Patient and Team Communication

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Patient and Team Communication

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Topics for today

- Risk management and malpractice defined
- Claims environment
- Patient communication
- Communication/teamwork among the health care team
- Patient orientation
Medical malpractice

- Duty
- Breach of duty (standard of care)
- Injury caused by breach
- Damages
- Malpractice plus (x-factor)
  - Service lapses
  - Non-clinical issues
  - Plaintiff attorney’s dream
Today’s environment

- Claims frequency stable
- Claims severity on the rise
- 1 in 4 jury verdicts exceeds $1.2 million
- The “x-factor” will continue the severity trend
Reasons for today’s malpractice environment

- Patient expectations and abilities
- Societal view of the system
- Societal view of financial amounts
- HIPAA
- The IOM Report of 1999
- Shift in focus from clinical issues to service lapses
“Illinois Mother Settles Med/Mal Lawsuit for $15.35M”

_The Insurance Journal, May 28, 2008_

“Jury Awards $20.5M for Fatal Liposuction”

_The Legal Intelligencer, May 27, 2008_

“New York Jury Awards $17.5M to Patient”

_The Insurance Journal, May 29, 2008_
“The St. Louis County Circuit had 7 cases since the start of 2007 where the plaintiff was awarded $2M or more”

Daily Record (Kansas City, MO), March 31, 2008
# Severity: average paid
(top 10 specialties)

<table>
<thead>
<tr>
<th>Position</th>
<th>Specialty</th>
<th>Average Paid</th>
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<tbody>
<tr>
<td>1.</td>
<td>Neurosurgery</td>
<td>$268,780</td>
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<tr>
<td>2.</td>
<td>OB/GYN surgery</td>
<td>$242,020</td>
</tr>
<tr>
<td>3.</td>
<td>Pediatrics</td>
<td>$236,140</td>
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<tr>
<td>4.</td>
<td>Anesthesia</td>
<td>$186,582</td>
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<tr>
<td>5.</td>
<td>Internal medicine</td>
<td>$175,506</td>
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<tr>
<td>6. Ophthalmology</td>
<td>$157,492</td>
<td></td>
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<tr>
<td>---------------------</td>
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<td></td>
</tr>
<tr>
<td>7. General surgery</td>
<td>$154,818</td>
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<tr>
<td>8. Radiology</td>
<td>$150,766</td>
<td></td>
</tr>
<tr>
<td>9. Orthopedics</td>
<td>$142,289</td>
<td></td>
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<tr>
<td>10. Family practice</td>
<td>$137,787</td>
<td></td>
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</table>
MY, THAT IS A TYPO... SO YOU WERE EXPECTING THE COLLAGEN INJECTION IN YOUR LIPS, AND THE LIPOGSUCTION ON YOUR HIPS?...
The most common medical “procedure”?

- The face-to-face patient interaction
- 150,000-200,000 visits in an average career
Yet …

- Very limited training
- Limited supervision in early stages of career
- No specific oversight as there is with other procedures
Quality of interaction is determined by quality of communication.
Patient communication

- Single largest contributing factor to medical malpractice claims
- Simple correlation: patients tend not to sue doctors they can communicate with
- Involves the entire team – physicians, administration, clinical and non-clinical staff (80:20 rule)
Patient communication

In virtually all specialties, communication errors or barriers are the main factors resulting in medical malpractice claims, second only to errors of clinical judgment or technical error (actual malpractice)
Patient communication

The major national risk management and patient safety trade organizations (ASHRM, NPSF, NAHQ, AMA) are focusing educational efforts on communication and culture – the “soft sciences” of health care.
Even in high-risk, procedure-based specialties, communication is a big factor.
Biggest contributors to OB claims:

- Substandard judgment 77%
- Miscommunication 36%
- Technical error 26%
- Inadequate documentation 26%
- Administrative failures 23%
Biggest contributors to surgical claims:

- Technical skill 67%
- Clinical judgment 62%
- Communication 33%
In nearly 70% of all sentinel events, communication and teamwork issues are named as a root cause.
Virtually every medical malpractice claim contains communication and/or teamwork issues.
Why do patients sue?

