

AMA/CME ARTICLE

Reducing Malpractice Risk Through More Effective Communication

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This activity is designed for physicians, health plan administrators, and other providers.

GOAL

To help physicians, health plan administrators, and other providers learn more about the relationship between provider communication behaviors and subsequent negligence litigation and learn how to reduce malpractice risk through improving communication behaviors.

OBJECTIVES

1. To describe research findings concerning the relationship between provider communication behaviors and subsequent claims of negligence.
2. To describe the major interviewing deficiencies that have been identified as precipitants of malpractice litigation.
3. To describe three functions of effective interviewing.
4. To describe training and learning methods that can improve provider-patient relationships, leading to improved clinical outcomes and decreased malpractice risk.

CONTINUING MEDICAL EDUCATION ACCREDITATION

The Long Island Jewish Medical Center, the Long Island campus for the Albert Einstein College of Medicine, designates this continuing medical education activity for 1 credit hour in Category 1 of the Physician's Recognition Award of the American Medical Association.

The Long Island Jewish Medical Center is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians. This activity is cosponsored by the Johns Hopkins University School of Medicine.

This CME activity was planned and produced in accordance with the ACCME Essentials.

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News of a lawsuit, or even a potential lawsuit, strikes a note of dread in the hearts of physicians, other providers, and medical administrators alike. For physicians, malpractice litigation (regardless of cause and outcome) quite commonly leads to depression, humiliation, isolation, and physical illness.¹ For health plans, hospitals, and insurance companies, the risks of malpractice litigation present relatively unpredictable and potentially devastating challenges to economic stability and professional credibility.

As the emerging managed care environment increasingly shifts the setting of care from hospitals to the community, the healthcare system is experiencing a dramatic increase in lawsuits arising from outpatient office practices.

What Is the Relationship Between Injuries Due to Negligence and Malpractice Claims?

One way to reduce malpractice risk, of course, would be to decrease or hopefully eliminate patient injury due to provider negligence. Although few could argue with this laudable objective and most health systems do, in fact, actively implement quality improvement strategies to improve care and prevent injury, injuries and lawsuits cannot be entirely prevented by this approach. In fact, several recent lines of evidence seem to converge on the surprising realization that the initiation of lawsuits bears no direct relationship to the frequency or severity of patient injury. For example, although about 1% of hospitalized patients develop a significant injury related to negligence, less than 3% of them decide to sue their caregivers.² Thus, the great majority of injured patients do not initiate lawsuits.

The lessons from these data are clear: although providers must continue quality improvement efforts to decrease or eliminate injury secondary to provider error, the focus of risk management efforts must reside elsewhere to uncover and mitigate the principal sources of malpractice claims. What variables distinguish the 3%

of injured patients who sue their doctors from the 97% who do not? If these factors could be identified and corrected, malpractice risk would decrease and patient satisfaction with care would increase.

Why Do Patients Sue Their Physicians?

Several lines of evidence now point to problems in physician-patient communication as the leading culprits in the initiation of malpractice litigation.³ Conceptually, these problems fall into three general areas: (1) inadequate understanding of the patient's problems, (2) poor rapport with the patient or family, and (3) inadequate education of the patient or family. In one recent review of malpractice depositions, 71% of all claims were related to breakdowns in doctor-patient communication. Of these claims, 13% arose from the perceived failure to understand the patient and/or family perspective; 32% from assertions that the patient was deserted; 29% from complaints that the patient or family view was devalued; and 26% from the accusation that information was delivered poorly.⁴

A similar study of obstetricians with a history of a high frequency of malpractice claims indicated that patients of frequently sued physicians were more likely to complain of inadequate time with the physician, feeling rushed and ignored, receiving inadequate explanation or advice, and feeling less satisfied overall with treatment.⁵ The only study comparing the actual communication behavior of frequently sued physicians with that of physicians who had never been sued also found that primary care physicians who had never been sued used more orienting statements, more humor, and more facilitation (soliciting patients' opinions, checking understanding, encouraging patients to talk).⁶

Can Physicians Learn to Improve Their Communication and Relationship Skills?

