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Covering Practice and Risk Management Issues for Physicians

Patient Relations, Customer Service and Communications: Malpractice Prevention *and* Marketing

BY DEBRA PHAIRAS

Patients are more demanding of the physician and office. Their expectations of service are higher than ever before. The same reasons patients sue their doctors are the reason they change physicians:

- The physician was aloof or abrupt.
- The physician was excessively familiar.
- The physician was evasive or inattentive.
- The patient experienced excessive waits or delays.
- The patient was left with an impression of questionable billing practices.
- There was a perceived breach of confidentiality.

Practicing communication skills, establishing excellent doctor/staff/patient rapport and instituting positive patient relations are the most effective actions a physician can take to improve patient care, prevent malpractice claims *and* market the practice.

It sounds so simplistic, yet it isn't. Effective communication:

- Is a developed skill
- Requires practice
- Requires personal commitment
- Requires a willingness to change your habit patterns

You must be willing to apply the same analytical skills, continuing education effort and professional approach to this human relations aspect of your practice as you do to the clinical aspects of patient care.

COMMUNICATION PHASES

Like any procedure, a "communication" with the patient should have a defined start, middle and finish to it.

The Opening Phase

- Introduce yourself by name (particularly to new patients)
- Make eye contact
- Make physical contact (shake hand or touch patient's arm below elbow)
- Ask patient how he/she wishes to be addressed and note in the record
- Ask patient the reason for the visit
- Listen when the patient speaks—you may be charting, but nod your head
- Tell the patient what you are going to do, e.g., "Today, I'll perform an initial exam which will include . . ."

The Questioning Phase

- Ask open ended questions—i.e. those which cannot be answered by yes or no
- Ask questions one at a time
- Allow the patient to respond in his/her own terms

The Facilitation Phase

- Encourage patient with verbal facilitation, e.g., "go on"
- Encourage using nonverbal facilitation, e.g. nod encouragement of understanding
- Paraphrase or restate ("mirror") what the patient has said
- Do not interrupt while the patient is speaking
- Identify with and reflect feelings, e.g., "you seem worried"
- Use the correct terminology, then translate it into lay language

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Patient Relations *(continued from page 1)*

The Summary Phase

- ➤ Summarize what has occurred
- ➤ Ask patient if he/she understands
- ➤ Ask for additional questions
- ➤ Develop a plan *with* the patient for future care

SUGGESTIONS FOR IMPROVING PATIENT RAPPORT

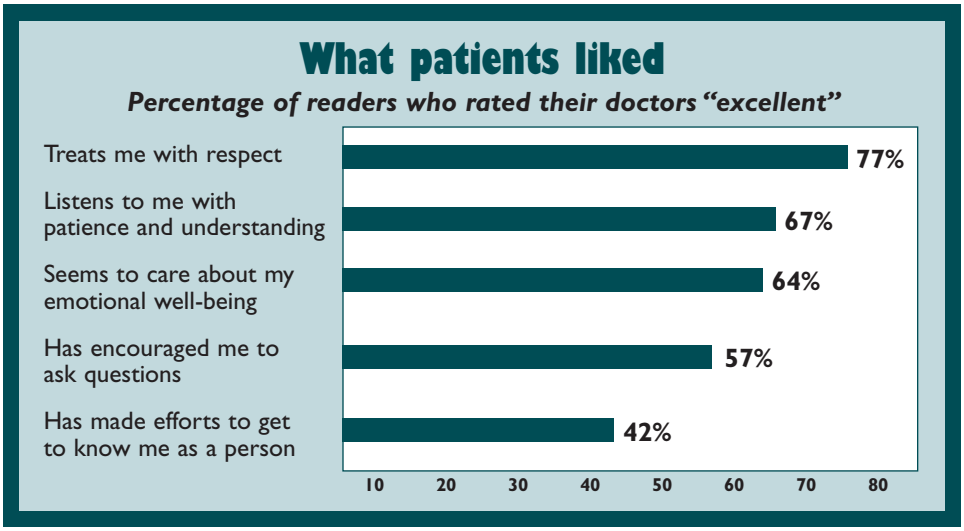
1. **Take a personal interest in each patient**