- Caregiver attitude: 35%
- Lack of (or poor) communication: 35%
- Financial incentives: 10%
- Media play: 7.5%
- Jousting: 7.5%
- Unrealistic expectations: 5%
Where good communication leads

- Solid physician-patient and provider-patient communication skills lead to:
  - More engaged patients
  - Patients more involved in their plan of care
  - Willingness to ask questions related to treatment
  - Adherence to their care plan
  - Satisfaction with care provided
  - Lower costs
  - Increased trust and loyalty
... all of which lead to better clinical outcomes and, as a result, fewer medical malpractice claims.
Patients are changing

- More prepared through research
- More medically savvy
- More challenging of medical opinions
- More “consumer” than patient
Establishing good communication with patients

- Build rapport/set the tone
- Elicit concerns
- Set the agenda
Build rapport/set the tone

- Be prepared
- Greet the patient
- Make eye contact
- Shake hands
- Introduce yourself (to everyone in the room)
- Use the patient’s (parent’s) name
- Learn everyone’s role
- Smile and be pleasant
- Make small talk
**Build rapport/set the tone**

- Attend to the patient’s comfort
- Acknowledge the wait, if any
- Convey knowledge of patient history
- Sit down (it makes a difference!)
- Maintain eye contact
- Explain need to enter information in EHR
Elicit concerns

- Ask with “beginner’s mind”

I nvite: “What can we address today?”

L isten with QUIET curiosity

S ummarize and check: “Your chest pain started a week ago and is worse when lying down. Have I got that correct?”
About listening … take a guess

“How long, on average, does a physician allow a patient to talk before interrupting?”

Beckman HB, Frankel RM-Ann Intern Med. 1984 Nov;101
Allow your patients to talk!

Beckman HB, Frankel RM-Ann Intern Med. 1984 Nov;101
Elicit the full spectrum of patient concerns

- On average, a patient presents with 3-4 concerns in the outpatient setting
- Get those concerns out and on the table early
  - Allows for correct prioritization
  - Avoids the “crushing chest pain” complaint as “one final thing”
  - Actually makes you MORE efficient
Set the agenda

- Avoid “premature diving”
- Ask “What else?” (if needed)
- Summarize the patient’s list of concerns
- Establish the patient’s priorities
- Introduce your own agenda items
- State your clinical concerns
- Offer a plan
"Never talk down to patients. I'll be back to explain why when the big hand's on the 12 and the little hand's on the 2."
Teamwork and communication between physicians and staff

- Nurses and other staff are best risk management tools in the medical office (also biggest exposure)
- Open dialogue/relationship between physicians and staff is often overlooked
Teamwork and communication between physicians and staff

- Physician’s perception of his/her approachability is often different than that of nursing and other staff
- Differing communication styles can result in roadblocks
  - Use “No pride” and “3 Ds” to break down barriers
“If you see me about to do something dumb… different … or dangerous … tell me!”
Quality of teamwork across 25 organizations: differences between physicians and nurses

Quality of Teamwork

Scale (1=very low to 5=very high)

Nurse rates Physician

Physician rates Nurse

Slide courtesy of Michael Leonard, MD
When BOTH physicians and nurses rated quality of teamwork at a 4 or higher ...

Positive outcomes resulted:

– ICU discharge return rates were 5% (vs. 16% when either rating was below 4)
– Critical mortality rates were lower – chance of survival doubled
Looking skyward for insights

- Crash of United Flight 173 on December 28, 1978
- 10 people killed, 23 seriously injured
- Very experienced captain – more than 28,000 hours
Two issues

- Pilot was overly focused on relatively minor landing-gear issue and not on the major issue: running out of fuel

- Other flight crew were afraid to question pilot on fuel levels
Fear can be deadly in medicine, too

Nearly 40 percent of nurses on a Safety Attitude Questionnaire said they would hesitate to speak up if they saw a physician making a mistake.
Make it easier for everyone to speak up: implement a critical language policy

- Choose one key word that conveys the importance and gravity of the situation (example: clarity)

- Enables staff to overcome barriers traditionally difficult to breach

- Eliminates practice of “hint and hope”

- Malcolm Gladwell wrote of this in *Outliers*
  – use “No pride” and “3 Ds” here
    - Dumb, different or dangerous
Avoid jousting

- Creates patient doubt
- Creates dissension in medical community
- Interferes with trust relationship
- Causes malpractice claims

Jousting can be:
- Intentional
- Unintentional
- Non-verbal
“Dr. Jones was called repeatedly and, as usual, he ignored every page.”
“Despite the best efforts of the nursing staff, the patient survived. Barely.”
FIXING THE FEEDBACK VACUUM

PULSE 360 helps physicians see themselves through the eyes of their team members.

