken out of order.

7. **Problem:** Office staff members are on personal phone calls or talking to one another while ignoring a patient waiting for attention.

**Suggestion:** Office staff members must be immediately responsive to arriving patients by greeting them; even if only to tell them that they will be with them in a minute. Have staff look up, make eye contact, nod acknowledgement of the patient’s arrival and hold up a finger to let them know they will be off very shortly.
8. **Problem**: The office requires patients to give insurance card every single visit and photocopies it every single time.

**Suggestion**: Train office staff to explain your reasons for this policy, assuming there is one. As a seemingly more sensible alternative, simply have office staff members remind the patient of what is in the office records and ask if it is still current.

9. **Problem**: Patient is told to get tests or follow-up procedure, but may not really understand what to do or where to go.

**Suggestion**: Office staff should offer to help every patient with follow-up tests by directing them where they need to go and how to arrange for the test. If possible, schedule and facilitate the referral for the patient or provide phone numbers and names to personalize the contact.

10. **Problem**: When a new patient contacts your office the first question your staff asks concerns his or her health insurance. The patient thinks your getting paid takes priority over their wellbeing.

**Suggestion**: Train staff to acknowledge the caller and the medical concern before asking about coverage.

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**Patient Satisfaction Surveys**

Patient satisfaction surveys can help uncover “hidden” problems that detract from the office experience and may affect the patient’s perception of quality care. One may dismiss the ability of patients to assess clinical competence. But when it comes to issues such as long wait times or rude receptionists, these instruments can provide you with valuable insights into how the office experience influences your patient’s satisfaction and can help you extinguish potential complaints. A sample survey is located in the Appendix 1 for your consideration.

**The Internet**

According to a recent survey, 147 million Americans[^1] - 73% of adults and 87% of teens[^2] - use the Internet. Of these, 84 million households, or 42% of American homes[^3] had broadband service in 2006, up 40% from just the year before.[^4]

Younger Americans are more “wired” than their elders, the well-to-do more connected than the less well-off, white Americans are more wired than minorities, well-educated more wired than those who do not continue education beyond high school and urban and suburban residents are more likely to access the web than rural residents[^5]

A good 80% of all of these users have looked for healthcare information online, a three-fold increase since the 1990’s.[^6] Google estimates that there were more than 2.6 billion health information searches, or 85 per second, in the year 2004.[^7]

This revolutionary phenomenon has spurred dramatic changes in how health information is communicated and it poses numerous challenges. Armed with a wealth of web-based health information, patients are more likely to want to make their own decisions and to actively challenge or test the information you provide. These patients may also want (or demand) to communicate with you or your office staff by e-mail.
Although the number of health information sources has tripled since the 1990’s, not all of it is credible, accurate or reliable. Physicians need to be alert to and caution patients who try to self diagnose or treat themselves based on information they get online. Patients need to be equipped to recognize the credibility of the source. One suggestion is to recommend that your patients access sites sponsored by government agencies, professional associations and educational institutions, i.e., sites with .gov, .org or .edu in the address.

Also be mindful that much of the web based information is inaccessible because it is written at a college reading or technical level. You may save time and spare frustration if you screen for particularly helpful, well written information and provide your patients with a link or print-outs.

These technological advancements raise a host of issues, such as confidentiality, HIPAA compliance, risks associated with providing advice or treatment without seeing the patient, that are beyond the scope of this guide (except to advise you to seek legal advice on these issues if you wish to communicate via internet-based means).

Satisfying the changing expectations of web-savvy patients ranks first of the top seven challenges facing modern American medicine, according to David Lawrence, M.D., former CEO and Chairman of Kaiser Permanente in his book From Chaos to Care.

In sharp contrast to this growing technology-oriented group, other patients struggling with low literacy or lack of access to or familiarity with technology have been on the other side of the “digital divide.” While the perceived gap between wired and unwired groups appears to be closing somewhat — there are more low income, minority and seniors logging on than ever before — many physician practices will still have patients who don’t use computers. Some factors that influence whether a patient will be comfortable using technology are age, education, culture, ease of access to computers, affinity or aversion for computers, and rural or other physical isolation. In order to serve these types of patients you will have to continue “low-tech” lines of communication, no matter how tech-savvy you choose to be in your personal affairs.

Overall, your awareness of these trends and where your patients fall on the spectrum of technical sophistication will add insight into your individualized, patient-specific approach and communication style.

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43. Leaffer, Note 35, at 56.
While the focus of this guide is primarily on patient-physician communication at the interpersonal level, careful and mindful communication among the physicians and other healthcare professionals within a medical team also plays a key role in improving patient safety and reducing liability exposure. This is particularly true in hospital or clinical settings, where multiple caregivers are involved in a single patient’s course of treatment, the opportunities for miscommunication are legion and the consequences can be dire.

Consider the critically ill intensive care unit patient who requires the use of high-tech equipment, multiple medications, and the care of six different specialist physicians. Constant changes to equipment settings and medication doses, coupled with the multiple orders of six doctors — each doctor focused on a different condition, making rounds at a separate time, and giving orders in relative isolation from one another — are the ingredients in a recipe for miscommunications and potential medical error. And when that potential medical error becomes an actual one, everyone — and at the same time no one — is to blame.

For example, the Joint Commission on Accreditation of Healthcare Organizations (“JCAHO”) determined that breakdowns in communication were root causes of 84 percent of sentinel events related to delays in treatment, with 17 percent of these breakdowns involving communication with or between physicians.[1]

Communication Failures Contribute to Errors

Traditional healthcare communication channels suffer from a strong tradition of physician autonomy — each specialist communicating separately with the patient and making narrowly focused decisions about care in a relative vacuum. Physicians function “as independent professionals with little or no experience in working collaboratively in care teams either with other medical professionals or with patients.”[16] While there is emerging discourse that interdisciplinary care teams are the way of the future, a cohesive team approach is far from engrained. Rather, most modern healthcare tends to function not as a team, but as “a collection of individual practitioners who loosely coordinate their actions.”[2]

In “The Wrong Patient,” a retrospective analysis[3] of why one hospitalized patient was wrongly subjected to an invasive procedure intended for another, the authors came to this conclusion:

The most important [system weaknesses, as opposed to identifiable errors of particular individuals] in this case include failures of communication, teamwork and identity verification. Perhaps the most striking feature of this case — one that will be familiar to all clinicians who work in large hospitals — is the frighteningly poor communication it exemplifies. Physicians failed to communicate with nurses, attendings failed to communicate with residents and fellows, staff from one unit failed to communicate with those from others, and no one listened carefully to the patient.[4]
Newspaper headlines of tragic deaths and injuries have turned a national spotlight on the role miscommunication plays in medical error.