Because the provider-patient relationship is centrally important in the initiation of malpractice claims, it behooves medical administrators and physicians alike to turn their attention to the medical interview itself. The following are questions to consider.

- Can physicians and other providers learn to improve their communication and relationship skills?
- Is it true, as some observers would suggest, that communication skills cannot be learned? In other words, either physicians possess these skills innately or they are doomed to poor performance.
- If these skills can be learned, how can they be learned?

- If doctors improve their relationship skills with patients, will they spend more time in the interview?

An abundance of new data confirm that physicians can indeed improve their communication skills, that these improved skills can lead to improved patient satisfaction and improved clinical outcome, and that improved interviewing does not necessarily take more time. In one flagship study, for example, an 8-hour training program led to significant changes in doctors' communication behaviors and patient outcome, *without increasing the interview time physicians spent with their patients.*⁷

Three Functions of Effective Communication

To begin learning new communication behaviors, physicians must begin to conceptualize the functions of the interview more strategically. One approach that has been widely used to help providers learn new communication strategies is the "three function model of the medical interview."⁸ In this model, effective provider-patient communication entails three conceptually distinct functions, each with its own uniquely separate set of concrete, teachable skills. The first function concerns use of data-collection skills to understand the nature of the patient's problem; the second function addresses relationship skills to build and maintain maximum provider-patient rapport; and the third function describes educational skills to ensure patient understanding, informed consent, and maximum adherence.

It is interesting to note that the empirical literature on malpractice and communication described above independently points to these same three domains of concern: physicians' understanding of the patient, physicians' rapport with the patient and family, and physicians' education of the patient and family.

Data-Gathering Skills. The first function of the interview is to efficiently collect information from the patient and other informants (eg, family members). Many physicians prematurely interrupt their patients and redirect the interview to the patient's first concern, which is not always the most important one. One study indicated that primary care physicians interrupt their patients, on the average, within the first 18 seconds of the interview!⁹ Premature closure leads to inefficiency in interviewing and increases the risk of totally missing significant patient problems.

The most important data-gathering skills involve (1) appropriate and effective questioning, (2) facilitation, (3) surveying, and (4) summarization. Interviews should begin with open-ended questions and stay as open-ended as possible for at least brief periods of time to

allow patients to report the narrative of their illness and their concerns in their own words. An open-to-closed cone of questioning can be used as the interview progresses to increasingly focus on the area of concern. Open-ended questions (eg, "Please describe the headache pain in more detail") cannot be answered in one brief word or gesture and encourages patients to discuss concerns in their own words. Closed questions, on the other hand, can be answered in one or two words and should generally be reserved for clarification purposes later in the interview. The premature use of closed questions leads to inefficiency in interviewing because time may be spent on problems that are not the most important ones and because the physician may not obtain the most robust understanding of the patient's problems if the interview focuses too early on the provider's template of concerns.

Facilitation refers to any behavior on the provider's part that helps the patient continue talking in an open-ended manner. Facilitation techniques are critical to good interviewing and are often underutilized. Physicians can make specific facilitating comments like "tell me more about your stomach problems" to begin focusing the patient on appropriate domains of concern. Other facilitating interventions include verbal and nonverbal behaviors such as head nods, comments like "uh-huh" or "go on," or simply attentive silence.

Surveying requires the physician to identify all the patient's problems before prematurely exploring any one in particular. Most patients have more than one complaint when they visit the physician. In at least 20% of interviews, some of these problems emerge in the very last moments of the interview, much to the physician's dismay. One way to increase interviewing efficiency and avoid the frustrations of the "door-knob" or "Oh, by the way, doctor..." questions is to include surveying questions early in every interview. After physicians elicit a chief complaint, good interviewers will consider asking a question like "What else is bothering you?" This "what else" question should be continued until all the patient's concerns have been identified. Physicians and patients together can then negotiate a priority list, or order in which these concerns should be addressed. If the list is too long for one visit, this problem should be identified early. Appropriate plans should be made to address all the patient's concerns (eg, a separate follow-up visit for a separate group of concerns).