"We've been disruptive once this month. I've been dealing with complaints. Why didn't you call me a disruptive physician?"
— Anonymous physician

Good point. And its one of the reasons Larry Harmon, Ph.D., avoids the term "disruptive physician" in his work. No one wants to be identified by their most negative trait.

Dr. Harmon, a voluntary associate professor in the psychiatry department at the University of Miami's Miller School of Medicine and director of the PULSE 360 Program/Physicians Development Program, is up to something more profound than labeling his work with medical organizations across the country, seeking to improve workplace culture and interactions among team members.

"Work is about remediation," he says. "It's not about getting rid of bad apples."

When pressed to explain what is meant by the term "disruptive physician," Dr. Harmon is quick to focus on the aspect of the characterization that offers the most potential for positive change: a disruptive physician, he says, "is often one who cares deeply about his or her work, but expresses that concern with aggressiveness or anger, diminishing other health care team members, often rendering them nervous and uncomfortable." As MMC's chief medical officer, Laurie C. Drill-Mellum, M.D., points out, "The implications to well-being, patient safety and risk are obvious and multiple." As just one example, in a recent survey of medical personnel by the Institute for Safe Medicine Practices, 33 percent of respondents reported the experience of having concerns about a medication error, but not acting on those concerns due to their reluctance to interact with an intimidating prescriber.

A 2012 event at MMC clients, several attendees expressed concerns about physicians receiving multiple complaints, a term Dr. Harmon prefers to "disruptive physician." It's more objective, and can't be argued with," he explains.

Clients worried out loud about the potential negative impact of problem behaviors on those institutions, and asked if MMC could play a role in helping them address this sensitive area of practice management.

According to Julie Starosta, MMC's senior vice president of business development, "MMC responded by searching for a partner with the expertise, national reputation and philosophy to help our clients deal successfully with these issues. PULSE 360 emerged as the leader."

Removed from reality

Much of Dr. Harmon's work with PULSE 360 boils down to helping health care providers benefit from something people in almost every other professional field benefit from feedback.

"Physicians work in a feedback-starved environment," Dr. Harmon explains. "Our work is about fixing the feedback vacuum."

Dr. Harmon believes that physicians function in hierarchies that can nurture an inflated sense of status and autonomy. They're put on a pedestal," he says. And the expectation in our culture is that, the higher up you are on the totem pole, the less right people have to give you feedback."

Think bosses. Think bosses.

The problem with this, according to Dr. Harmon, is that without feedback, it's very easy for physicians to develop inaccurate perceptions about how they are viewed by others, how their behavior affects others, and even, in extreme cases, what reality is. In medicine, being removed from reality is never a good thing. And in high-stress environments like emergency departments, it's even more dangerous.

TEAMWORK IMPROVED 21% IN 1,314 PHYSICIANS AFTER PULSE 360 SURVEY FEEDBACK FROM THE 23,617 RATINGS SUBMITTED.

The PULSE 360 Survey puts a different spin on what it means to be a leader, and helps physicians understand the impact of their behavior on their colleagues.

How it works

When the PULSE 360 Survey is implemented in a medical institution — and Dr. Harmon strongly recommends using it across as broad a group as possible to achieve maximum benefits — physicians both score themselves and designate others to score them on a range of motivating behaviors (e.g., "remains approachable, even when stressed out") and discouraging behaviors (e.g., "acts sarcastic or angry when asked important questions").

Responders are also invited to describe what they would like the physician to start doing, stop doing and keep doing. The survey typically takes about five minutes to complete, and responses are automatically
Our partners can help with communication

Helen Riess, M.D.
Chief Scientist and Chairman of Empathetics

Web-based training that demonstrates what can happen when providers communicate with greater empathy
Orienting your patients

- The most overlooked risk management tool
- Few patients are able to evaluate clinical skills
- Quality of care is judged on personal interactions
- Most patients don’t understand how a medical office operates
- Office procedure is taken for granted by physicians and staff
- For most patients the process seems chaotic
Orienting your patients

- Orienting your patients is the responsibility of the entire staff
- Tell your patients what to expect and how long it should take
- Explain the basic office flow
- Monitor patient waiting times and give updates when appropriate—it’s not the wait but the not knowing
- Use staff brochures in waiting room
Contact us

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