- Betsy Lehman, a 39 year old, popular *Boston Globe* reporter, died at the Dana–Farber Cancer Institute from a severe chemotherapy overdose. A fellow’s order prescribing a dosage to be administered *over four days* was mistakenly entered as directing a *daily* administration of the 4-day dose.[14]

- Josie King, an 18-month old girl admitted to Johns Hopkins for severe burns died of severe dehydration and misused narcotics, due to a complete lack of communication among caregivers and the care team’s failure to listen to a distraught mother’s deep concerns.[5]

- Jesica Santillan, a 17 year old Mexican immigrant, died at Duke University Hospital in 2003 after receiving a heart lung transplant from a donor with an incompatible blood type.[6]

These headline-generating tragedies and JCAHO research noted earlier have resulted in industry-wide recognition that miscommunication among caregivers inside healthcare facilities causes errors and needs attention and improvement. For example, effective January 1, 2006 JCAHO imposed a new requirement (2E) requiring facilities to take a standardized approach to hand-offs, including an opportunity to ask and respond to questions.[7]

Many of the concerns arise from the hand-off of care from one caregiver to another. For example, an evaluation of patient handoffs at Indiana University School of Medicine identified communication barriers as one of 4 major impediments to effective care handoffs.[8] Other impediments included lack of structure and standardization, ambiguity about who is responsible for managing the patient’s care and differences in communication style. The authors of the Indiana University study concluded that a standardized, precise, unambiguous face-to-face communication hand-off is the most effective, safe and satisfying.[9]

**Structured Communication**

For some time there has been increased awareness and focus on structured communication as a way of avoiding error in the aviation and other high risk/high consequence industries. It is only recently that hospitals have taken a more structured team communication approach to improve care. One of the first groups to implement structured communication was an open heart surgical care team at Concord Hospital.[10] The team first changed rounding patterns. Instead of conducting independent rounds discipline by discipline, all disciplines-social workers, nurses, therapists, nurse practitioners, home care practitioners, surgeons, etc.-meet and round together. This convergence creates a much more cohesive, integrated and comprehensive care plan. Two years after starting this process, operative mortality dropped from expected levels established by the Northern New England (NNE) Cardiovascular Disease Study Group to less than half of the NEE’s expected levels.[11]

The nation-wide Kaiser Permanente system and the OSF St. Joseph Medical Center in Bloomington, Illinois also employ a structured team communication model termed SBAR (Situation, Background, Assessment and Recommendation).[12] At St. Joseph, a team developed a series of forms to help standardize hand-offs, including charge nurse to charge nurse briefing tools, and staff shift hand off reports.[13] In response to Betsy Lehman’s death, the Dana–Farber Institute completely revamped its approach to care team communications, now approaching patient care as a team responsibility with clear accountability resting with the lead physician. The process emphasizes clear, precise and open communications at all levels within the team, particularly with “hand-offs” between caregivers.[14]
Communication Culture

Other initiatives include communications policies which promote a culture where residents, nurses, pharmacists and other staff are encouraged to question physicians and physicians are discouraged from expressing irritation or annoyance when questioned.[17]

Elizabeth Rider, M.D. of the Harvard University Medical School has developed twelve strategies to improve clinical team communication:

1. Be respectful and professional in your interactions.
2. Listen intently and openly – repeat back or paraphrase what you hear to check understanding of what you hear.
3. Try to understand the other person’s viewpoint.
4. Acknowledge the other person’s thoughts and feelings – this doesn’t mean you agree. “You seem upset.” “That’s another way to look at it.”
5. Be cooperative and assume the other person is acting in good faith.
7. State your feelings and viewpoint as your own rather than as accusations or judgments of another.
8. Don’t take things personally.
9. Learn to say, “I was wrong” and apologize.
10. Don’t feel pressured to agree instantly.
11. Think about possible solutions before meeting and be willing to compromise.
12. Think of conflict resolution as a gradual, step-by-step process.


Much communication — most notably entries on patient charts — in hospital settings take written form and sometimes the mistakes are astonishing.

CHART OF AMUSING BLOOPERS

- Patient has two teenage children, but no other abnormalities.
- She stated she had been constipated for most of her life until she got a divorce.
- The patient is tearful and crying constantly. She appears to be depressed.
- The patient refused an autopsy.
- Healthy-appearing decrepit 69-year-old man, mentally alert but forgetful.
- Discharge status: Alive but without permission.
- She slipped on the ice and apparently her legs went in separate directions in early December.
- Examination of genitalia revealed that the patient is circus sized.

Source: Purported to be actual entries from medical records; probably sent to you as an e-mail from all 50 of your closest friends. Among other places to read these and more like them is Mercola newsletter at http://www.mercola.com/fcgi/pf/2004/apr/3/medical laughs.htm. Accessed July 6, 2004.
Written Communication Tools

Also noted earlier, tools to improve written communications can be very helpful in avoiding misunderstandings. The Johns Hopkins University Hospital (JHU) uses a “patient goals” form, which calls for the physician to physically complete a checklist establishing daily treatment goals. Before using the goals form, fewer than 10% of residents and nurses said they understood their patients’ daily care goals. After implementing the form, more than 95% asserted that they did. The JHU form helps the communications process by prompting physicians to anticipate and address specific aspects of the patient’s care and set out specific tasks to be accomplished that day for all to see and know.

Staff members in the medical intensive care unit at Beth Israel Medical Center in New York also use a patient worksheet as a way of improving understanding of each patient’s treatment goals and impact on length of stay. The comprehensive worksheet is completed daily during interdisciplinary rounds and posted at each bedside. In a study conducted by the hospital, the worksheet significantly improved both nurses’ and physicians’ perceptions of their understanding of patient goals and contributed to a reduced mean stay from 6.4 to 4.3 days.

“Silence Kills”

Another communication problem contributing to medical error is the failure of co-workers to speak up when they observe a colleague engage in risky and dangerous behavior. A 2005 study sponsored in part by the Association of Critical Care Nurses, examined the results of focus groups, interviews, workplace observations and survey data from 1,700 participants including nurses, physicians, clinical care staff and administrators. The report, dubbed “Silence Kills,” revealed that more than half of the healthcare workers surveyed had witnessed colleagues breaking rules, making mistakes, cutting corners, or acting incompetently. Yet, less than 1 in 10 discussed their concerns with the colleague.

In the “Silence Kills” study most workers did not feel it was their responsibility to call attention to these issues. About half of the respondents said the problems had persisted for more than one year, 1 in 5 physicians said this type of behavior caused harm to patients and 23% of nurses were considering leaving their units because of their concerns over colleagues’ behavior.

Silence Kills Examples

A group of eight anesthesiologists agree a peer is dangerously incompetent, but they don’t confront him. Instead, they go to great efforts to schedule surgeries for the sickest babies at times when he is not on duty. This problem has persisted for over five years. (Focus Group of Physicians)

A group of nurses describe a peer as careless and inattentive. Instead of confronting her, they double check her work, sometimes running in to patient rooms to retake a blood pressure or redo a safety check. They’ve “worked around” this nurse’s weaknesses for over a year. The nurses resent her, but never talk to her about their concerns. Nor do any of the doctors who also avoid and compensate for her. (Focus Group of Nurses)
JCAHO Recent Focus on Communications

In its 2004 National Patient Safety Goals\(^\text{[15]}\) JCAHO began to focus on very specific communication concerns as a contribution to medical error. The 2004 goals addressed, among others, two aspects of caregiver communications to which a large number of medical errors were attributed:

1. “Read-back” verification of verbal orders and test results.
2. Standardization of the abbreviations, acronyms and symbols used throughout the organization, and publication of a list of abbreviations, acronyms and symbols NOT to be used.

