COMMUNICATING WITH PATIENTS AND OTHER PROVIDERS

Patient dissatisfaction with the physician-patient relationship is frequently part of the issues that lead to claims. Some of the underlying issues that contribute to patient dissatisfaction are:

- situations in which patients are confused by information and instructions for treatment
- unmet expectations for treatment outcome
- how they were treated by the physician and office staff

All of these factors closely relate to the patient's perception of the quality of the service they receive in a physician's office, and they all involve communication. Other communication-related claims develop out of inadequate, or lack of communication between care providers.

A majority of Princeton's claims involve one or more component/s of inadequate or absent communication.

Office Culture

It is said that much of communication is non-verbal, and what takes place in and around your office can speak volumes. How are patients treated when they call to schedule their appointment? Is the sign out front easy to find, or is it overgrown with bushes and vines? How does the front desk staff member greet the patient? Is the waiting room cramped and crowded, with a blaring television or music? These are just a few of the things that shape your patient's first impressions; and they are made even before the patient meets with the physician.

Physicians, staff, and even your office space combine to create a culture which you can mold suiting your needs and those of your patients. To improve patient safety and reduce the likelihood of claims your practice should work to create a culture of patient-centered service.

Creating and maintaining a service-oriented office culture focused on providing quality patient care and a high level of service is an important strategy for reducing your risk of a malpractice claim. A focus on customer service also is the foundation for your practice's efforts to engage patients in shared responsibility for their health care.

Promoting a service mind-set in a physician's office requires:

- physician leadership involvement to convey the message that the practice is committed to service excellence
- a Mission Statement that reflects the importance of patient satisfaction
- protocols that outline expected behaviors and mechanisms to achieve the mission (e.g., maintaining patient confidentiality, use of patient satisfaction surveys, how to handle complaints, etc.)
- involvement of all staff in setting priorities and attaining improvement in your practice's level of service

© Copyright 2006 Princeton Insurance. All Rights Reserved.

Making a Positive Impression

Techniques that enhance communications with your patients and convey a positive impression include the following:

Remember Common Courtesies

- be certain that your front desk staff greets your patients in a friendly manner upon entering your office
- require your answering service to follow the same rules of courtesy that you expect from your staff
- knock before entering an exam room
- make immediate eye contact
- greet the patient and introduce yourself
- address patients by their title (e.g., Mr., Ms., and Mrs.) and last name, unless given permission by patients to call them by their first name

Making and keeping eye contact is becoming even more crucial as healthcare moves into an age of electronic records and caregivers are tempted to focus on computer monitors instead of the patient in front of them. It has always been important to interact with the patient and avoid focusing on the chart in your hands. For those physicians and staff who are learning to work with laptops, or keyboards and monitors, this can be a bigger challenge.

If you are working with electronic health records it is important to remember that the patient is the focus of your attention. The monitor and the keyboard should only require occasional glances, and the monitor should be positioned so that looking at it allows you to keep looking at your patient. It should not cause you to turn your back on your patient.

Listen

- listen to your patients and let them speak without interrupting them
- repeat key information back to the patient after they have concluded their description of their chief complaint or reason for the visit
- determine what the patient hopes to get from the visit

Ensure Understanding

- involve the patient's family and significant others in the discussion (with patient permission)
- be considerate – restate information as needed
- use simple words and explain medical terms
- allow time for questions
- ensure that the dialogue is comprehensive enough to give patients a full understanding of their condition and the treatment plan
- pose open-ended questions to ascertain whether the patient understands
- be mindful that there is a wide spectrum of health literacy that is independent of a person's age, education, and economic status
- ask the patient to explain their understanding of the conversation to you so that you can be sure they are comprehending the situation and the proposed treatment plan
- consider cultural beliefs and practices that may influence your interactions
- have a mechanism available to provide medically knowledgeable interpreters for those patients who need them (this includes those patients who are hearing impaired)

© Copyright 2006 Princeton Insurance. All Rights Reserved.

Follow Through

- Patients, particularly the elderly or those on a complicated medical regimen, should be sent home with a brief written summary of their visit (this summary can be in the form of a pre-printed check-off sheet, requiring the physician to simply fill in reminders of what was discussed, such as changes in medications or returns to the office). Visit Summaries are also discussed in the Communication Tools segment of this section of the toolkit.
- Patients should be given instructions to call the office for results of tests if they have not heard from the office in a specific amount of time (this action does not represent an adequate method of patient notification of test results, but is intended to serve as a safety net, should your normal protocol of actively calling patients with results fails)

Mastering communication skills such as these serve not only to make a positive impression, but they can significantly improve patient trust and adherence to their treatment plan. This in turn improves patient safety. When trust is established between a physician and patient, as well as between the patient and the practice, the patient is more likely to be forthcoming with information that they may have withheld in other circumstances. Being fully aware of the patient's status allows the physician to make better informed care decisions, and fewer (if any) diagnostic errors.