- ➤ Record hobbies, interests, occupation and family member names on history intake form. Train your assistants to also use this as a conversational opener. If you briefly review this prior to walking into the room, you can ask how the grandchildren are or how the golf game is going.
- ➤ If you are involved in similar activities, share this with the patient. It will make you more approachable.
- ➤ Demonstrating an interest in something the patient is involved in can lead to good rapport. It makes the patient feel like a person, not a medical condition, and is more effective in establishing rapport than walking in and saying "well what seems to be the problem today?"
- ➤ One of the most common complaints patients report about doctors is that they appear to see them as a condition they are treating.

2. **Smile at the patient.** In conducting a referral satisfaction survey for an internal medicine subspecialist, referring doctors reported that patients said the doctor looked "angry and mean." It turned out that this doctor would frown when he was concentrating on what patients were saying, and, with his heavy eyebrows, his concentration was interpreted as anger. In fact, he had a beautiful smile and we worked on smiling and not thinking/frowning during the exam room time.

3. **Look the patient in the eye when you are talking to him/her and when the patient is talking to you.** Look up from the chart/laptop/computer.

4. **Listen when the patient is speaking.** Listening skills are the least learned and practiced communication skills in all professions and business, not just medicine!



Source: Consumer Reports

5. **Don't interrupt the patient unless it is to focus attention back on the subject at hand.** Repeatedly interrupting the patient exhibits poor communication skills. Interestingly, interruption seems to have male/female characteristics. Several studies have shown that male doctors interrupt female patients twice as often as male patients. Female physicians interrupt both sexes less than male doctors and male patients interrupt female doctors more than male doctors.

6. **When you are explaining risks, benefits, alternatives during your informed consent discussions, sit down at eye level with the patient.** Being on the same eye level with the patient conveys a sense of talking *with* the patient rather than *at* the patient. Draw or use pictures to convey what you are saying.

7. **Don't permit interruptions such as non-emergency phone calls**. When you interrupt the patient by taking a phone call, you are indicating to the patient the person on the telephone is more important.

8. **Non-sexual touching can be a very effective method of establishing rapport**. Shaking the patient's hand or a light touch on the arm is usually not offensive to most people. Should the patient look uncomfortable or pull away you will know this approach is not appropriate for this patient. From a claims prevention perspective, the rapport benefits outweigh the malpractice risks. The so called "undue familiarity" claims almost always result from sexual relations, harassment, or touching in inappropriate areas—not a sympathetic touch on the arm.

9. **Return phone calls promptly.** Delays can cause harm and irritate the patients. Communicate with staff approximate times you will return phone calls i.e., at noon time and between 5 and 7:00pm. This shortens the time the patient will expect your call and they will not become anxious and worried that you have forgotten them and call back to the office to harangue your staff. Staff can say, "Doctor X returns phone calls during these times, please give me a number where you can be reached during those times."

10. **Call back to the office from the hospital or have the staff there call your practice to let them know you will be delayed.** Staff should have patient home and cell phone numbers to alert patients that the doctor is running behind. My OB-GYN office in San Francisco does this and it is greatly appreciated if you are rushing to get to the office or stuck in traffic.

11. **Don't hide from patients**. Patients become irritated when overprotective staff places a barrier between them and the doctor.

12. **Show awareness of financial costs of illness that can impact a patient and family.** Tell them you are giving samples to allow the patient to try out the medication or to save them a bit of money. Be aware of cost differences in treatment and be sure to give the patient alternatives when clinically equivalent.

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Communication Is Essential to Care of the Surgical Patient

BY MICHELLE LI, MD

Good communication is the basis for nearly every aspect of quality health care delivery. From our first encounter with a patient, to our weekend sign out, to instructions for long-term follow-up, the way that we convey information to our patients and colleagues impacts the entire experience. In a review of more than 7000 medical incident reports, the Veterans Health Administration determined that communication failure was responsible for nearly 75% of medical errors. The Joint Commission has named communication as either the first or second most common cause of poor operative and postoperative outcomes including retention of foreign objects, wrong-patient/wrong-site/wrong-procedures, delays in treatment, and maternal and perinatal complications.

