

Crisis Situations Call For Clear Communication

Those in healthcare hear the word “crisis” all too often: malpractice-liability crisis, public-health crisis, Medicare crisis, nursing crisis, chronic-disease crisis, pandemic crisis, health-insurance crisis—and that doesn’t even count the everyday crises that occur in emergency departments, intensive-care units and doctors’ offices across the country.

But dealing with crisis on a regular basis doesn’t necessarily make it easier, nor does it ensure that physicians will communicate effectively under pressure.

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In addition to a compressed time frame, crisis brings up intense emotions for all involved. Anger, fear, grief, con-

fusion, denial are all common responses to crisis. Dealing with these emotions adds challenge to the situation.

The circumstances are often complicated by the fact that many crises take place in emergency departments or hospital floors where the physicians may not be well acquainted with the patient or family. “These are significant events,” says Dr. Carroll,

“watershed happenings between total strangers, usually not within a longstanding relationship.”

In the heat of the moment, physicians may not feel that they have time to think about how they communicate during a crisis, but slowing down long enough to prepare for these conversations can pay off—for the patient’s emotional and physical health as well as the physician’s own well-being.

Delivering Bad News

“The way in which diagnostic information—good, bad or no news—is delivered affects how well (or not well) the patient will accept that news,” says Richard Frankel, Ph.D., professor of medicine and geriatrics at Indiana University School of Medicine in Indianapolis and a leading researcher in the field of healthcare communications. It can also affect the decisions patients make about treatment options—which in turn can affect outcomes.

“We know from published research, as well as our own practice, that the way bad news is first communicated can impact, for better or worse, people’s adjustment to a diagnosis,” says Dr. Jennifer Mack, attending physician at Dana-Farber Cancer Institute in Boston.

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Tips for Delivering Bad or Sad News

- Prepare for the visit by identifying appropriate time and place.
- Have a plan for what you wish to accomplish in the visit.
- Elicit the patient’s perspective before providing your own.
- Use clear, unambiguous language, and be brief.
- Once you deliver the news, be silent and let the patient absorb the impact of the information.
- Limit goals of the visit to a minimum once the news is delivered.
- Check the patient (or patient and family) comprehension.
- Plan next steps (for next 24 hours, next 7-14 days and long-term).

Source: The Four Habits Approach to Effective Clinical Communications.

“good stress”) of practicing medicine, delivering bad news and dealing with death and dying can be sources of negative stress and burnout among physicians.

“Doctors are problem solvers,” explains Dr. Frankel. But when the problem can’t be solved or is out of the physician’s hands, a sense of failure can result. That’s especially true if the physician feels inadequate in explaining the situation to patients and their families. “Doctors often feel responsible for patients’ other problems, but are not skilled in dealing with those areas.”

What’s more, a review of the literature published in JAMA in 1996 found that the stress of delivering bad news may start hours before the actual appointment and continue for up to three days afterward. That constant stress can wreak havoc on a physician’s health and feelings about his or her job.

Oncologists—who often deal with more than their fair share of bad news—may be particularly at risk for burnout from delivering bad news. (Cardiologists, surgeons and intensivists are also at high risk.) In one study published in a 1991 edition of the *Journal of Clinical Oncology*, 56 percent of oncologists reported “professional burnout” and ranked dealing with dying patients as one of the top three causes of that burnout. Improving communication skills may be an important way of dealing with that stress and therefore reducing burnout.

Dr. Mack and colleague Dr. Holcombe E. Grier reviewed the literature for their article “Day One Talk,” which was published in the *Journal of Clinical Oncology* in February 2004. Although their article dealt specifically with pediatric cancers, they write that the same principles apply to any serious illness. They identified the following recurring themes and advice for informing a patient or family of a poor prognosis:

■ **Plan the conversation beforehand if possible.** Preparation is vital, even if the patient and his or her family are anxious to have

The way bad news is delivered can also have a profound effect on physicians’ experience of their profession. While the challenge of diagnosing and treating disease can add to the thrill (the “good stress”) of practicing medicine, delivering bad news and dealing with death and dying can be sources of negative stress and burnout among physicians.

the conversation right away. Taking time to prepare, even just for the physician to collect his or her thoughts and to have the pertinent information at hand, is worth a slight delay. Such a delay can also give the patient time to gather family members or others. Martie Moore, R.N., senior vice president of patient care at MaineGeneral, adds that physicians should take a few seconds to find out something personal about the patient or family—something that is not related to the diagnosis. She points out that this is a good practice any time, but especially in crisis. “Patients want to know that you know they’re whole people,” she says.

■ **Find a quiet and private setting for talking to the patient and/or family.** Ms. Moore suggests that if the physician doesn’t have time to set up a room, a nurse or other staff member may be able to help. “Take time to have a space that’s comfortable. Make sure there’s water to drink and tissues,” she adds.