A “minimum list” of dangerous abbreviations, acronyms and symbols has been approved by the JCAHO. The following items must be included on each accredited organization’s “Do Not Use” list:

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Potential Problem</th>
<th>Preferred Term</th>
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<tbody>
<tr>
<td>U (for unit)</td>
<td>Mistaken as zero, four or cc.</td>
<td>Write “unit”</td>
</tr>
<tr>
<td>IU (for international unit)</td>
<td>Mistaken as IV (intravenous) or 10 (ten).</td>
<td>Write “international unit”</td>
</tr>
<tr>
<td>Q.D., Q.O.D. (Latin abbreviation for once daily and every other day).</td>
<td>Mistaken for each other. The period after the Q can be mistaken for an “I” and the “O” can be mistaken for “I”.</td>
<td>Write “daily” and “every other day”</td>
</tr>
<tr>
<td>Trailing zero (X.0 mg), Lack of leading zero (.X mg)</td>
<td>Decimal point is missed.</td>
<td>Never write a zero by itself after a decimal point (X mg), and always use a zero before a decimal point (0.X mg)</td>
</tr>
<tr>
<td>MS, MS04, MgS04</td>
<td>Confused for one another. Can mean morphine sulfate or magnesium sulfate.</td>
<td>Write “morphine sulfate” or “magnesium sulfate”</td>
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In addition, each organization must identify and apply at least another three “do not use” abbreviations, acronyms or symbols based on its own experience with problematic abbreviations.\(^\text{[15]}\) Avoiding these abbreviations, and being aware of others, that may have helped create communication errors, in both your office practice and facility practice can help reduce common miscommunication.

As noted earlier in this Chapter, JCAHO is continuing to focus on addressing and correcting specific areas of common communication breakdowns contributing to medical error.
**How to be More Patient-Friendly in the Hospital**

When interacting with patients in a hospital setting, remember that being a patient can be a bewildering, frightening, and overwhelming experience, especially for seriously ill patients and their families. It’s easy to forget that the daily routines and commotion of hospital life — second nature to you — may be brand-new and completely foreign to them. Patients’ inherent vulnerability and helplessness only compound the situation. Remain sensitive to the importance of orienting your patients and offering to help them understand their surroundings and “how things work around here.”

If your practice is in a teaching hospital, help create communication skills programs for residents, who are a primary source of information for many patients and families. Someone on the medical team should “orient” the patient and family to hospital or unit practices and routines, covering such topics as:

- How physician “rounds” work
- How often nursing shifts change
- What to do if the nurse doesn’t respond, if the patient’s medications are late and other frequently asked questions.

**What Not To Do**

A 90 year old man, otherwise quite healthy, broke his back falling off a step ladder as he was trying to change a light bulb. He required extensive surgery involving rods, pins, harvested and donated bone. In pre-op, the morning of the surgery, the surgeon appeared at the foot of the patient’s bed and began talking. The patient had been flat on his back for three days and the surgeon had habitually placed himself at the foot of the patient’s bed. The patient’s daughter, who was standing near the head of her father’s bed, moved away and suggested that the surgeon take her place so her father could see him. The surgeon replied, not inclined to move, “Why? He just saw me yesterday.”

*Source: Author’s personal experience*

Improved focus on fundamental common courtesies and the “little things” is a good starting point for humanizing and demystifying the hospital experience, and finding opportunities to make system improvements. To make the focus more concrete, suggest that administration create a frequently asked question sheet to orient the patient to unit processes.

Just like your communications with patients in an office setting, those with your hospitalized or nursing home patients and their families can be enhanced by being aware of some simple, but common, pitfalls and heeding these behavioral tips to avoid them:

- Knock before you enter the room.
- Avoid standing in the doorway or far away from the patient during your conversation.
- Sit down so you will be at patients’ eye level. It reduces the power imbalance and puts patients at ease.
• Greet the patient and family members, if present, by name. It is disrespectful to launch into a conversation with a patient without acknowledging the caring visitor right in front of you.

• Protect confidentiality by checking with the patient before discussing his or her condition in front of the visitor or respectfully ask the visitor to leave the room.

• Wear a nametag and introduce yourself or remind the patient of your name, if you have treated the patient before.

• Tell the patient what your role in his or her care is, and what you have planned each day.

• Use orienting statements to help the patient understand how you will be managing his or her care, who else will be seeing him or her, when and why.

• Talk frequently with the patient’s other care-givers to check for clues on the patient’s condition. Don’t rely solely on chart notations as “coordinated care.”

• Avoid treating the patient in isolation from other caregivers. Work with your colleagues to develop integrated plans of care.

• Leave the patient or family member your business card at the bedside so that they can remember you and know how to contact you.

• If you are not the first person to talk to the patient, explain why you may have to ask the same questions someone else already asked. Assure your patient that you are trying to verify accurate information or hear the patient’s description of symptoms in his or her “own words” not because you and the other caregivers are not communicating with one another.

• Review the chart before you enter the room. Make and read personal reminder notes about the patient to personalize your visit.

• Suggest to patients that they write down any questions they might think of after you have left the room for the next visit.

• Check with the patient before you leave using the “teach back” approach. Does he or she understand what will be happening next, when, and how long that will take? Does the patient know when you or your associate will be returning? Do they know what tests are ordered and when they will happen?

Consider doing your charting at the bedside rather than in the hall or at the nurses’ station. One physician, who had himself been an inpatient and felt his doctor spent too little time with him, adopted this practice as a way of adding a precious few minutes to his patient visits. [23]

Not every physician deals with team communications in healthcare settings. But most doctors do participate at times as part of a professional team caring for a particular patient. Excellent communication is essential to assuring that both you and the other team members have the information you need to effectively carry out your part in the care of the patient.
References


5. Sorrell King Speech to IHI Conference October 11, 2002.

6. NY Times 2/22/04


9. Id.


11. Id.


13. Haig, Note 12, at 169.


19. Information recorded included tests, medications, catheters, consultations, nutrition, family discussions and other daily matters.


22. Id.

CHAPTER 5

Disclosing Poor Prognoses Or Medical Errors

Physicians dread delivering bad news, customarily understood in the medical community to mean “any information which adversely or seriously affects an individual’s view of his or her future.”[1] Sometimes it is telling a patient that he or she is dying from a terminal illness like some cancers; sometimes it is disclosing that a poor prognosis is the result of, or has been exacerbated by, a medical error. Whatever the particular item of bad news is, the conversation is difficult, challenging and uncomfortable. Some doctors’ dispassionate, scientific orientation is at odds with a caring, compassionate delivery; while others struggle to contain their own emotions so they don’t get in the way of an effective conversation. This chapter will consider some of the issues and challenges to these difficult conversations and summarize some insights from those who have experienced or studied the complex human dynamic of communicating “bad news.”

Breaking Bad News (Poor Prognosis)

The way physicians tell their patients that they have a serious illness or may die varies as much as the number of physicians who have to do it. Bluntness, indirectness, euphemisms and veiled messages, combined with the fragile emotional state of the patient, all contribute to a complicated, nuanced process that has the potential to result in poor communication.

In these situations, you, the doctor, are not entirely to blame. Studies show significant variability in how much patients really want to know. One study found that 87% of patients wanted all the information.[3] Yet other studies show that many patients are in denial and resist hearing bad news. A high degree of such patient resistance was found by the investigators in a 2003 study[2] from Yale University surveying 214 terminally ill patients. The researchers found that as many as 40% of those surveyed preferred not to discuss their prognosis. The study also found significant gaps between what doctors and patients remembered about the conversation in which the diagnosis was delivered. While all doctors recalled providing a prognosis, 69% of the respondents said they did not receive one. Fully 89% said they did not receive information about life expectancy, even though their doctors uniformly remembered providing it.