Standardized protocols and checklists have been implemented to help improve patients' operative experiences. But what about the time outside of the OR? What more can we do to improve patient outcomes and mitigate against suboptimal ones? As good as we believe our communication skills to be, we can always do better. Keeping in mind that communication comprises both the spoken and written word, the following is intended to be a review of some ways to address shortcomings that can occur in the care of the surgical patient.

COMMUNICATION IN THE PREOPERATIVE PERIOD

Good communication begins preoperatively because this is the time when we can best shape patient expectations. Patients need to understand what their postoperative limitations will be so that they can be adequately prepared. This may extend beyond what is typically addressed in the informed consent. A patient who feels that their recovery is not proceeding as quickly or easily as they thought is more likely to believe that something went wrong, even if their recovery is normal or uneventful in our estimation.

COMMUNICATION IN THE PERIOPERATIVE PERIOD

Surgeons are now subject to protocols to facilitate and safeguard the perioperative process. Still, there remain opportunities for us to improve our communication. Reviewing, clarifying and documenting the operative plan is required, but is especially critical if you are not the original consulting surgeon. If a contralateral defect is identified at a laparoscopic inguinal hernia repair, should it be addressed? Is a sterilization procedure planned at the time of delivery? Should that suspicious skin lesion

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Patient Relations *(continued from page 2)*

13. **Respect the patient's time.** What is the patient tolerance time from the appointment time and when they expect to see the physician? Most studies report 13-15 minutes, so be aware of this and acknowledge and apologize when you walk into the room. Give Starbucks or coffee coupons when patients have to wait longer than they should. They will tell all their friends/relatives how wonderful you are. Some practices give the patient a restaurant type beeper and tell them to go grab a coffee down the hall and they will page you when it is time.
14. **Set up policies and procedures with your staff so that doctor and staff are communicating the same time frames for results.** Build in an extra day so that the patient will be pleasantly surprised and delighted to receive the results a day earlier than expected.
15. **Call the patient at home after surgery or procedures.** Patients are thrilled their doctor cared enough to check on them after a surgery/procedure. You can catch potential complications early and the patient relations benefits are tremendous. They will think you are terrific even if complications develop!
16. **Role play and practice with staff techniques to diffuse difficult or angry patients.** Recognize that the underlying emotion behind anger/frustration is unmet needs and often the patient is fearful or anxious. Let the patient vent and listen, take notes, lower your voice, speak softly and then keep asking the patient questions to redirect anger by saying "What will it take to resolve this situation? What would you like to see happen? What will make you happy?" In other words, redirect the anger to solutions.

Many plaintiff attorneys believe the majority of patient lawsuits are brought because of physician-patient communication or physician attitude problems.

Many plaintiff attorneys believe the majority of patient lawsuits are brought because of physician-patient communication or physician attitude problems. These are preventable and utilizing these techniques can lower your malpractice risk, increase patient satisfaction and build your practice with happy patients. ■

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Communication *(continued from page 3)*
adjacent to the planned incision site be removed in the current operation? Making sure that both the patient and surgeon are clear on intent seems obvious, but this clarity has been surprisingly absent in cases that end up undergoing medical-legal review.

COMMUNICATION IN THE IMMEDIATE POSTOPERATIVE PERIOD

The post-operative note may be the first event of the post-operative period. Operative notes are the vehicle by which we can recall the conduct of a procedure or convey the details of a procedure to anyone who wasn't there. The content of the note tells the reader what happened, and tells the coder how to bill. The language one chooses may make the difference between being assigned a "complication" versus a "complexity" code (e.g. "enterotomy" versus "difficult dissection necessitating enbloc removal of a portion of the bowel"). This is a topic unto its own, but suffice it to say that we need to be thoughtful with the words we use. Furthermore, operative notes need to be dictated in a timely fashion. This is now a requirement. Failure to do so within a 24 hour period may lead to loss of hospital privileges, or to penalties in reimbursement. Late notes may also lead to errors in recollection, or a perception of error in recollection. It is difficult not to look with suspicion at a note dictated weeks (or even days) after an operation, especially if a complication has occurred.

