AMA Journal of Ethics®

March 2017, Volume 19, Number 3: 289-295

HEALTH LAW

Strategies for Acing the Fundamentals and Mitigating Legal and Ethical Consequences of Poor Physician-Patient Communication

MaryKatherine Brueck and Angelique M. Salib, JD

Abstract

This article explores how the absence of effective verbal and nonverbal communication in the physician-patient encounter can lead to poor outcomes for patients and physicians alike. The article discusses legal and ethical topics physicians should consider during a medical encounter and provides educational and practical suggestions for improving effective communication between physicians and their patients.

Introduction

Consider the hypothetical case of a young university student, Patient Johnson, who enters the doctor's office experiencing frequent headaches and anxiety. After checking in and waiting in the main office, Johnson is greeted by a nurse and taken back to an exam room, where she anxiously sits and waits for 20 minutes for the physician to arrive. Dr. Smith enters the room, quickly glances at the chart, remains standing, and begins asking a series of general questions using a slew of medical terminology—particularly psychological and neurological vocabulary—when responding to Johnson's concerns about headaches. While Dr. Smith does not appear concerned, the use of unfamiliar terms leaves Johnson uneasy and unclear about her current health status.

Over the course of a career, a physician may have as many as 150,000 patient interviews, making a patient interview one of the most common components of a physician's practice [1]. Although communication is recognized as an important physician competency, physicians are not well trained to communicate effectively [2]. Additionally, physicians' position of authority in the physician-patient relationship may intimidate some patients, rendering them overly deferential or susceptible to undue influence in health care decision making. However, patient satisfaction is largely dependent on a physician's ability to communicate empathetically and to include patients in the decision-making process [3].

Physician communication is also associated with patient health outcomes, which includes both self-reported [4] and objectively measured outcomes [5]. Studies have shown that certain physician behaviors are linked with negative patient health outcomes, including using medical jargon the patient does not understand, an uninviting posture,

standing rather than sitting, interrupting the patient, making assumptions, asking leading questions, and wearing a white coat or medical uniform [3, 6, 7]. While this list is not exhaustive, it highlights common examples of language—including nonverbal communication—that can negatively impact patients' care experience and, ultimately, their health outcomes.

This article will explore the ethical and legal implications of physicians' verbal and nonverbal communication with patients in addition to techniques that can improve communication styles.

Ethical Dimensions of Communication in the Physician-Patient Encounter

In conversations between a patient and physician, there exists an inherent imbalance of power, as the patient, compromised by illness, turns to the physician for answers, medical advice, and treatment [8]. This imbalance of power is present—and necessary—due to the conditions of the clinical encounter wherein the physician holds the medical knowledge and skills the patient wishes to access. While the imbalance of power does not threaten the physician's ability to provide quality care intrinsically, it may be exacerbated through ineffective communication. Failed verbal and nonverbal communication runs the risk of distorting the ideal collaborative physician-patient relationship: the physician may fall into involuntary paternalism, controlling medical decision making in the belief that he or she knows what's best for the patient; or, contrarily, the patient may become distrustful of the medical profession in cases in which the physician was not transparent or clearly understood [9, 10]. In both instances, a patient may become unable or unwilling to participate in shared decision making, compromising quality care. A physician may not necessarily be morally culpable for the patient's withdrawal in these cases, as the patient also bears responsibility for participation in decision making; however, the physician maintains responsibility for treating the patient and delivering quality care. With this goal in mind, the physician has a duty to mitigate the threats to effective clinical decision making that result from ineffective communication.

Poor communication in the physician-patient relationship may not only introduce a barrier to practicing medicine effectively but also raise concerns about the appropriate allocation of health care resources. Although more research needs to be done on this topic, patients who feel that the physician does not respect their concerns, show empathy, or provide relevant information may have lower rates of compliance with recommended treatment options, leading to greater costs and expenditures, including those associated with increased hospital admissions [10]. Physician communication, then, impacts not only the trajectory of the individual patient's care, but also the health care system as a whole. Recognizing that health care resources are limited and valuable, physicians should participate in a system that maximizes efficiency and quality of care, starting at the root of care in the physician-patient encounter [11].

Legal Consequences of Poor Communication

Studies indicate that a breakdown in communication between a physician and patient is the "root cause" of malpractice claims [12]. In one analysis of claims data from 2004-2008, communication failures in test result notification accounted for 4 percent of malpractice claims by volume and 7 percent of the total cost [13]. This data underscores the importance of effective communication during the physician-patient encounter and the potential for detrimental effects of legal action on a physician's practice in its absence.

What types of breakdowns in communication can lead to adverse legal action? Studies have shown that, in cases of medical error, patients' uncertainty about whether they have received all the relevant information and physician dishonesty [12] can lead to litigation. Lawsuits have also resulted from failure to obtain informed consent and breach of a patient's privacy rights [14].