These and other studies point to the need for physicians to be attuned to their patients and tailor their information and approach to each individual as best they can.[4]

Oncologists are among the specialists faced most with delivering bad news as a routine part of their practice. In an informal survey[5] of 500 oncologists attending the 1998 Annual Meeting of the American Society of Clinical Oncology (ASCO), 60% responded that they broke bad news to patients from 5 to 20 times monthly. Another 14% said they did so more than 20 times per month. A combined 64% of the latter group stated that they felt either “not very comfortable” or “uncomfortable” when having “bad news” conversations.

Perhaps not surprisingly, only 4.8% of oncologists said they had ever received any formal training in communications techniques. In 2004 only 31% of oncology training programs addressed communication, and of these, the format was usually a lecture as part of a fellowship curriculum.[6] Recent studies demonstrate that intensive interactive training programs produce more effective questioning techniques, expressions of sympathy and appropriate responses to patient cues, greater ability to elicit patient feelings and
improvements in other aspect of communication. These training programs include role playing, group demonstration, group discussion and structured feedback for each of the participants; all led by a trained facilitator in the ASCO study.

The majority of respondents in both groups strongly desired techniques for disclosing bad news, but felt ill-equipped due to their lack of training. Short of interactive training, the researchers in the ASCO study synthesized recent literature on the topic and developed a step-by-step technique called SPIKES to help physicians deliver news of a poor prognosis. While developed for oncologists, the protocol will help any physician confronted with advising a patient of a poor prognosis.

SPIKES is an acronym in which each letter relates to the six steps of the protocol.

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<th><strong>Set up the interview</strong></th>
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<td>Arrive to deliver the bad news in a private setting, although you should include the patient's significant others, when appropriate. Set aside enough time to deliver the news and respond to all questions. Instruct staff to block all interruptions. Once the patient arrives, sit down, allow time to establish rapport, and consider offering a comforting physical touch.</td>
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<th><strong>Assess the patient’s Perception</strong></th>
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<td>Rather than simply delivering the bad news, first probe the patient to discover what he or she thinks, or is afraid, the news you are about to deliver is going to be.</td>
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<th><strong>Obtain an Invitation to proceed</strong></th>
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<td>Some patients do not want to know everything in detail until such time as you are ethically obligated to tell them. Probe the patient for how much detail to provide at that session, offering to discuss any additional points at a later appointment, or perhaps with a friend or family member.</td>
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<th><strong>Give the patient your Knowledge and the diagnostic information (the bad news.)</strong></th>
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<td>Start with a warning that the bad news is coming up, then deliver it. Hit the delicate balance between vague euphemisms and cruelly blunt language. Like prescribing medication, delivering bad news should follow the “start low, go slow” principle: break down the bad news into smaller, more comprehensible disclosures that build on each other to complete the entire range of medical information you want to impart. Watch your word choice and sentence structure, matching them a bit below the level the patient would understand under less stressful circumstances.</td>
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<th><strong>Respond with Empathy to the patient’s Emotions.</strong></th>
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<td>Watch carefully how the patient reacts. No patient is the same; no one is entirely predictable, or for some, even predictable at all. Don’t interrupt. Let the patient ventilate. Then say something to indicate you understand why the patient is feeling the way he or she is, assuming you do. A person may cry out of fear of death or bodily decay. Or he or she may be terrified at the prospect of suffering excruciating pain. If you are not sure what is driving the patient’s emotional response, gently ask.</td>
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<th><strong>Summarize and Strategize</strong></th>
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<tr>
<td>Start the patient going down the road to the next step: what to expect and what the options are. Start working with the patient to develop a plan of action.</td>
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Researchers, Tina Randall and Andy Wearn, surveyed international studies on patients’ needs and wishes when learning bad news and compiled another guide for physicians. The guide, set forth below, serves as a complement to the SPIKES protocol.

**Summary of the Main Principles of Breaking Bad News**

- Private and quite setting
- Manage time constraints and interruptions, allow time for questions
- The presence of a supportive person should be encouraged
- Enough seating for all present. Doctor should remain at the same seating level as the patient
- Avoid artificial barriers, e.g., tables
- Doctor should always show the patient respect
- Direct approach prepares without misleading
- Information must be honest, reliable and comprehensive
- Avoid euphemisms, jargon and acronyms
- Discuss treatment options with the patient and involve them in the decision making
- Deliver the news at a pace that is suitable for the patient
- Always convey a sense of hope
- Reassure the patient that any emotional reaction is normal
- Touch the patient to comfort them if it is appropriate
- Provide information leaflet, summary or recording of the interview. Repetition of information may be necessary
- Arrange an additional meeting
- Provide information about support services or liaison staff that are available

**Disclosing Medical Error – What Patients Want to Know**

When a medical error does occur, studies have shown that what patients think and want are at odds with what physicians think and want. One of the most difficult times in a physician’s professional life is when a patient has a bad outcome that is attributable to a medical error that must be disclosed to a patient or her family. It is particularly hard when the physician is, or believes him or herself to be, responsible for that error. This chapter will summarize a number of facets to medical error disclosure including what patients expect, the changing regulatory and ethical contexts and observations on the critical role of honesty and apology in managing the relationship issues between physician and patient.

It is well known that, although patients want to know when a medical error has occurred, many physicians have been slow to embrace this concept. Researchers who conducted a series of focus groups on medical error disclosure in 2003 highlighted the
gap between what patients want to know and what physicians feel comfortable disclosing. Patients wanted full disclosure and an apology but doctors were reluctant to provide either. Understandably, they were concerned that full disclosure would make a lawsuit more likely, would lower their patient’s trust in them and would mean admitting a personal failure. As discussed later, these concerns, while instinctively well founded, do not surface during effective medical error disclosures.

**Patients Want to Know:**

- What happened? (Don’t confuse patients with indifference, explaining that it may take a while to find out exactly what went wrong.) Patients are willing to wait if you are honest and upfront about both what you know and what you don’t know.
  - What does the error mean for my health?
  - Why did it happen?
  - How will the medical problem be corrected?
  - How will you make sure it doesn’t happen again to me or someone else?
  - Who will pay [financially] for the mistake?
  - Do the institution and the physician regret what happened?
  - Are the physician and the hospital willing to accept responsibility and apologize?

**Regulatory and Ethical Requirements**

The culture of most institutions not so long ago was one of nondisclosure and fierce legal protection of information about adverse events. Forcing change in a culture that has traditionally resisted full disclosure of medical error, agencies, legislators, and physician policy organizations recently have been busy and aggressive.

The JCAHO requires that patients be informed about unanticipated outcomes, and at least twenty-three states have legislated some version of a requirement that physicians and other providers disclose medical errors to patients. Additionally, codes and policy statements from numerous physician and medical organizations encourage disclosure as a matter of moral and ethical imperative. Among these are:

*American College of Physicians Ethics Manual,*

“Physicians should disclose to patients’ information about procedural and judgment errors make in the course of care, if such information significantly affects the care of the patient.”


“Physicians must ensure that patients are completely and honestly informed before the patient has consented to treatment and after treatment has occurred. ... Physicians should also acknowledge that in health care, medical errors that injure patients do sometimes occur. Whenever patients are injured as a consequence of medical care, patients should be informed promptly because failure to do so seriously compromises patient and societal trust. Reporting and analyzing medical mistakes provide that basis for appropriate prevention and improvement strategies and for appropriate compensation to injured parties.”