Structured communication that includes attention to common courtesies, listening, and ensuring understanding don't necessarily take more time to accomplish, rather these skills can help to focus the patient visit and can reduce, and possibly eliminate those "afterthought" or "doorknob" questions that patients have. These skills can empower patients to be active participants in their care.

Patient Satisfaction

Actions that demonstrate a commitment to patient satisfaction in a physician office practice include:

- courteous treatment of all patients at all times without exception – in-person and on the telephone
- developing a telephone menu for automated call answering which is "user friendly"
- timely access to appointments and medical advice as needed
- providing adequate time for each patient visit to allow patient to effectively communicate their reason for the visit without feeling rushed
- monitoring of patient wait times with frequent updates to patients regarding delays, and the option to reschedule when a delay is longer than 30 minutes
- respecting patients' modesty, dignity and confidentiality
- continuously soliciting feedback on patient satisfaction during their visits (simple questions like: is that OK with you? are you comfortable? can give a patient an opportunity to give necessary and timely feedback which the practice can use)
- addressing patient complaints promptly on a case-by-case basis
- analyzing any trends in patient complaints and applying corrective actions to improve service
- rewarding staff for good customer service

© Copyright 2006 Princeton Insurance. All Rights Reserved.

Patient Satisfaction Surveys

Patient surveys are a valuable and more formal tool used to ascertain a patient's perception of the services provided by the medical practice. They are an invaluable means for improving communication between the health care provider and the patient. A survey is most useful if it is conducted at least annually.

One method of surveying a practice's patient population is by utilizing a mailed survey. Not all practices are able to take on that expense. Therefore, another effective method of distributing the survey is to hand them out at the reception desk, encouraging the patient to drop the anonymous, completed questionnaire in a designated box before leaving. Please note, however, that a survey handed out in the office has a potential weakness. There can be a general tendency to hand the survey to people who are friendlier and to avoid those patients who are upset. If using a survey in the office it must be distributed consistently to all patients.

A full survey is a formal collection of data and its results are to be compiled mathematically. An example patient Satisfaction Survey along with general instructions for its use and scoring can be found in the Forms section of this toolkit. This information is based on material from the Bureau of Primary Health Care, which is part of HHS' Health Resources and Services Administration.

Once the results are compiled, it is suggested that the practice manager provide an opportunity to review the results with the entire staff. Continually gauging patients' likes and dislikes will help improve the overall practice and reduce the risk of litigation.

An annual survey is typically conducted for a day or a week and, therefore, samples a limited portion of your patient population. To augment this result, mini-surveys can be done periodically throughout the year to address single issues and get a more varied survey sample. These mini-surveys can be used to ask single questions about specific issues the practice wishes to target for possible change, such as the phone menu or use of television vs. radio in the waiting room.

The practice can also survey its own staff to get their viewpoint on how they treat patients. This is a good reminder to each staff member of the behaviors they are encouraged to model. A form for self-evaluation of staff behavior is found in the Forms section of this toolkit.

Patient Triage

Scheduling patient appointments – based on assessed patient needs – in a timely manner is another opportunity to generate a positive perception of your office. Scheduling should adhere to standard written procedures that utilize the following criteria, modified as necessary to fit your practice:

- **Emergency Care** – life-threatening condition that requires immediate referral to an emergency room
- **Urgent Care** – conditions that require medical attention the same day
- **Routine Care** – conditions that are not urgent but require a timely appointment in the near future
- **Preventive Care** – physical examinations and similar services that require a visit within a reasonable period of time
- **Walk-Ins** – if walk-in patients are routinely accepted, regular patient scheduling must be amended to accommodate interruptions in visit flow.

© Copyright 2006 Princeton Insurance. All Rights Reserved.

Effective Telephone Communication

Telephone communication is a routine but significant component of every physician practice. Everyone in your office should be instructed to regard telephone calls as an opportunity to provide patients with good service and to obtain important information. A patient's first and lasting impression of your practice is often from a telephone call.