■ **Have accurate information ready.** Be ready with pertinent test results and background information, as well as details on

The SPIKES Protocol for Breaking Bad News

Dr. Robert Buckman, an oncologist at the Toronto-Sunnybrook Regional Cancer Centre and a professor in the University of Toronto Department of Medicine, developed a six-step communication model to follow when delivering bad news to patients. In an on-line book on the Website *Conversations in Care* (www.conversationsincare.com), Dr. Buckman describes his protocol, which is called SPIKES:

■ **Setting.** Setting should foster communication by providing for privacy and comfort. Eliminate distractions such as phone calls or other interruptions. Patients may choose to have family members present during the discussion. Sit near the patient without physical barriers, such as a desk, coming between you. Maintain eye contact with your patient.

■ **Perception.** Before you break the news to your patient, try to get an impression of his or her perception of the medical situation. Does your patient have an idea of the seriousness of his or her condition? Conform your language to the patient’s level of vocabulary. Listen for signs of denial but don’t confront the denial at the first interview. “Confronting denial at this early time will most likely just raise the patient’s anxiety unnecessarily or, more likely, set up an adversarial

community resources, if appropriate. Having Websites and patient information ready can be helpful, too. Patients and families need something to do during the “down time” between diagnosis and start of treatment. Learning more about their condition can help fill that time and avoid the buildup of anxiety that can come from just waiting.

■ **Communicate clearly without jargon or euphemisms.** If it’s cancer, use the word. Don’t hide behind medical jargon.

■ **Let the patient’s or family’s reaction guide the flow of conversation.** Most people will need some time to digest the information at their own pace and in the order that makes sense to them. Letting the patient guide the conversation helps ensure greater understanding.

■ **Share your own emotional response to create a sense of connection.** Showing empathy—in both words and body language—assures the patient and family that the physician is considering the whole person when recommending treatment.

and antagonistic relationship,” Dr. Buckman writes.

■ **Invitation.** Your patient may not want to know all the details about his or her medical situation. Ask the patient: “Are you the kind of person who prefers to know all the details about what is going on?” or “How much information would you like me to give you about your diagnosis and treatment?” If your patient prefers not to hear all the details, ask if he or she wants you to talk to a family member instead. Make sure your patient understands that he or she can come back at any time to ask questions.

■ **Knowledge.** Don’t blurt out your news; ease into it, using the same language your patient uses. Avoid technical, scientific language. Give the information in small pieces and clarify that the patient understands what you have said, using such questions as “Do you see what I mean?” or “Is this making sense so far?”

■ **Empathy.** Acknowledge the patient’s emotions as they arise and address them. Identify with the patient’s emotions with such statements as “Obviously this piece of news is very upsetting” or “Clearly this is very distressing.”

■ **Strategy and Summary.** Before the discussion ends, summarize the information you provided and detail the steps that will be taken going forward.

■ **Realize that the stress of receiving bad news may prevent a patient from retaining all the information.** Be prepared to go over the facts again later in the conversation or in subsequent appointments.

■ **Keep the lines of communication open.** Make it clear to patients and their families that they can come back with more questions or concerns.

“The heart of the encounter is not in what the physician says, but in the patient and family’s response,” Drs. Mack and Grier write in their article. “Careful listening, assessment of their understanding, and a willingness to be flexible can help the physician to respond to the individual needs of the family. Listening and the openness of silence may be more important than the words themselves.”

Dr. Frankel recalls talking to a physician whose patient was dying. There was no more he could do for her, and he felt helpless. “The only thing I could do was bring in some slippers for her,” the physician told Dr. Frankel. And while the doctor felt that this wasn’t enough, it probably meant a great deal to the patient. “It shows you’re connected to the patient,” Dr. Frankel says. “There are so many different things that can be therapeutic if you just keep your eyes and ears and heart open.”

When Things Go Wrong

After the Institute of Medicine’s 1999 report, *To Err is Human*, revealed that 98,000 people die each year from medical errors, healthcare organizations and patient advocacy groups have focused on how to prevent and deal with medical errors. States are requiring disclosure of medical errors, setting up confrontations and conversations that physicians and administrators are often unprepared to handle effectively.

Communications training is part of the answer to both preventing and dealing with errors, says Dr. Carroll. By communicating more clearly upfront, physicians and other healthcare professionals can avoid errors—using the repeat-back method employed by air traffic controllers and even staff at your local Starbucks. Repeating back instructions is a built-in safety check.

When things go wrong despite safety checks, it is important to be upfront with patients and families. They need to be in the

loop, too. But that conversation may be more difficult than just repeating back instructions. And unfortunately, physicians are rarely trained to have this crucial conversation.