The statement “urges all health care professionals and institutions to embrace the principle of dealing honestly with patients. When a health care injury occurs, the patient and the family or representative are entitled to a prompt explanation of how the injury occurred and its short-and long-term effects. When an error contributed to the injury, the patient and the family or representative should receive a truthful and compassionate explanation about the error and the remedies available to the patient. They should be informed that the factors involved in the injury will be investigated so that steps can be taken to reduce the likelihood of similar injury to other patients.”

The Physician Charter.

This statement of ten Professional Responsibilities was published in 2002 by the Medical Professionalism Project which, in turn, is sponsored by the American Board of Internal Medicine (ABIM) Foundation and the American College of Physicians (ACP) Foundation contains. One of the Professional Responsibilities is a “Commitment to honesty with patients.” The charter has been endorsed by over 90 professional associations, colleges, societies and certifying boards. [Id.]

These principles embody the recognition that a policy of honesty and disclosure serves the public interest in patient safety, as well as the individual interests of both the patient and physician involved in the incident.

Some of the benefits of disclosure are summarized below:

**Benefits to Patient**
- Peace of mind
- Informed basis for decisions about current and future care
- Increased trust, improved relationship
- Ability to address and correct medical and health issues promptly
- Opportunity to express emotions

**Benefits to Physician**
- Opportunity to learn from error and improve quality
- Better positioned if claim is filed
- Emotional value, opportunity to apologize, redress
- Reduced patient anger, frustration
- Patient may not sue or go to the press


Help with Disclosing the Medical Error

Most physicians understandably dread having to break bad news to their patients, and many physicians have been advised by risk managers and defense lawyers to withhold key information about adverse events. Although concern about admitting legal liability
may account for much of their reluctance, physicians also may feel inadequate to deal with the patient’s emotions, or may want to avoid their own feelings. The emotional aspects of medical error are profound. Patients experience a range of emotions including sadness, anxiety, anger, fear and frustration. Physicians are upset, guilty, disappointed, feel self-doubt, and are fearful of litigation and the impact on their reputation. The disclosure conversation offers an opportunity for these very human reactions to be acknowledged, expressed and understood by the other party. Physicians may also experience guilt if the bad news is something that should not have happened or could have been avoided, like a missed or delayed diagnosis. This section provides you with some insights into disclosure conversations, as well as practical tips on how to make them less stressful, more empathetic and less vulnerable to miscommunication and misunderstanding.

**Theoretical Underpinnings**

Most people try to avoid conversations that are uncomfortable, stressful or hold the potential for triggering overwhelming emotions. In their book, Difficult Conversations, co-authors Douglas Stone, Bruce Patton and Sheila Hen explore the elements and themes that pervade all types of difficult conversations. As a result of studying hundreds of such conversations they identified a common tripartite structure among them and asserted that understanding this structure is the important first step in improving how we deal with them.

1. The “What Happened?” Conversation – This is the part of a difficult conversation in which information is conveyed. The physician must tell the patient that she has been diagnosed with metastatic breast cancer, for example. This part of the conversation becomes much more difficult if the bad situation was avoidable or preventable: “You have advanced breast cancer which has spread to other parts of your body — and I/my office missed an abnormality on your mammogram 9 months ago.”

2. The Feelings Conversation – Every difficult conversation will evoke complex feelings on the part of both parties. The question is not whether strong feelings will arise but how to handle them when they do.

3. The Identity Conversation – This is the internal conversation that each party has to assess what this situation reveals about them. The patient may wonder what he or she did wrong or feel he or she is to blame. The physician may also feel he or she is to blame and may question his or her competence or ability to stay “on top of everything,” particularly when there has been a medical error.

Each of these conversations plays a role when a physician is delivering bad news to a patient. In preparing to deliver bad news and in reflecting on conversations afterwards, it is helpful to bear in mind that each one of these dynamics should be considered both individually, and as it relates to the other two dynamics at work in the conversation.

These three conversational elements will be discussed in the context of a physician delivering bad news to a patient.

**The “What Happened?” Conversation**

Preparation, or having enough information going into a difficult conversation, is key to a successful conversation. The patient will want to feel that you have spent time thinking about the situation, gathering all the facts and applying your expertise to “fixing” whatever
it is that's wrong. If the incident happened in an institutional or facility setting, the conversation should be planned and coordinated with the facility's management. If resources are available, having the benefit of a sounding board or coach to help you think through the conversation and anticipate the questions and emotions that are likely to arise can be invaluable.

The level of preparation for conveying bad news will obviously depend on the complexity of the diagnosis and treatment options. When a diagnosis is common and the treatment plans straightforward, this aspect of the conversation will be relatively simple. When, however, the patient's problems are complex and there is no clear "straight line" course of treatment, the conversation obviously will require more preparation on your part.

Consider, how much time you will need and schedule accordingly. The conversation will not go well if you rush or the patient thinks you are in a hurry. Think about what questions the patient may have and how long it will take you to answer them. Also, plan on incorporating time for silence, as the patient will need time to absorb the information, and time to allow for emotional regrouping. Allow time for repeating yourself and going over the same ground more than once. You will be dealing with an individual who may be in a physically or emotionally fragile state, unable to process what you are saying quickly or completely.

Be sensitive to the setting. These conversations should take place in a completely confidential setting, as a matter of both human decency and federal patient privacy law (HIPAA). But also consider the need for quiet, comfortable chairs, the availability of tissues, should the patient or family start to cry, and water, if they have difficulty talking or choke up with emotion. Use empathetic phrases like "I know this is not the news we were hoping for." Give a warning that bad news is coming. "I'm afraid things are more serious than we hoped." Share information in simply stated, digestible hunks, pausing to let each piece sink in and to let the patient ask questions. Observe your patient's reactions carefully to gauge the pace of information.

Invite follow-up phone calls or suggest another appointment. As the news sinks in, patients often have additional questions. They need to know these inquiries will be welcome, not bothersome. Help the patient think about support, logistics, family and friends who can help.

Engage in active listening. Active listening means letting the speaker know, through body language, non-verbal responses and words that you are focusing on, hear and understand what the speaker is saying; or what he or she is thinking (often wrongly). In active listening, the listener should be able to accurately paraphrase back to the speaker what he or she has said. Some tips for improving your active listening are found in Appendix 3.

**The Feelings Conversation**

Dealing with emotions is one of the two hardest parts of having a difficult conversation; the other is effective listening. The physician who understands how emotion, both in the patient and him or herself, affects communication will be better prepared to identify and handle the emotional situations that invariably arise in the course of difficult conversations.

Social psychology research posits three components to emotion: expressive, physiological, and cognitive.
**Expressive Component** – The expressive part of emotion is how people convey feelings through tone of voice, facial expression and body language. How different people show the same emotion, such as anger, is individualized, influenced by personality, genetics, upbringing, and culture. It is more difficult than one might think to accurately perceive how someone is feeling by “reading” that person’s expression of emotion; most of us are not good at it. We tend to assume that another person is feeling a certain emotion if he or she expresses it in the same way we do. If you are a “yeller” when you are angry, you are more likely to think that a person with a very calm demeanor is not angry. In one study of adults’ ability to accurately “decode” expressive emotion, only 10-15% of men and 20-25% of women were right. To put it another way, when we try to “read” another’s emotions, most of the time we get it wrong. To compound the situation, the research subjects were more confident that they had read the feelings accurately when, in fact, they had gotten it wrong.

Because we are such poor interpreters of another’s feelings, asking questions designed to elicit feelings — rather than assuming we know what they feel — is a more reliable way to perceive the emotional state of a patient. Then, attentive, active listening helps bring about a better understanding of the feeling.