Intraoperative consultants should be included in carbon copy lists, particularly for pathology results, as the meaning or implication of those results may not be evident to the primary surgeon.

If the patient gives permission in advance, it is useful to discuss findings and expectations with a trusted family member or friend. We know that patients frequently don't recall any of our immediate post-operative remarks, so expecting them to act appropriately based on that discussion can be problematic. For same-day patients without a contact, a follow-up call at a later time may suffice. Preparing pre-printed post-operative instruction sheets for commonly performed procedures is a worthwhile investment, as they can help to answer frequently-asked questions, provide a reference for forgotten instructions, and allay concerns about potentially anxiety-provoking developments, such as low grade fever or peri-incisional bruising.

In many or even most instances, it is reasonable to have a care extender call a patient with normal test results. If, however, the result is abnormal or of special concern, the physician should make the call.

For inpatients, daily rounds are the norm, but night and weekend coverage may change whom the patient sees. Preparing them to expect a visit from someone else will make subsequent visits easier for both the patient and the covering physician.

COMMUNICATION AFTER RETURNING HOME AND IN THE LONG RUN

Follow-up care in the short term is usually related to managing the wound(s), associated pain, and diet and/or activity restrictions. Again, reminding patients that call duties are shared will help to temper their expectations. If multiple hand-offs or shift changes are imminent, the patients should be prepared for them.

In the longer term, developing a system where patients don't get "lost" is critical, especially in cases where careful follow-up is paramount (e.g. cancer).

Positive lab or imaging results must be conveyed to the patient in a timely fashion. Communicating a suspicious result cannot be delayed weeks or months. The results should not only be accompanied with a plan for what's next and in what timeline, but the conversation needs to be well-documented. For example, borderline or atypical biopsies require vigilant follow-up. Clear, legible chart documentation decreases the likelihood that an important finding or result is missed, or that a covering provider fails to follow-up appropriately.

A word on patient notification. In many or even most instances, it is reasonable to have a care extender call a patient with normal test results. If, however, the result is abnormal or of special concern, the physician should make the call. Unless your MA/PA/NP is able to fully understand and convey the significance of the result, there is a risk that the patient will not register the importance of your recommendation for short-term follow-up, repeat imaging, or serial tests. Particularly in an era of cost-consciousness, if a patient does not believe that they are "ill", they may be reticent to pay for costly studies that are seemingly "negative."

It is difficult not to look with suspicion at a note dictated weeks (or even days) after an operation, especially if a complication has occurred.

Patient compliance can be difficult. There is a joint responsibility between the provider and patient to ensure appropriate follow-up is completed. When there is a sufficiently high index of suspicion or worry, it is important that the patient understand your concern. Tracking systems and task lists (as with Allscripts EHR) can help to remind *us* to remind *them*. And I'll mention it again: document the concern, document the reminders. If a patient fails to follow-up after multiple attempts, a final, registered letter should help to ensure that the message is received by the patient and to clarify your intent should your actions ever come under scrutiny.

FINAL THOUGHTS

It is impossible for us to be personally available 24/7/365 for our patients. Whether we take off for a few hours, a few days, or a few weeks, it is important that we establish guidelines for patient expectations, and leave relevant information for our coverage group or partners. Hopefully, the EMR will help to facilitate this continuity, but it will only be as useful as the information we enter. ■

Dr. Li, a colorectal surgeon practicing with San Francisco Surgical Medical Group, has been an active member of the Patient Care and Management Committee of Physicians Reimbursement Fund since 2007.