Phone Set Up

- train all office staff in telephone etiquette, including handling an angry or dissatisfied patient; the attitude of the person who answers the telephone will set the first impression of your office
- a caller should always have the option of speaking with a person
- try to answer the telephone by the third ring and monitor calls that are put on hold; allow callers to speak first, and ask for and get permission to place them on hold
- if your office is equipped with an automatic call distribution system, limit the menu selections to four or five at most; the first message should always be, "if this is an emergency, dial 911 or go to the nearest emergency room immediately"
- conduct telephone conversations out of the hearing of patients to protect the caller's privacy
- install additional phone lines if all lines are frequently in use or chronically busy

Giving & Receiving Medical Information

- Obtain the caller's phone number and confirm identifying patient information.
- When a return call is required, ask the caller what time he or she will be available, and give an approximate time for the return call. Then, make return calls as promised. This conveys a message to patients that you care and are respectful of their time and concerns.
- Develop a Telephone Advice Protocol Manual for nursing and other staff authorized to give telephone advice that addresses areas such as handling routine questions and doing telephone assessments and triage. Monitor staff compliance with the protocol.
- Instruct staff to consult a physician or other designated clinician whenever they have concerns or questions regarding their telephone assessment or advice. Respond promptly and positively when staff seek guidance.
- Develop a policy and procedure for handling phoned-in lab reports that include how "panic values" are to be relayed to the physician.
- The practitioner who orders a test should be the person who calls the patient to communicate sensitive results.
- To reduce the chance of miscommunication when calling in a prescription or giving treatment instructions, ask the person with whom you are speaking to repeat what you said, and then you repeat it once more.

Handling Prescription Refill Requests

- Protocols for handling requests for prescription refills should include review of the patient's chart, physician/prescriber approval and documentation in the chart of the request and refill.

© Copyright 2006 Princeton Insurance. All Rights Reserved.

What to Document

- Document every telephone communication with a patient or family member, including date, time, caller's name, complaint, and advice/prescription given. Also document all telephone calls with other providers. Consider use of duplicate telephone message pads, and maintain one copy chronologically in the patient's medical record. Princeton will provide, at request, patient telephone call record pads for after-hours calls; these notes peel off the original pad and stick to the chart sheet, providing a complete record for continuity of care and minimization of liability.
- Date and document the medical record when you call a patient and must leave a message with a family member or on a recording device, or if there is no answer.
- Maintain appointment books and telephone logs with entries written in black or blue ink. Entries should never be erased or obliterated with erasure fluid. When making a change, write a single line through the information already entered, and record the change below. Keep old appointment books and telephone logs for as long as you maintain medical records.

Answering Service

- Use a reliable answering service during off-hours. Place test calls regularly to assess the quality of the service. Provide the service with an emergency number in the event that the physician on call cannot be reached.
- If you do not use an answering service, have a process in place to promptly retrieve and respond to off-hours calls.

Monitor Trends

- Consider keeping a log of categories of calls received such as scheduling, test results, prescription refills, etc., as a way to identify trends possibly needing revision or improvement in your system for managing telephone communications.

Communicating Test Results is Critical

When tests, consults, or referrals are ordered, the practice should inform the patient of the results of the tests or exams. This includes notifying them of both abnormal and normal findings, and documenting that notification in their medical record. This exercise of notification is part of a continuum of tracking the test from order to notification and documentation. Tracking is discussed in more detail in this toolkit's Tracking and Follow-Up section.

Failure to follow up on test or consult results leads to claims. In Princeton's experience, this is a persistent problem which can only be improved by a determined approach to the process of ensuring that information is communicated to the patient. It is suggested that all test results be consistently handled by being:

- routed to the physician who ordered the test
- reviewed and appropriately signed off by that physician (i.e. initialed and dated)
- shared with the patient on a timely basis
- documented in the patient record

Each practice should establish what 'timely' means to them and their patients, but in general it means that "panic" or critical values require immediate notification (usually by the physician themselves). The definition of what constitutes 'panic' or 'critical' should also be established by

the office and that sometimes may be in part determined by a specific patient's condition. It most definitely will not only be what a lab labels as panic or critical. To be specific, a patient whose normal potassium level is above normal (as patients with kidney disease may be) will have a different level for a critical value, but it will be very important to respond quickly if the patient reaches their personal panic value.

In keeping with that same example, other values which are abnormal for the patient may require a phone call within 24 to 48 hours. This phone call might request a return to the office, a medication adjustment, or another test for confirmation of the initial results. The difference between the two reactions is not subtle; patients with true critical values may be in potentially life threatening situations needing immediate follow up, but other abnormal values require a quick response instead of an immediate reaction.

Notifying the patient of their test results on their next visit can be effective if the results are within normal limits and if the visit is scheduled within a few weeks of the first visit. If the circumstances are different, however, it is appropriate that the patient be notified by phone or mail that their tests or consult report were negative. This reassures the patient, completes the practice's responsibility regarding timely notification, and improves patient satisfaction.