**Physiological Component** – This dimension of emotion deals with the physical reactions people experience when in an emotional state. Being “emotionally flooded” severely impairs our ability to think rationally about complex decisions or issues. Studies show that it only takes from 2 to 20 seconds from the time we hear about an emotionally laden event to become so emotionally flooded that we cannot take in or process information. Once flooded, a person needs at least another 20 to 30 seconds to able to think clearly once again. Allowing a patient to experience both the flooding and its ebb — whether by venting, crying or simply remaining silent — is a difficult, but important, aspect of having a difficult conversation. Continuing to “talk” to or otherwise engage patients when they are flooded is not only ineffective but in some instances it may actually compound the problem.

Recognizing that information imparted during a difficult conversation may not have registered with the patient, be prepared to gently repeat the information again after the emotions have subsided. Waiting patiently and empathetically, allowing time to take its course, will make the rest of the difficult conversation more effective.

**Cognitive Component** – This element of emotion is what forms the motivation for certain actions or behavior. Unresolved emotions often drive behaviors, such as unexpressed anger motivating revenge or a quest for justice. A simple acknowledgement of the patient’s feelings can go a long way to diffusing emotion that might otherwise remain unresolved. It’s tempting to jump over the patient’s feelings in a desire to address the problem and make everything better. But that often is not the most helpful course.

Understanding these three components of emotion in the “Feelings Conversation” can help you respond more appropriately and helpfully when faced with emotionally charged conversations.

**The Identity Conversation**

The Identity Conversation concerns the physician’s internal dialogue about, among other things, how to deal with feelings of responsibility. Physicians should also be aware of their own feelings — after all, you are human, too. A physician involved in a medical
error is in a sense, a “second victim,” who is often overlooked, paling in comparison to a tragically injured patient yet after they have made a mistake, physicians often experience panic, shame, guilt, embarrassment and humiliation, inadequacy and isolation. These feelings can be very powerful and can affect and cloud an otherwise effective communication. Being aware of them is the first step toward more effective management of them. And, don’t be reluctant to acknowledge that you may need help, too. Reaching out to colleagues for support or seeking professional counseling are positive and helpful responses to help cope with your own emotions.

The Role of Apology

Many physicians have been advised by their lawyers and others that they should not apologize when something goes wrong with a patient. There is a common misperception that an apology is tantamount to an admission of liability. This section reexamines that misperception and discusses the power an apology can have in defusing anger, frustration and other potent negative feelings that can poison a patient-physician relationship, leading sometimes to costly litigation.

The role of apology in disclosing medical mistakes has not been studied empirically, but it is receiving growing attention in the field. And, it appears that attitudes are changing. An authentic apology carries the potential for healing power and addresses the human psychological and emotional needs of the individuals involved in an adverse event. And, as will be discussed later, although giving an apology does carry some risk, the potential legal as well as emotional benefits for the apologizer appear to be much greater.

Four Kinds of Apologies

The effect an apology has on the giver and receiver depends in large part on what kind of apology it is. Four kinds have been identified:

1. Tactical
2. Explanation
3. Formalistic
4. Authentic — acceptance of responsibility

A tactical apology is used to try to soften up another party to try to make them more amenable to a settlement. Lawyers who apologize on behalf of clients are generally using the apology as a bargaining tactic.

An explanation apology begins with the apology words, “I’m sorry” immediately followed by a “but,” which can sound like a justification or rationalization for the apologizer’s act. “I’m sorry you had an allergic reaction to the new antibiotic, but you didn’t tell me you were allergic to penicillin” comes across more as a defensive accusatory, statement rather than a conciliatory one, especially since the physician should have checked or asked.

An apologizer making a formalistic apology makes a statement more because it is socially expected than because the apologizer feels genuine remorse. A parent requiring a child to apologize for breaking the neighbor’s window and court-ordered apologies are examples.
An authentic apologist feels and expresses genuine empathy and regret and also takes responsibility for his or her actions. When an authentic apology is given, both the giver’s and the receiver’s feelings may change and there is potential for trust to be restored. For one thing the apology sends a message of caring and removes doubt that the apologist “doesn’t care.”

**Impediments to – and Benefits of – Acknowledgement of Error and Apology**

As mentioned before, one of the biggest reasons more physicians do not offer authentic apologies when they are responsible for an adverse outcome is the fear of admitting fault and being legally liable. And for many, their lawyers have counseled against giving apologies for that very reason.

But there are three ways to give a “safe” apology. One way to give a safe apology is to practice in one of the twelve states that as of early 2006 has passed legislation prohibiting statements of sympathy or apologies from being used against the apologist later in court. Ask your practice’s attorney if you are in one of them but be mindful that the protection varies, ranging from protection for statements of sympathy only to much broader protection which includes statements of responsibility. As of mid year 2006, three states–Colorado, Oregon and Connecticut–provide the broader protection. A second way is to say “I’m sorry that this happened,” stopping short of acknowledging responsibility. A third way is to offer the apology in the context of a mediation which enjoys a confidentiality privilege in many states. Again, check your jurisdiction and its protections.

Even without formal legal protection, recent research suggests that giving an apology, if it is the right kind, may be the better course legally.

While the particular dynamics of a situation involving medical error should not be discounted, the results of a research study testing the effect of apology in a hypothetical bicycle accident nonetheless shed light on the role of apology in medical injury claims. In the study 145 participants were asked to read the same summary of the simulated accident and were then asked to evaluate the same settlement offer under three conditions: (1) no apology was made; (2) a partial apology was given; and (3) a full apology was given. The partial apology included an expression of sympathy but no expression of acknowledgement for causing the harm. The full apology involved both the expression of sympathy and an acknowledgement of responsibility. The study found that full apologies were far more effective in prompting the “claimant” to accept the settlement offer than were partial apologies. In some respects, partial apologies were even worse than no apology at all.

After seven years of embracing its policy of disclosing and accepting responsibility for medical errors, the Dana–Farber Cancer Institute experienced “zero legal claims by families on disclosed errors” and a number of other institutions are experimenting with policies of disclosure and acknowledgement of error. These initiatives are surveyed in Chapter 6. More research is being conducted on the impact of apologies and institutions have only begun to assess the effect of disclosing medical errors and accepting responsibility for them in empirical ways. However, early indications from these initiatives are that openness, honesty, caring and accepting responsibility are key ingredients to effectively delivering difficult news, disclosing medical errors, reducing liability claims and rebuilding trust in the physician-patient relationship.
References


4. Id.


17. Stone, Note 16, at 89.


23. Id.

CHAPTER 6
EARLY INTERVENTION AND MEDIATION:
WHAT THEY ARE AND WHY THEY MEAN HELP IS ON THE WAY

In the past several years, the term “mediation” has crept into the healthcare lexicon. Largely unknown in the healthcare field in years past, there is a growing recognition that mediation and its related alternatives to traditional litigation offer faster, fairer, more human and humane and more satisfying resolution processes for medical liability and other healthcare disputes.

Mediation is a voluntary, non-binding process in which a neutral third party facilitates negotiations between two disputing parties in an effort to reach a mutually agreeable resolution. Key to the process is that the parties themselves participate in the process and control the outcome. Its application to medical malpractice and other healthcare disputes holds great promise.