To err is human. Although it is inevitable that there will be some breakdowns in communication over the course of a physician's career despite his or her best efforts, it is still possible for the physician to remediate the situation. In the case of medical errors, physicians may be reluctant to discuss how "things went wrong" for fear of liability, retaliation, or being perceived as incompetent. In an effort to reduce physicians' fear of being transparent with patients and their families, policymakers have passed "apology statutes," whereby physicians can express sympathy, apologies, or condolences without fear of those statements being used against them in court. To date, 36 states plus the District of Columbia have passed such laws [15]. For example, the medical apology statute in Connecticut provides that any statement or gesture expressing apology, fault, or compassion made by a health care professional as a result of an unanticipated outcome of care is inadmissible as evidence in a civil action brought by an alleged victim [16]. Studies to date have shown that apologies in cases of medical error reduce the cost of litigation and facilitate faster settlement times [17]. Although errors inevitably happen, acknowledgment of fault and expressions of apology can be a means to remediate the physician's relationship with the patient and lessen the possibility of adverse legal action.

Making a Change: Methods to Improve Communication with Patients

Having addressed ethical and legal considerations that result from failed communication in the clinical encounter, we now identify what physicians can do in order to proactively prevent these concerns from arising.

Patient-centered communication (PCC) that promotes shared decision making has been widely endorsed, including by the National Academy of Medicine (formerly the Institute of Medicine) [18], as a key aspect in improving the quality of care delivered in the clinical

encounter. PCC involves (1) considering patients' needs, wants, perspectives, and individual experiences; (2) offering patients opportunities to provide input into and participate in their care; and (3) enhancing partnership and understanding in the patient-physician relationship [19]. Additionally, Opinion 2.11 of the AMA *Code of Medical Ethics*, "Informed Consent," discusses the importance of creating a space that encourages shared decision making [20]. The opinion notes that a physician should be actively engaged in assessing a patient's ability to understand and process information (to the best of his or her ability), presenting relevant information accurately and sensitively, and documenting the conversation. Yet, comprehensive utilization of these guidelines must also take into consideration the effects of nonverbal communication—facial expression, voice tone, body position—that accompany verbal information sharing [21]. All of these recommendations take time to put into practice but are essential to collecting accurate information and fostering a collaborative relationship. Especially in cases in which ample time is not allowed to thoroughly establish the clinical relationship due to institutional constraints and pressures, physicians should pay careful attention to their demeanor, presentation, and delivery of relevant information [22]. Although physicians see many patients each day—often witnessing similar symptoms, cases, and behaviors—it is important for them to recognize that each patient is unique and should be approached with the same attitude of care, whether it is the first or last patient seen that day.

Another way to improve physician-patient communication is to enhance the teaching of communication skills during undergraduate medical education [2]. This is particularly important, as studies have shown that students become more cynical and less empathetic during medical school [23]. Reflective writing is one established method for teaching medical students empathy, as are general courses in medical humanities [24]. Another way to improve communication skills is to implement an alternative communication model in clinical practice. The Studer Group developed the AIDET® model for physicians to improve effectiveness in the patient encounter [25]. The five fundamentals of communication include:

> Acknowledge—greet the patient by name, make eye contact, smile.
> Introduce—your name, title.
> Duration—give time expectations for tests, next steps.
> Explanation—what to expect, answer questions, how patients can contact you.
> Thank you—express gratitude and support [25].

Conclusion

Physicians are frequently pressed for time as they care for many patients and fulfill other responsibilities of their job. However, by employing patient-centered communication using a model such as AIDET, physicians' investment in communicating effectively can

pay off in several dimensions of their practice, legally and ethically, and also contribute to providing quality care for their patients.