All notifications, whether by phone, in person, or by mail, should be documented in the patient's medical record. If the notification was by mail, a copy of the letter to the patient, filed in the chart, is sufficient.

As a safety practice, it is appropriate to tell patients to call the office if they have not been notified of their test results after a few weeks. This backup measure can be helpful in catching any missed notifications; it also keeps the patient involved in, and a responsible party in, their own care.

Email Communications

Both patients and physicians may feel that email is a helpful alternative to missed phone calls or voice messaging. It has the advantage of flexibility (it can be sent or accessed at any hour), speed (test results can be sent much quicker), documentation (it provides a written record of every communication), and information (it can be used to provide readers links to resources the practice feels important for them).

But email has risks. Patient privacy and confidentiality can be breached; this includes possible violations of HIPAA. Email can be intercepted, misdirected, or forwarded. Practices can be accused of not sending responses to a patient's email, or test results, in a timely manner because email can be its own proof. It provides a record of what was sent and, conversely, what was not sent; and all email records are timed and dated. Deleted emails can be recovered so a practice cannot maintain that they sent something and then delete records of the email. Emails are also subject to discovery in malpractice cases.

If a physician or practice decides to use email as a form of communication with patients, steps should be taken in preparation for implementation, developing guidelines for acceptable and unacceptable use. **Please note. It can be deceptively easy to move from simply making appointments online to dispensing medical advice and diagnosing online. The latter two activities represent an unacceptable risk level. We are, therefore, providing you the following suggestions**:

© Copyright 2006 Princeton Insurance. All Rights Reserved.

- the practice should develop a policy regarding email, specifying uses and limits, allowable content of messages (no anger, sarcasm, criticism, or remarks that could be interpreted as such, or any other negative values)
- the practice should develop a policy regarding email, specifying restrictions on patient-identifiable information being sent to anyone besides the patient or their designee
- HIPAA regulations require encryption (such as password protection) for all email which transmits patient PHI (protected health information)
- patients should be informed of permissible uses such as prescription refill requests and appointment scheduling requests or reminders
- patients should be informed that email is not the appropriate format for relaying questions of a serious nature, since there could be a delay in receiving or checking the emails and these questions need to be answered more quickly
- patients should be informed of inappropriate uses such as relaying sensitive information (HIV, behavioral health information, etc.); specifically, the patients should not be sending this information or discussing this information via email
- to keep emails private (since patient emails to the practice are usually not encrypted) patients should be informed of appropriate set-up of their emails (they should put a category in the subject line and their name and patient ID number should be put in the body of the email for extra privacy)
- patients should be informed whenever their treating physician is unavailable, the name of the covering physician, and informed that their email may not be addressed until after their treating physician returns
- the practice should determine a reasonable turnaround time for resolution of email messages from patients and should communicate that expectation in an automatic reply acknowledging receipt of the message
- the automatic reply should also direct patients to call 911 or go directly to an emergency department if their situation is an emergency
- patients should be informed that all matters that need to be addressed more quickly than the email turnaround time would allow, should be handled by other forms of communication (specifically they should call if they need a quicker response)
- if the practice intends to engage in email dialogs with patients, or to send information to patients via email, the practice should develop a consent form for use of practice/patient email (this form would be used to obtain the patient's written consent to email them) and the signed form should be placed in the patient's medical record
- if group mailings are sent patient names should be blind copied so that no recipient can read the names of other recipients
- the practice policy should also include keeping email software up to date, maintained, and regularly backed up on secure storage devices such off-site secure servers (for disaster recovery)
- specific patient emails, appropriate to the care of the patient, should be printed out and included in the patient's record (if using paper charts), or copied into the patient's electronic medical record

Shared Decisions, the Dialog of Consent

Informed consent is often equated with invasive procedures, yet patients and providers engage in consent discussions every day in all types of situations. For example, a dialog regarding the pros and cons about changing a patient's medication regimen can be an exercise in shared decision making.

© Copyright 2006 Princeton Insurance. All Rights Reserved.

The U.S. Preventive Service Task Force (USPSTF), part of the Agency for Healthcare Research and Quality (AHRQ) defines shared decision-making as a process involving the clinician and the patient “in which the patient:

- understands the risk or seriousness of the disease or condition to be prevented
- understands the preventive service, including the risks, benefits, alternatives, and uncertainties
- has weighted his or her values regarding the potential benefits and harms associated with the service
- has engaged in decision making at a level at which he or she desires and feels comfortable

This process has the goal of an “informed and joint decision.”