Medical liability law and the current court system assign legal fault in a conflict and decree a legal winner and a loser. The court system also is concerned only with dispensing financial compensation awards as the sole remedy for a patient’s injuries. Students of human behavior and advocates of alternative dispute resolution processes understand that, particularly in medical liability cases, the issues are as much — or sometimes more — about the human, emotional aspects of the case than they are about money. When you think about the reasons people sue and the emotions both patients and physicians experience in the wake of medical error, mediation offers the parties the opportunity to process, address, and resolve these issues in a setting and manner that recognizes this human dimension.

Those who use mediation find that it can diffuse anger, restore positive communication and rebuild the relationship between provider and patient.

In mediation, with the help of the trained mediator, the parties can fashion their own solutions, crafting creative, non-monetary remedies borne of the human interests and needs of the parties. These solutions range from giving and receiving an apology to innovative initiatives that institutions and physicians can take such as:

- establishing a memorial fund that provides holiday gifts for hospitalized children in memory of a deceased child
- funding and sponsoring lectures on risk management dedicated to the injured party in the department in which the error occurred
- playground equipment dedicated to a child and funded by a hospital
- changes in hospital policies or procedures to correct processes that contributed to medical errors
- conducting annual communications training programs for medical residents and staff

All of the above examples come from actual mediations with which the author is familiar.
Mediation is not Arbitration

Mediation is often mentioned in the same breath as arbitration and, in truth, they have some degree of commonality, as both fall under the broader rubric of “alternative dispute resolution” or “ADR.” However, arbitration actually has much more in common with litigation than with mediation. In arbitration like similarly in a trial, the dispute is decided by a neutral third party. The arbitrator’s decision is binding and there is a narrow, limited right to appeal. Binding arbitration is usually quicker, less formal, less costly and more private than litigation. But, like litigation, the parties come to the process as adversaries, presenting evidence and witnesses and arguing their cases to the decision-maker. The goal is persuasion, being right and winning the case; not problem-solving and finding a compromise resolution with which everyone can live.

Mediation and Arbitration compared:

<table>
<thead>
<tr>
<th>Mediation</th>
<th>Arbitration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voluntary, non-binding</td>
<td>Not voluntary if you are the defendant, always binding</td>
</tr>
<tr>
<td>Private, confidential</td>
<td>Public</td>
</tr>
<tr>
<td>Parties retain control over the process including selecting the mediator</td>
<td>Parties turn control of the dispute over to an arbitrator</td>
</tr>
<tr>
<td>Money and creative non-monetary</td>
<td>Money is usually the only option remedies available</td>
</tr>
<tr>
<td>$</td>
<td>$$$$$$$</td>
</tr>
<tr>
<td>Parties communicate directly with each other</td>
<td>Parties do not communicate with each other; testify only</td>
</tr>
<tr>
<td>Potential for compromise</td>
<td>A winner and a loser</td>
</tr>
<tr>
<td>Opportunity for minimal discovery</td>
<td>Extended, lengthy discovery</td>
</tr>
<tr>
<td>Can resolve case very early</td>
<td>Requires full case preparation as in a trial</td>
</tr>
<tr>
<td>Concern for the relationship</td>
<td>No concern, can be harmful</td>
</tr>
<tr>
<td>Collaborative process</td>
<td>Adversarial process</td>
</tr>
<tr>
<td>Addresses interests of the parties, including opportunity for emotional healing or closure</td>
<td>Addresses legal issues only, emotional issues relate only to “pain and suffering” damages</td>
</tr>
</tbody>
</table>

Early Intervention Successes from Around the Country

Several mediation-based approaches to medical liability claims being implemented around the country hold significant promise as an effective alternative to consuming litigation, arbitration and claims management processes.

The COPIC Program

In Denver, a professional liability insurer, COPIC, has implemented an innovative, early intervention program to resolve healthcare situations in which there is an unexpected or adverse outcome. COPIC’s 3Rs Post-Incident Risk Management Program is a “structured, patient-centered approach for addressing medical injury and complications in a way that preserves the physician-patient relationship and compensates the patient for related unreimbursed expenses.” The 3Rs stand for “Recognize, Respond and Resolve.” COPIC’s philosophy includes reliance on research and experience that shows that most patients WON’T sue if you explain how an injury or complication occurred, but one in five will sue if you don’t acknowledge the event but the patient finds out about it another
way. COPIC’s experience has taught them that early and honest communication with patients relieves much of the anger and frustration that fuels claims and suits. One hallmark of this program is the timing: the intervention begins within the first 48-72 hours after the adverse outcome or unexpected medical event. The resolution process is initiated by the physician with the support of the risk manager. The physician then approaches the patient and invites the patient to participate in the program.

The program is designed to preserve the patient-physician relationship and to compensate the patient for any unreimbursed expenses related to the injury up to a cap of thirty thousand dollars ($30,000).

In the first two-and-a-half years after this program was implemented, 425 cases were resolved with an average payout of $4,500 per patient. Patients do not waive their right to sue, yet in only two of the 425 cases were lawsuits filed. This program has great potential to directly impact malpractice premiums. Since the physician approaches the patient with the option to discuss the event immediately, there is no written patient complaint to be reported to the National Data Bank unless a claim is later filed.

**National Naval Medical Center/Kaiser Ombuds Program**

Early intervention and a trained professional are keys to the impressive success of a program pioneered at the National Naval Medical Center in Bethesda, Maryland. There, the hospital employs a full-time internal person, with clinical training, whose primary role is to identify potential compensable events and immediately begin working with the physician, patient and family to resolve the situation. In over 240 events between 2001 and 2003, the hospital resolved all situations with no claims and no settlement payments. The model is being replicated by the Kaiser Permanente Health System, the largest non-profit health system in the country.

**Lexington (Kentucky) Veterans Hospital**

The Lexington Veterans Administration Center reduced its claims experience dramatically by promptly disclosing and resolving medical errors. The “Lexington Model” includes fair compensation as part of its disclosure policy, advising the patients and their families to hire a lawyer to help them understand the compensation process and represent them in discussions with the hospital. Lexington Veterans Administrative Center employs its own physicians and receives certain other protections because of its government status. Nevertheless, as of 2000, Lexington was averaging $15,000 per settlement compared to $98,000 for all VA hospitals. Due to Lexington’s success, full disclosure is required for the entire system of VA hospitals.

**Co-Mediation by Practitioners**

In Chicago, Illinois, Rush Presbyterian-St. Luke’s Medical Center developed a unique program to resolve cases after a lawsuit has been filed. Since 1995, Rush has used trained mediators from among members of the plaintiff’s and defense malpractice bars to co-mediate medical liability disputes. The plaintiff may choose co-mediation or, alternatively, may choose to have his or her dispute mediated by a single judge from a panel of retired judges. Once mediation is convened approximately 90% of the cases settle.

In Philadelphia, Pennsylvania, also established in 2004, a co-mediation program Drexel (Health Care Resolutions, LLC, a corporation wholly owned by the author of this publication, is Drexel’s exclusive mediation service provider.) Drexel’s program, however, differs from Rush’s in several key respects. It emphasizes more of the traditional elements...
of classic mediation, such as requiring the parties to be present, spending more time on the underlying interests of the parties, using a facilitative approach, fashioning non-monetary remedies in addition to monetary remedies, and reserving evaluative techniques for breaking impasse.

**UPMC Claims Mediation and Intermediation**

The University of Pittsburgh Medical Center launched a two-phase mediation program in the Fall of 2004. In the first phase, UPMC selected cases from its litigation caseload to propose mediation to plaintiffs' counsel. In the first nine months, 37 cases were referred for mediation, 27 went to mediation and 24 were successfully settled. The second phase, in its infancy in 2006, involves offering mediation immediately after the patient expressed a concern about his/her case.