Finally, physicians could improve their interviewing efficiency by summarizing the information they have obtained for the patient's review. The interviewer can provide several minisummaries as the interview unfolds, or can wait to the end. A typ-

ical summarizing statement might be "I would like to review my understanding now of what you have been telling me." This type of summarization serves several important purposes. It allows the patient to correct misunderstandings and provide additional key information. It also confirms for the patient that he or she has been heard and the physician understands. Thus, summarization aids appropriate data gathering, and it also builds rapport.

Relationship and Rapport-Building Skills. The second function of the interview concerns providers' ability to establish and maintain maximum rapport with the patient. Efficient data collection (function 1) and effective education (function 3) are often sufficient to establish good rapport. However, the second function explicitly addresses the emotional domain of the provider-patient relationship. Sickness is an emotional experience, and providers should have the skills to explicitly manage patients' emotional concerns and reactions.

Many physicians sometimes feel that this domain of communication cannot be taught or learned: "either you have it or you don't." Nothing could be further from the truth. Relationship skills, like other interviewing skills, can be improved with sufficient motivation and time for learning. Providers can use many verbal and nonverbal techniques to maximize patient rapport.

The principal of maximizing rapport rests on the understanding that patients' emotional concerns should be explicitly acknowledged and addressed as soon as they manifest themselves in the interview. Most commonly, patients will demonstrate anxiety, sadness, or anger. Whenever these emotions become apparent, providers should acknowledge and respond to them. Although numerous responses could be utilized, my own writing and teaching programs focus on five specific interventions: (1) reflection, (2) legitimation, (3) support, (4) partnership, and (5) respect.

Reflection entails a statement acknowledging an observed emotion. Specifically, when a provider notices a patient's affective response (anxiety, sadness, anger), the provider should interrupt the normal flow of questioning and acknowledge the observed emotion. For example, a physician could make a comment such as "I see this is distressing for you" or "I see that you are irritated." Many physicians may avoid this type of comment because they are afraid it may intensify an emotion and open a Pandora's box. Reflective comments do, indeed, allow patients to further express their feelings, but only rarely do these comments irreversibly open a Pandora's box. To the contrary, a great deal of time is not needed to

acknowledge and discuss patients' feelings early and repeatedly in the interview (as they appear), and this discussion winds up saving the physician time in the long run. When the physician avoids emotions, the patient feels ignored, which interferes with rapport and the overall communication process. Avoiding emotion, in general, costs the physician more time and leads to inefficiency in the interview.

The other four relationship skills are similarly effective for responding to patients' emotions and building rapport. Legitimation refers to statements by the physician that validate the patient's emotions: for example, "I can understand why you would feel this way, under the circumstances." Support refers to explicit statements of support from the physician, such as "I want you to know that I am personally here to help you with this problem." Partnership statements confirm the collegial approach to problem solving: for example, "Let's you and I together discuss ways that we can improve the situation for you." Finally, respect refers to statements by the physician that explicitly acknowledge positive coping behaviors or attributes of the patient: for example, "I am certainly impressed by how well you are coping under the circumstances."

Educational Skills. The third and final function of the interview concerns the manner in which providers inform their patients of the patients' illnesses and the treatment recommendations. In general, physicians do not do this well. The malpractice and communication literature repeatedly cites inadequate education as a principal reason for initiation of lawsuits. This should come as no surprise. Physicians do not receive any training in educational techniques. Not only is education difficult, but physicians need to accomplish complex educational goals in situations of high emotional intensity, with limited time available. Physicians must often give patients bad news and then try to implement effective management plans. Small wonder, then, that out of this matrix of poor medical prognosis and understandably high emotional intensity comes malpractice claims.

An essential part of good educational technique is always to pay appropriate attention to function two. That is, the provider should address emotional concerns when they arise.

Good education always starts with establishing a baseline of the patient's concerns and current knowledge. Physicians should start an educational process by clarifying what the patient (or family) thinks is wrong. If the physician has a diagnosis to provide, he or she should mention it briefly and ask what the patient knows about this condition. If the patient or family has

some great concern or misinformation about the diagnosis, the physician should understand these issues before he or she launches into any explanations.

After establishing the patient baseline and correcting any misinformation, the physician can begin the educational process. Information should always be provided in small chunks. The more serious the condition, the shorter and simpler the physician should make the informative statements. Patients should repeatedly be given the opportunity to ask questions. Whenever the physician observes an emotion, he or she should address it empathically, using the techniques described above.