References

1. Institute for Healthcare Communication. Impact of communication in healthcare. http://healthcarecomm.org/about-us/impact-of-communication-in-healthcare/. Published July 2011. Accessed September 8, 2016.
2. King A, Hoppe RB. "Best-practice" for patient-centered communication: a review. *J Grad Med Educ*. 2013;5(3):385-393.
3. Bendapudi NM, Berry LL, Frey KA, Parish JT, Rayburn WL. Patients' perspectives on ideal physician behaviors. *Mayo Clin Proc*. 2006;81(3):338-344.
4. Safran DG, Taira DA, Rogers WH, Kosinski M, Ware JE, Tarlov AR. Linking primary care performance to outcomes of care. *J Fam Pract*. 1998;47(3):213-220.
5. Stewart MA. Effective physician-patient communication and health outcomes: a review. *CMAJ*. 1995;152(9):1423-1433.
6. Montague E, Chen P, Xu J, Chewning B, Barrett B. Nonverbal interpersonal interactions in clinical encounters and patient perceptions of empathy. *J Particip Med*. 2013;5:e33. http://www.jopm.org/evidence/research/2013/08/14/nonverbal-interpersonal-interactions-in-clinical-encounters-and-patient-perceptions-of-empathy/. Accessed October 24, 2016.
7. Brase GL, Richmond J. The white coat effect: physician attire and perceived authority, friendliness, and attractiveness. *J Appl Soc Psychol*. 2004;34(12):2469-2481.
8. Koeck C. Imbalance of power between patients and doctors. *BMJ*. 2014;349:g7485. http://www.bmj.com/content/349/bmj.g7485.long. Accessed October 24, 2016.
9. McKinstry B. Paternalism and the doctor-patient relationship in general practice. *Br J Gen Pract*. 1992;42(361):340-342.
10. Wong S, Lee A. Communication skills and the doctor patient relationship. *Hong Kong Med Diary*. 2006;11(3):7-9.
11. University of Minnesota Center for Bioethics. Distributing limited health care resources. http://www.ahc.umn.edu/img/assets/26104/Limited_Resources.pdf. Revised April 1997. Accessed October 24, 2016.
12. Huntington B, Kuhn N. Communication gaffes: a root cause of malpractice claims. *Proc (Bayl Univ Med Cent)*. 2003;16(2):157-161.
13. Gale BD, Bissett-Siegel DP, Davidson SJ, Juran DC. Failure to notify reportable test results: significance in medical malpractice. *J Am Coll Radiol*. 2011;8(11):776-779.
14. Van Kempen A. Legal risks of ineffective communication. *Virtual Mentor*. 2007;9(8):555-558.

15. States that have passed medical apology laws (generally) as of September 2016: Arizona, Colorado, Connecticut, Delaware, District of Columbia, Georgia, Hawaii, Idaho, Indiana, Iowa, Louisiana, Maine, Maryland, Massachusetts, Michigan, Missouri, Montana, Nebraska, New Hampshire, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Utah, Vermont, Virginia, West Virginia, Wyoming. States that have passed medical apology laws (related to an accident) as of September 2016: California, Florida, Massachusetts, Tennessee, Texas, Washington. See National Conference of State Legislatures. Medical professional apologies statutes. http://www.ncsl.org/research/financial-services-and-commerce/medical-professional-apologies-statutes.aspx. Published January 21, 2014. Accessed September 8, 2016.
16. Conn Gen Stat sec 52-184d.
17. Saitta N, Hodge SD. Efficacy of a physician's words of empathy: an overview of state apology laws. *J Am Osteopath Assoc*. 2012(112):302-306.
18. Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academy Press; 2001.
19. Epstein RM, Franks P, Fiscella K, et al. Measuring patient-centered communication in patient-physician consultations: theoretical and practical issues. *Soc Sci Med*. 2005;61(7):1516-1528.
20. American Medical Association. Opinion 2.1.1 Informed consent. *Code of Medical Ethics*. https://www.ama-assn.org/sites/default/files/media-browser/code-of-medical-ethics-chapter-2.pdf. Published 2016. Accessed January 31, 2017.
21. Friedman HS. Nonverbal communication between patients and medical practitioners. *J Soc Issues*. 1979;35(1):82-99.
22. Dugdale DC, Epstein R, Pantilat SZ. Time and the patient-physician relationship. *J Gen Intern Med*. 1999;14(suppl 1):S34-S40.
23. Hojat M, Mangione S, Nasca TJ, et al. An empirical study of decline in empathy in medical school. *Med Educ*. 2004;38(9):934-941.
24. DasGupta S, Charon R. Personal illness narratives: using reflective writing to teach empathy. *Acad Med*. 2004;79(4):351-356.
25. Rubin R. AIDET® in the medical practice: more important than ever. Studer Group. https://www.studergroup.com/resources/news-media/healthcare-publications-resources/insights/november-2014/aidet-in-the-medical-practice-more-important-than. Published November 17, 2014. Accessed September 26, 2016.

MaryKatherine Brueck is a fourth-year undergraduate at Loyola University Chicago, where she studies philosophy with a concentration in bioethics. During the summer and fall of 2016, she was an intern for the American Medical Association's Ethics Group.

Angelique M. Salib, JD, is an attorney in Chicago focusing on health care transactions, compliance, and policy. She graduated from the University of Chicago Law School with a certificate in health administration and policy.

Related in the *AMA Journal of Ethics*

After the Apology—Coping and Recovery After Errors, September 2011
Communication Skills Training in the Twenty-First Century, February 2015
Difficult Patient-Physician Relationships and the Risk of Medical Malpractice Litigation, March 2009
From *Doctors' Stories* to Doctors' Stories, and Back Again, March 2017
"I'm Sorry" Laws and Medical Liability, April 2007
Medical Culture and Error Disclosure, May 2008
Medical Malpractice Reform—Historical Approaches, Alternative Models, and Communication and Resolution Programs, March 2016
Resolving Harmful Medical Mistakes—Is There a Role for Forgiveness?, September 2011
State Medical Board Attempts to Censure Physician Communication Styles, July 2007

The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.

Copyright 2017 American Medical Association. All rights reserved.
ISSN 2376-6980