**Triad Health System**

Triad started a program of open disclosure and early intervention in 2004. Comparing claims experience before and after the program, the total number of payouts increased by thirty percent, but the aggregate cost of those payouts dropped by seventy-five percent.

**University of Michigan**

The University of Michigan Hospital System has reported significant cost savings in the first two years after implementing a full disclosure, early intervention program.

- Number of pending lawsuits reduced by 50%
- Defense costs reduced by $2 million or $2\/3

**Sorry Works**

A coalition of physicians, insurers, patients, lawyers, hospital administrators and researchers calling itself “Sorry Works!” worked for legislation in Illinois to encourage policies of full disclosure and early offers of fair compensation. That legislation, passed in May 2005, includes:

- Physician immunity for apologies
- Tort reform
- Stronger physician discipline
- Caps on non-economic damages ($500,000 physicians, $1 million hospitals)

Supporters believe that full disclosure and fair compensation payments will reduce claims costs. To encourage a pilot program, two hospitals agreed to participate in the program for two years. If their medical liability costs increase, rather than decrease, they will be reimbursed by the state of Illinois for that increased cost.

**Continuum of Intervention Opportunities**

The success of the handful of early intervention programs, the co-mediator model, and other mediation approaches suggest that these programs can be highly effective tools in resolving medical liability cases out of court. In considering the “life” of a malpractice claim, there are multiple opportunities to prepare for, intervene, and change the course of events to avoid the typical — and, until recently, the only options to resolve these cases — expensive, time consuming and unpredictable litigation.
The accompanying chart, “Continuum of Intervention Opportunities,” depicts this range of opportunities as they relate to the claim development process in graphic form. Opportunities exist immediately after the event occurs to after a claim is filed. The upper part of the chart reflects these alternative opportunities. The lower line represents traditional litigation. Intervention opportunities also promote enhanced communication, improved relations, and the creation of non-monetary remedies tailored to the specific and unique interests of patients and their families. They also offer the opportunity for enhanced communication, improved relations, and the creation of non-monetary remedies tailored to the specific and unique interests of patients and their families. Several of these intervention opportunities as they relate to the case development process are depicted in the diagram below.

References

CONCLUSION

What is a good doctor? Here is one doctor’s opinion:

“Science is good, but we need human understanding, too. Patients do not respect the doctor who investigates them with the endless blood samples or other sophisticated examinations. With such treatment a patient will never be content. We must use more common sense. Patients need someone that listens, someone who cares; touch of mind and body.”[1]

The benefits of a solid, positive patient-physician relationship and effective communication radiate to include improving patient care and reducing the likelihood that a patient will sue when something does go wrong. Understanding and positively addressing barriers to effective communication, such as low health literacy and a hostile legal system, practicing good communication habits and treating patients as partners in a team effort will help physicians build stronger and more effective therapeutic relationships. And, when things do go wrong, physicians who have strong relationships, who are prepared to make prompt and effective disclosures, who accept responsibility and apologize when appropriate, who approach conversations with humanity and compassion and who take advantage of early intervention and mediation resources will fare far better than those who perpetuate old habits.

Reference

Appendix 1

Patient Satisfaction Survey

Generally speaking, a patient satisfaction survey should, at minimum, address those aspects of the patient experience that relate not so much to technical results, but to the patients’ “holistic” experience while present in your physical space. Thus, questions should concern the physician’s communication skills and interpersonal manner and the comfort and convenience of the office environment, including the civility of the office staff.

Here is a simple set of survey questions:

1. The doctor spent the time with me that my medical problem required.
2. The doctor listened to me carefully about my concerns and questions.
3. The doctor understood my problem or condition.
4. The doctor treated me with courtesy and respect.
5. The doctor explained what was being done and why.
6. The doctor helped me with my problem
7. Overall, I was satisfied with my visit with the doctor.
8. The overall phone service for scheduling my appointment was satisfactory.
9. My needs and schedule were considered when this appointment was scheduled.
10. The doctor was available for an appointment within the time I needed.
11. The amount of time I spent waiting to be seen by the doctor was reasonable.
12. The staff was courteous and helpful.
13. The office, including the waiting room, restroom and exam rooms were clean and orderly.
14. The office was comfortable.
15. The office was convenient to travel to.

Please add any comments that you feel would help us improve our service in the space provided below:

Survey Questions

☐ Completely Agree ☐ Somewhat Agree ☐ No Opinion ☐ Somewhat Disagree ☐ Completely Disagree
Appendix 2

Questioning Tips

Questions can be used to gather relevant and useful information and also to help focus a person's thinking.

Types of Questions

1. Open-ended questions let the patient tell his or her story in his or her own words.

   Examples include:
   
   "What happened?"
   "How did your symptoms come about?"
   "What brought you here today?"
   "Can you tell me more?"

2. Questions to help determine how the patient feels about treatment.

   "What will this do for you?"
   "How will you benefit from this?"

3. Questions to obtain greater specificity.

   "How specifically?"
   "What specifically?"
   "How often do your headaches occur?"

4. Menu approach and either/or questions help the patient focus and make choices.

   "Do you want to continue with the medication or try another that might have fewer side effects?"
   "We can either remove the mole now or watch it closely for any change."

5. Contrast and compare questions help the patient describe symptoms.

   "How bad is the pain compared to when we last met?"
   "Can you tell me about another time you had shortness of breath?"

6. Introspective questions help elicit the patient's feelings and attitude.

   "What do you think might be causing your insomnia?"
   "How do you feel about that?"
How to Use Questions

- Open-ended questions should be used while developing rapport. Then move to other styles of questioning. Open-ended questions are also useful if you feel the patient is holding back or providing guarded replies.

- “Why” questions may put person on the defensive.

- Use short questions. The more words you use, the more likely you are to influence the answer.

- Be aware of choice points. These are situations which cause a person to select one course over another. Probing choice points will give insight into a person’s reasoning and willingness to try/comply with a course of treatment. (See menu of questions on previous page.)

- Use silence between questions to allow the patient to form his or her thoughts. Looking expectantly at the patient generally encourages the patient to provide more information, but be careful not to break rapport when using silence.
Appendix 3

Many people, including physicians, are poor listeners because they suffer from some common pitfalls: They:

- assume they know how the speaker feels (often incorrectly)
- anticipate what the speaker is going to say (often incorrectly)
- think about what they are going to say while the other person is still talking
- wish the speaker would just “get to the point”
- get defensive when they feel they are being criticized
- are anxious to follow their own agenda rather than the other’s
- are experiencing their own strong emotions that cloud their ability to take in information or interpret correctly what is being said
- allow their minds to wander

Tips to improve and help you overcome these pitfalls and improve your active listening skills:

- Control distractions. Turn off your beeper and ask staff not to interrupt you except in an emergency
- Concentrate on what the speaker is saying not only mentally but physically. Sit attentively, make eye contact, lean forward, relax your posture.
- Be patient; don’t interrupt
- Don’t daydream
- Generally avoid “finishing” the speaker’s sentence, although if the speaker is struggling you may want to helpfully suggest a word or two you think they might be searching for.
- Agree when you can. If you don’t, still acknowledge the legitimacy of the other’s statement and then communicate yours
- Paraphrase back what you have heard to check accuracy of your interpretation

AND

- Be mindful of and consciously try to avoid the above common pitfalls preventing effective, active listening.