Surgery Is Not Over When You Leave the Operating Room

BY STEPHEN J. SCHEIFELE, MS, MD AND ROBERT D. NACHTIGALL, MD

Even without indispensable and appropriate informed consent, patients and physicians are generally aware that all surgical procedures carry inherent risks. Yet even after a flawless procedure, the risks of surgery are not over when you leave the operating room. In fact, your professional conduct and attention to detail in the post-operative days and weeks may be as important as meticulous surgical technique in minimizing the risk of an unforeseen medical-legal complication. Communication, documentation and appropriate follow-up will keep you out of court.

As in all doctor-patient interactions, practicing good communication skills plays a central role in maintaining a positive and trusting professional relationship. Starting in the recovery room, the physician should become attuned to the physical and emotional needs of their patient and family. Even routine surgery is almost universally anxiety provoking for patients and their loved ones. Share your findings and expectations with the patient and their family as soon after surgery as possible. Genuinely acknowledge their anxieties and clearly communicate your expectations and instructions for follow-up, especially if they are to be immediately discharged from an outpatient setting. Be sure to provide clear instructions concerning:

- Their level of activity over the following days
- What and when they can eat including any dietary supplements
- What they should anticipate in terms of pain intensity and location
- The pain medication you are prescribing and how often to take it
- The side effects of any discharge medications
- Instructions on wound care
- Arrangements for home health care if necessary
- When they can expect to drive and return to work
- The circumstances and telephone number to call with questions
- The timing of their follow-up appointment

Complications from surgery are inevitable. Early recognition and prompt intervention can and will mitigate any subsequent lawsuit. Empower the patient/family with the warning signs of potential complications such as fever, bleeding, increasing pain, abdominal distention, nausea and vomiting, etc. Encourage patients to call if they are concerned. A five minute phone conversation may be all that is required to allay their fears. Or that phone call could alert you to the early signs and symptoms of a potential complication. Maintaining a timely and caring rapport with the patient and family will often head off future legal action even in the face of an unexpected outcome.

Maintaining a timely and caring rapport with the patient and family will often head off future legal action even in the face of an unexpected outcome.

One observation that has become crystal clear is that the likelihood of a lawsuit may not be a function of the actual medical outcome per se, but rather the patient's and family's ensuing anger over how the provider communicated and interacted with them. It is always instructive to place yourself in the patient's situation and view things through their eyes. What we deal with on a daily basis is a once-in-a-lifetime experience for them.

A second key observation is that from a legal defense perspective, you are only as good as what you document. Written instructions, while never completely all-encompassing, will support your intention and the thoroughness of your verbal instructions. Surgeons take time and care when dictating the minute details of the surgical procedure. Equal time and thought should be applied to documenting the details of ongoing care and instructions after a procedure. Chart notes are central to every defense. When legible and comprehensible, they will become the "facts" that can win a case. Absent these supporting documents, juries are left to guess at the accuracy and veracity of your recollections and intentions in the face of an unfortunate medical outcome and a potentially injured patient.

Follow-up does not just mean when to schedule the next appointment. It encompasses all that needs to be done to ensure that the patient has a good outcome. The surgeon has a duty to provide ongoing care until the patient is released. The patient needs to be instructed when, where, and who to call with their concerns. Clear communication about the patient's status to back-up physicians for nighttime and vacation coverage will facilitate a smooth transition and reassure the patient/family. Choose your associates carefully as their care will reflect on you both professionally and legally.

The division of responsibility for follow-up care amongst the surgeon, consultants, and primary care physician should not only be made clear to each provider and the patient/family – it also needs to be documented. Outstanding medical issues as well as laboratory and pathology reports need to be tracked. This is especially important when the surgeon is covering for an associate and may not follow the patient post-operatively. It remains the surgeon's responsibility to follow-up on pathology reports and other tests he/she ordered before relinquishing care.

Attention to these post-operative risk management details will improve patient outcomes and maintain a positive provider patient/family relationship. Wise physicians continually ask themselves: "If I were this patient or loved one, what would my expectations be?" ■

Dr. Scheifele is the chair of PRF's Risk Management & Education Committee and Dr. Nachtigall is the editor of PRF News.