The task force also describes informed decision-making as the “individual’s overall process of gathering relevant health information from both his or her clinician, and from other clinical and non clinical sources, with or without independent clarification of values.”[i]

Making patients part of their own health care treatment plan decisions can empower them and also make them more responsible for their own health. Each practice, therefore, should incorporate basic shared decision making communication techniques into its processes. In procedure based practices and practices that utilize high risk medications or other treatments, these communication techniques can be expanded to include a consent form. In all practices, the decision whether to use a shared decision or informed consent discussions should be based on whether the proposed treatment is:

- a surgical or invasive diagnostic procedure
- any treatment where the risk of complication is common
- any treatment where the risk would have grave consequences (such as with high-risk drugs, some immunizations, etc.)

This type of dialog becomes even more important as patients experiment on their own with personal empowerment for their health decisions. They ask for, and sometimes demand, tests or medications that they have heard about, and that they believe will be important to their diagnosis and treatment. As a clinician, the physician may believe the requested test or drug may be unnecessary, or even detrimental. In these situations a shared decision making process helps both patient and practitioner come to a conclusion that can maintain patient safety and quality care.

Shared decision making and informed consent are points on the same timeline. They are not mutually exclusive. In shared decision making the patient is given information, sometimes through brochures and videos along with discussions with the physician, and then makes their decision after weighing their options. Shared decision making is, in effect, that fundamental basis upon which true informed consent is based. A patient who has a consent form in their hand, and is asked to sign, should have been given the opportunity to dialog at length with the physician, and review brochures, videos, or other educational materials as available and appropriate. The decision made in informed consent should be a process, shared with the physician.

More information on shared decision making can be found in a Risk Review article on the topic.

© Copyright 2006 Princeton Insurance. All Rights Reserved.

Communication Tools

Your practice can incorporate a number of tools and processes into your routine which enhance communication with your patients and within the practice team. Some of the tools are Patient Agendas, Practice Brochures, Websites, and Visit Summaries. Team Huddles enhance team communication.

Patient Agendas

A patient agenda is an effective tool for helping to keep an office visit focused on what prompted the patient to come in. It can help to ensure that all of the patient's expectations for that visit are met. It can be especially effective for those patients who have longer lists of complaints each time they come in, or for those patients who tend to forget something important while they are with the physician, thereby necessitating a call to the office one or more times with extra questions. Having an agenda filled out by a patient with a long list of issues allows the physician and patient to pick the top two or three issues that can be covered in the current visit, and when appropriate perhaps make a second visit to address the rest.

Practice Brochures/Websites

Not all practices will decide to develop their own brochure or website, but they can be effective tools. Brochures and websites are a great way to introduce and orient patients to your practice. While they are not a substitute for effective communication, brochures and websites can provide patients with information ranging from your care philosophy and core values to practical office matters, such as scheduling appointments and office hours.

Brochures and websites can help you showcase your services and accomplishments. However, they should never promise perfect results or contain unnecessary superlatives describing physician skills.

Visit Summaries

A practice may consider offering an information sheet that summarizes the most important points of the patient's visit and explains what he or she needs to do after leaving your office. This can be valuable in achieving patient adherence to agreed-upon treatment and follow-up. In today's hectic environment, a summary of the office visit can be invaluable. It's also particularly useful for parents of pediatric patients as well as primary care or specialty practice patients who may be confused or have memory loss. It can be helpful for older patients whose children cannot attend the visit, but want to know what was discussed and what the care plan is. It enables the patient to leave knowing they have a reference for what was discussed and what the plan is for further action.

To simplify doing visit summaries, the practice can use a standard format with checkboxes and space to write brief notes. Those practices with EHR systems may already have the capability to print a visit summary embedded in their software.

© Copyright 2006 Princeton Insurance. All Rights Reserved.

Team Huddles

The quality of patient care, as well as the efficiency of the office practice, relies on a well-designed framework to facilitate communication. Team huddles can be a very effective framework for enhancing communication within the team so that everyone has a better idea of what the day will bring. Team huddles, or briefings, are utilized by crew members of airlines to assure safety and efficiency. Everyone is made aware of the plan, any alternations to the plan and their roles and responsibilities.

In an office practice, a team huddle may take different forms. Staff may gather at the end of the day, when all charts have been pulled for the next day. During this brief meeting the group goes over the plan for the next day, anticipating as many needs as possible in advance. In other situations, this type of huddle may occur before patients arrive in the morning. In large practices it could be divided up into huddles which include individual physicians and their staff. These meetings are always brief and simply orient all members of a particular team to their plan for the day. It brings focus to the task at hand and the mission of the day, which is good patient care.