Gambone and Reiter developed a useful device to help physicians ensure that they have communicated adequately about the risks and benefits of treatments or procedures recommended.¹⁰ The "PREPARED" provider structures an educational interview in a uniquely comprehensive way that can save time, improve patient understanding and patient satisfaction, and decrease malpractice risk. "P" stands for procedure (or treatment recommendation). "R" refers to the reason the procedure or treatment is being recommended. "E" concerns the expectations that the patient and family should have if the treatment plan is accepted. "P" refers to the probability for success, "A" refers to alternatives, "R" stands for risks, and "E" represents expense. Finally, "D" stands for the decision.

Conclusion: Reducing Malpractice Risk Through Improved Communication

In this article I have reviewed the research indicating that malpractice claims most commonly result from breakdowns in provider-patient communication, rather than negligence per se. Training programs oriented to improving physicians' communication skills hold great promise for increasing patient satisfaction with care, improving clinical outcome, and decreasing malpractice risk. In the absence of specific training programs, physicians who desire to improve their personal skills can make focused attempts on their own. Some possible personal programs include reading relevant books and articles. Physicians can also make tape recordings of their interactions with patients, listen to the tapes, and begin trying to improve their own interviewing behaviors. Another option would be to engage one or more colleagues to review personal audiotapes or videotapes. Getting feedback from colleagues can be very helpful. Alternative strategies can be attempted with patients or in role playing.

Any and all of these activities can be helpful for

improving interviewing skills in the effort to deliver better care and to decrease malpractice risk.

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CME QUESTIONS: TEST #039704

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Instructions

After reading the article, "Reducing Malpractice Risk Through More Effective Communication," select the best answer to each of the following questions. In order to receive 1 CME credit, at least 7 of the 10 answers must be correct. Estimated time for this activity is 1 hour. CME credits are distributed on a yearly basis.

1. About _____% of hospitalized patients suffer injury from negligence.
 - a) 1%
 - b) 3%
 - c) 5%
 - d) 7%
2. About _____% of injured patients sue their physicians.
 - a) 1%
 - b) 3%
 - c) 5%
 - d) 7%
3. The more serious the injury, the more likely the chance of a malpractice suit.
 - a) true
 - b) false
4. Breakdowns in communication account for the initiation of most lawsuits.
 - a) true
 - b) false
5. Primary care physicians who had never been sued were more likely to do extremely thorough physical examinations on their patients.
 - a) true
 - b) false
6. Primary care physicians who had never been sued were more likely to make use of facilitating comments in their interviews.
 - a) true
 - b) false
7. The average time it takes primary care physicians to interrupt their patients is:
 - a) 10 seconds
 - b) 15 seconds
 - c) 18 seconds
 - d) 22 seconds
8. About _____% of interviews have "doorknob" exit questions by the patient.
 - a) 10%
 - b) 20%
 - c) 30%
 - d) 40%
9. Which is not one of the three core functions of the medical interview?
 - a) gathering data
 - b) using humor appropriately
 - c) establishing rapport
 - d) educating the patient
10. Which is not a data-gathering skill?
 - a) open-ended questioning
 - b) facilitation
 - c) providing clear instructions
 - d) surveying
 - e) summarizing

<p>AMA/CME TEST FORM AJMC Test #039704 Reducing Malpractice Risk Through More Effective Communication <i>Application for 1 Credit Hour of AMA Category I</i> (Test valid through April 15, 1998. No credit will be given after this date.)</p>	<p>Please circle your answers:</p> <p>1. a b c d 2. a b c d 3. a b 4. a b 5. a b 6. a b 7. a b c d 8. a b c d 9. a b c d 10. a b c d e</p>	<p>(PLEASE PRINT CLEARLY)</p> <p>Name _____ Address _____ City _____ State/Zip _____ Phone # _____</p> <p>Please enclose a check for \$10, payable to American Medical Publishing, LLC, and mail with this form to:</p> <p style="text-align: center;">The AJMC CME Test American Medical Publishing 1816 Englishtown Road, Suite 101 Old Bridge, NJ 08857</p>
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