Tracking the Non-Compliant Patient

BY STEPHEN J. SCHEIFELE, MS, MD

For the last few years, *PRF News* has been publishing articles that highlight the importance of maintaining an office tracking system. Whether paper-based or electronic, tracking systems not only offer the promise of improved patient care, but reduce the chances for a medical record-keeping error that can result in a lawsuit.

One area of potential risk is the non-compliant patient. While the courts are increasingly acknowledging the patient's role in being responsible for their care, healthcare providers share in the liability for patient non-compliance whether it is a missed appointment, a test that was ordered but not performed, or a recommendation that was not enacted. Physicians not only need to recognize that patients can vary greatly in their ability to direct their healthcare, but be aware of potential barriers to compliance which can include comprehension, language, culture, cost, and simply the pace and distractions of modern life. So while it may appear somewhat reassuring that juries are more willing to hold competent patients responsible for their actions, California statutes of comparative negligence still hold the healthcare provider liable for his/her proportionate share of both economic and non-economic damages. Enduring the emotional and financial cost of litigation to prove that you were only 30 percent responsible seems more of a pyrrhic victory than a reassurance!

Inadequate patient follow-up has become such an active area of litigation that **physicians have been found liable for not having an established tracking system.** A tracking system needs to be reliable, timely, and well documented. Missing an opportunity for a timely medical intervention can have costly results. One example is in obstetrics where inadequate tracking of gestational age can prevent pregnant patients from exercising their full spectrum of medical options. The obstetrician could be left with a "bad baby" outcome and the responsibility for a lifetime of care for failing to recognize that a patient did not have a critical prenatal test. The sensitivity of the tracking system should be proportional to the importance of the test, return visit, recommendation, or referral. But occasionally, even a seemingly "routine" test can generate an abnormal result, which turns out to be the first warning of a significant medical problem. The subsequent delay in diagnosis can result in an adverse outcome and the inevitable lawsuit.

Documentation is always your best defense in any lawsuit. First, you need to know what information or test result you are missing. Then you need to document what was done about it. Without a system to keep you informed, your first hint of what the patient missed might be a 90-day notice! The relative importance of a recommendation and the risks of non-compliance need to be discussed with the patient, and the discussion needs to be documented. Memories cloud when time passes and scenarios change. Without contemporaneous documentation, juries are left making decisions in a "he-said, she-said" situation based on whoever appears to be the most plausible. Regardless of the facts, that may not be you! Failed or cancelled appointments are an overlooked opportunity to reduce risk. Establish a policy to inform patients of the importance of re-scheduling. Specialists should alert the primary care provider when a referral is not kept. Adhere to your policy and document what was done.

To some, the administrative overhead of medical practice appears to be overshadowing the provision of care. As more and more tests are being ordered by multiple practitioners at multiple sites in different systems, the possibility for errors and delays multiply. **Risk management awareness is a tool to improve care and help patients experience better outcomes. Reducing liability is the byproduct.**

We suggest that you incorporate these risk management strategies into your practice:

- Employ the patient as a resource. Educate the patient and empower him/her to actively participate in their care and follow-up. Give them a sense of ownership.
- Delineate and document who will be responsible for outstanding issues—the primary care physician or specialist. Inform the patient.
- Have a system to track results pending at discharge or transfer. If you ordered it, you own it until it is resolved.
- Recognize the problem of "inattention blindness." We all overlook things in plain sight. Empower the health care team to call to your attention missed appointments or abnormal results.
- Critical results require an immediate response. Recommendations for follow-up need to be documented and tracked for compliance.
- Be sensitive to the costs of healthcare. Prescribe less expensive medications when the patient's inability to pay will preclude compliance.
- Pay particular attention to the unusual test. It may be difficult for the patient to obtain the test. Results may be delayed and hard to interpret. ■

Dr. Scheifele is the chair of PRF's Risk Management & Education Committee.

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