Posters

At Princeton Insurance, we encourage physicians to build a partnership with their patients by helping them to take a more active role in their care. When patients ask questions and seek to understand their doctor's point of view, they are more likely to arrive at an agreed-upon understanding of their condition and treatment. Ultimately, this partnership can reduce the likelihood of medical errors and miscommunication.

In the past, much of the responsibility to ensure that effective communication takes place between physicians and their patients has fallen squarely on physicians. Princeton's approach seeks to get patients more involved, ultimately helping them begin to take more responsibility for their own health.

In conjunction with the various techniques referenced in this Princeton Insurance Physician Office Practice Tool Kit, physicians can foster a partnership with their patients by encouraging dialogue between themselves and their patients.

Patient communication tools, developed by Princeton, may be used in several ways to accomplish this goal. They are available in both English and Spanish.

Communication posters may be placed in your waiting room and in each exam room for patients to reference while they are waiting for you.

Click below to view posters in your browser:

- 11"x17" color Communication poster
- 8.5"x11" color Communication poster

Click here to order posters for your office. These posters are free of charge, when ordered appropriate to the size of the practice. You may also contact our Risk Resource Line at 1-866-Rx4-Risk (1-866-794-7475) to order.

© Copyright 2006 Princeton Insurance. All Rights Reserved.

Handouts

You may provide patients with a two-page patient communication handout (which can be copied as one double-sided page) as they arrive at the front desk to sign in. Your staff can instruct patients to review the information on the handout and encourage them to make sure the physician addresses their questions before their appointment is over.

Click below to view downloadable **handouts** in your browser:

- 8.5"x11" color Communication handout
- 8.5"x11" black & white Communication handout

Also available in Spanish:

- 11"x17" color Communication poster in Spanish
- 8.5"x11" color Communication poster in Spanish
- 8.5"x11" color Communication handout in Spanish to download
- 8.5"x11" black & white Communication handout in Spanish to download

All of the above tools can be downloaded to your computer after opening the file by right clicking on the file name and selecting the "Save Target As" option.

Please note: These downloads require Adobe Acrobat reader. This Adobe Acrobat software, which comes standard with almost all new computers, can be downloaded for free at www.adobe.com/products/acrobat .

Communicating Under Stress

Though attempts are made to keep communication between practice, patient, and family members as stress-free as possible, medical care can be a tense area for all parties. The following are a few of the situations you may encounter in which you will find communication more stressful.

In all of these situations, communication should be kept non-confrontational. This is not easy to do when a patient or family member is upset, but confrontation may be minimized if:

- the possibility of confrontation is considered and planned for
- the patient and family are treated with honestly, respect, kindness, and an attempt at understanding them
- practice staff and physicians do not become defensive

Anger and Violence

Though it does not happen frequently, office practices may be required to respond to patient or family anger. The anger may be expressed in a variety of ways, through letters, phone calls, or direct confrontation and/or threats. Now that there are websites which encourage patient review of physicians and their practices, there can also be angry postings on the internet.

Responding to patient/family anger resembles the steps listed in the section on Patient Complaints. However, responding to patient anger may require more preparation on the part of physicians and staff. To be prepared to handle anger, and possible violence, the practice should have a policy in place that:

© Copyright 2006 Princeton Insurance. All Rights Reserved.

- includes a zero-tolerance policy for violence (including verbal and non-verbal threats, sexual misbehavior, and any form of bullying)
- defines the difference between anger and violence, or potentially violent situations
- covers not only patients and visitors, but also covers all staff and physicians
- encourages prompt reporting of any incidents in a non-punitive environment
- defines security for the practice, both inside and on the grounds
- commits to the safety of staff, physicians, and all others who may be present (other patients and family members)

Consideration should be given to establishing emergency signals or codes to be used by staff and physicians if a patient is violent or in danger of becoming so, or in situations where the patient is using verbal, sexual or other bullying behavior.

Angry behavior carried out through letters, phone calls, and other media such as web postings can be addressed in ways specific to the approach taken by the patient or family. The practice's policy may include instructions that:

- angry letters should be responded to verbally whenever possible, since it is easy to misinterpret what a person has written, and it may be impossible to understand until you have a chance to discuss the situation with them
- angry phone calls can be handled by the physician, who may be able to clarify with the caller the reason for their emotion
- abusive calls, or calls which become abusive, may be politely terminated
- web postings may be nullified or reduced in intensity by positive reviews; at this time there are no other workable measures to counteract this type of complaint

Angry or disruptive behavior on office premises requires a different approach. The practice's policy may define responses to these patients and visitors in a different manner because the goal will be the protection of staff, physicians, and other patients/visitors. The policy may include instructions such as:

- patients or visitors who become abusive or disruptive in the office may be escorted to a private area in which to discuss their complaints so that others are not upset by their behavior and so that they may be calmed
- a disruptive person who is asked to go to a quieter part of the office can only go there of their own free will, they cannot be coerced or physically moved in that direction
- this part of the policy can also include information on:
    - keeping the disruptive person at least two to three arms length distance from any staff member or physician
    - always making sure that there is a safe exit for staff (that is, the disruptive person should never be placed between staff and the door)
    - there are no potential weapons (sharp, heavy objects) in the room
    - using a firm tone of voice, and no defensive behavior or speech
    - promising the offender that they will be escorted from the office if they cannot amend their behavior

If it is believed that the disruptive person is too much of a threat to be brought back into a more private area, they can be asked to leave the practice premises with an explanation that their current behavior is not allowed by practice policy. Also, if it is believed that the disruptive person remains a threat (lurking in the parking lot, cruising up and down the street, or in any way

© Copyright 2006 Princeton Insurance. All Rights Reserved.

indicating that physicians and staff will not be safe when they leave) local police may be notified of the situation.

In all cases involving angry patients, whether or not they become violent and threatening, the practice may consider discharging the patient from the practice.

If a decision is made to try to work with this patient, it is appropriate to write a clear and simply worded statement describing the behaviors they have manifested, and that will not be accepted in the future by the practice. The statement can also review the consequences of further disruptive behavior. The physician may review this statement with the patient and the patient can sign and date it. A copy of the statement can then be sent home with the patient, while the original remains in the patient's medical record along with documentation of their behavior and discussions with them about it.

Disclosing Difficult Information/Apologizing

Unanticipated or adverse events can happen in the course of care, and when they do the patient and/or family should be told about them. Each practice should have a policy for handling this type of situation. The policy should address what an adverse event is; what will be disclosed; when, who, how, and where the disclosure should take place.

An adverse event is any event that:

- causes injury to the patient
- causes (leads to) the patient's death
- causes the treatment plan to change unexpectedly (even minor things)

The event should be disclosed when the event is discovered, or as soon as possible afterwards. In the practice setting this may mean that the patient may be required to return to the office for the discussion.

The physician involved and/or the patient's treating physician (if they are not the same person) should be present. In most cases only the treating physician will be there, but if a partner is involved in the event, they should also be present. Some practices may wish to have a managing partner present in all such discussions.

The exception to this would occur in situations where the involved physician is emotionally distraught. In circumstances such as these it may be advisable to have a group discussion, bringing in another physician from the practice and possibly a staff member that the patient or family is comfortable with.

The actual disclosure conversation:

- shares only the facts that are known
- uses clear language, words that the patient/family understand, and communicates with them very simply (at approximately a fifth grade level)
- is honest and caring
- does not speculate as to cause, responsibility or blame
- asks the patient/family open-ended questions such as "How can we assist you?"
- promises to keep the patient/family informed of any future pertinent information which may become available

© Copyright 2006 Princeton Insurance. All Rights Reserved.

- is held (if at all possible) in a quiet, comfortable setting (in a practice this might be in the physician's office with the physician sitting with the patient/family, not behind the desk)

Apologies have their place in healthcare. For instance, if you were detained and your patients had to wait an extra fifteen minutes in the waiting room, it is simple courtesy to apologize when you see them. Doing something as simple as this can help reduce tensions and ill will in your patient; this can ultimately increase patient satisfaction.

In the same way, an apology may be appropriate after an adverse event; however, it is best if this apology is more carefully thought out than the prior example. When a patient has suffered an adverse event, the exact cause of that event is often not clear until after an extensive investigation. Therefore, it may be appropriate to express regret for what the patient has actually suffered (inconvenience, pain, anxiety, etc). On the other hand, saying that you are sorry that you (or someone else) made a mistake may turn out to be incorrect because the investigation may show that a process error led to the event.

In all cases of disclosure and/or apology it is necessary to document in the patient's medical record that the conversation took place, what the patient was told, the patient's response, and the agreed upon plan between the patient and the practice.

Patient Complaints

Patients do not always complain. As noted in the patient satisfaction section, patient's feedback can be solicited at any time during any visit. In this way, practice staff and physicians may discover something that could be improved, something that is bothering that or other patients. Doing this may forestall future complaints, or loss of patients due to their dissatisfaction with the practice.

In spite of efforts at prevention, the practice, or individuals in it, may receive complaints. The practice staff and physicians, therefore, can:

- have a policy prepared in advance which details how the practice will respond to a complaint
- make sure all staff and physicians are familiar with the policy since patients may complain to anyone in the practice
- listen carefully and respectfully to each complaint
- ask for clarification, if necessary, only after the complainant has finished their initial complaint
- apologize for the inconvenience or frustration experienced
- offer a workable solution (if it is appropriate for the practice and within the respondents power to accomplish)
- promise that the practice will take a close look at the problem to identify possible solutions, and implement them (if this is required)
- thank the complainant for taking the time, and making the effort to share this with the practice

© Copyright 2006 Princeton Insurance. All Rights Reserved.

Patients Who Record Conversations with You

You may encounter situations in which patients ask for permission to tape their conversations with you. More information on this can be found in a Risk Review Online article.

Other times, you may find that they already have taped you surreptitiously. This situation is addressed in an additional Risk Review article.

Communicating With Other Providers

A majority of Princeton's cases are rooted in communication breakdowns, whether between physicians and patients/families or among the physician and other providers of care. In the practice setting, management of a patient's care depends on good communication between the various parties involved in the patient's care. Phones, faxes, emails, written reports, and the occasional 'hallway consult' all are vehicles used to accomplish this task.

Consults and Referrals

While often a time-consuming and inadequately reimbursed process, referrals necessitate the need for diligent communication and coordination of care across multiple settings and providers. Consultations must be performed following a systematic process and in a timely manner to maintain continuity of care, enhance patient care and satisfaction, and to help prevent serious adverse consequences that would impact all those involved in the care, especially the patient.

Direct communication helps to establish clear responsibility for monitoring or follow up and avoids the false reliance of one physician upon the other that the patient is being followed. Failure in communication between the primary care physician (PCP) and the specialist as to who will monitor and follow up with the patient on a continuing basis is a common source of liability exposure.

For referring physicians

When referring a patient to a specialist, be cognizant of the process:

- whenever possible, speak personally with the consultant, before the patient is seen, especially in "urgent" situations
- avoid leaving a request for a consult with an answering service; however, if absolutely necessary, be sure to follow up to ensure consultation request was received
- explain to the patient why the consult is being requested and document this discussion in the medical record
- develop a standardized format for ordering consults; information should be provided, such as: relevant patient history, working diagnosis, what tests/diagnostic studies have been performed and current medications
- indicate the type of consultation being requested and notify the specialist of its urgency
- keep track of all ordered consults on a log sheet (if using a manual system) to facilitate accurate tracking

For consulting physicians

- answer a consult in a timely fashion
- speak with the PCP before and after the consult, and clearly establish who will follow the patient regarding your findings
- respond to the consult according to the type of consult requested
- explain to the patient your role in his/her care

© Copyright 2006 Princeton Insurance. All Rights Reserved.

- avoid inflammatory verbal or written remarks about previous care and treatment
- provide the patient with feedback as to your findings, their therapeutic options and whether further studies or follow-up are indicated, explaining why they are needed

Careful tracking of a patient's care and good documentation of the same help minimize liability risk. Some information on this can be found in both Reducing Risk documents and Risk Review articles.

- a Risk Review article on consults
- tracking and follow-up of tests and consults are discussed in a Risk Review Online article

Most of these topics are addressed in more detail in other sections of this toolkit; this section will focus on hallway consults.

Hallway Consults

Informal requests for advice from one physician to another are made routinely and they can be helpful. They also pose a risk for both physicians. When involved in "hallway consults", it is a good idea to remember the risks and requirements of your role in the discussion.

If you are requesting information:

- bear in mind that the advice you receive may be inaccurate since the person you have talked with may not have had a chance to examine your patient and/or review their records
- unless they are formally brought in as a consultant, do not record their name in your patient's chart as the source of the advice you are following
- ask for a full "official" consult when your patient's case is complex

If advice or information is asked of you:

- remind your colleague that your advice could be inaccurate since you only have a partial picture of the case
- suggest that a full consult may be more appropriate if the case is complex
- suggest that a full consult may be more appropriate if you are approached multiple times on the same case

More information on consults, referrals, and their follow-up can be found in this toolkit's section on Follow-Up systems.

---

[i] Sheridan, Stacey L., MD, MPH, Russell T. Harris, MD, MPH, Steven H. Woolf, MD, MPH, for the Shared Decision-Making Workgroup of the U.S. Preventive Services Task Force, *Shared Decision Making About Screening and Chemoprevention: A Suggested Approach from the U.S. Preventive Services Task Force,* American Journal of Preventive Medicine, 2004.

© Copyright 2006 Princeton Insurance. All Rights Reserved.