“It’s important to realize that we’re not going to be perfect, and there are going to be bumps in the road,” says Dr. David Hatem, internist at University of Massachusetts Memorial Medical Center and director of the Physician, Patient and Society course at the University of Massachusetts Medical School. “There are going to be patients who are not satisfied, and we should have language to talk about that. We should apologize when things don’t go well. But these are things that we aren’t trained for.”

When physicians are not prepared for the possibility of errors, it can lead to defensiveness and shame—neither of which is helpful when trying to communicate clearly. “If people haven’t been given the anticipatory guidance that this is something all physicians face, all of a sudden [the physician thinks]: ‘How come nobody told me this? And if nobody told me this, it must not be happening to them, and if it’s not happening to them, then what did I do wrong?’” Dr. Hatem says.

The truth is that even most patients know that things go wrong sometimes. In a survey of patients conducted for the American College of Physician Executives (ACPE) earlier this year, 53 percent agreed that “Medical science is so complex that medical errors are bound to happen.”

Although there are different philosophies about how to approach the disclosure of medical errors, there is a growing

Dealing with Strong Emotions: Behavior Checklist

- Observe nonverbal clues to patient emotions.
- Maintain professional demeanor in the presence of strong emotion.
- Empathy skills: reflection, validation, support, partnership, respect.
- Calibrate response to emotions.
- Explore the sources of patient emotion.
- Reflect upon your personal responses to patients.

Source: Doc.com, Online Communications Training from the American Academy on Communication in Healthcare (www.aachonline.org).

movement towards being upfront and even apologizing when appropriate. In a companion survey of physician leaders conducted by ACPE, 81 percent said that healthcare organizations should encourage making apologies for medical errors.

Dr. Lucian Leape, adjunct professor of health policy at Harvard School of Public Health in Boston and a member of the Institute of Medicine panel that produced the 1999 report on

“Just as patients are entitled to know all the results of laboratory tests, opinions from consultants, risks of treatment and alternative therapeutic options, they are entitled to know what the causes of the breakdown are when things go wrong,” says Dr. Lucian Leape, adjunct professor of health policy at Harvard School of Public Health.

medical errors *To Err Is Human*, calls full disclosure of medical errors “an ethical imperative.” In an article in the March/April 2006 issue of *The Physician Executive*, Dr. Leape writes, “Just as patients are entitled to know all the results of laboratory tests, opinions from consultants, risks of treatment and alternative therapeutic options, they are entitled to know what the causes of the breakdown are when

things go wrong. It is also what each of us would want for ourselves. We want to know what went wrong, why, and what will be done to prevent it from happening again.”

Dr. Leape writes that many physicians fear the consequences of error admission, specifically the risk of being sued. But full disclosure of adverse events and errors may actually prevent malpractice lawsuits.

In the ACPE survey of patients cited above, 57 percent said they would be less likely to sue in the case of a medical error if the hospital or physician apologized for the error. (Ninety-two percent said they would be more likely to sue if the responsible parties tried to hide the mistake.)

“Anger—not greed—is what drives most medical malpractice lawsuits,” says Dr. Steve Kraman, former chief of staff at the Lexington, Ky., Veterans Administration Hospital. “Patients and families become angry when the door is slammed in their face and doctors don’t communicate.”

Dr. Kraman is on the board of a new organization called Sorry Works! Coalition. The group advocates that doctors and hospi-

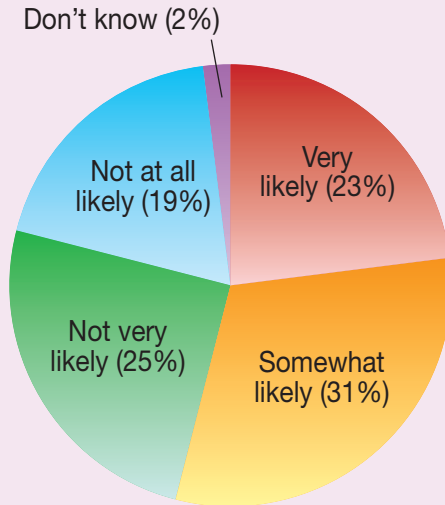
tals establish structured disclosure and apology programs for bad outcomes and medical errors.

Under the Sorry Works approach, when medical mistakes or unanticipated outcomes occur, doctors and hospitals should thor-

Patients Seek Truth From Doctors

An overwhelming majority of the public (88 percent) say that physicians should be required to tell their patients if a mistake is made in their treatment, according to a 2004 survey by the Kaiser Family Foundation. But a much smaller percentage said they trust their own physician to tell them if a mistake were made in their treatment.

If a medical error were made in your care, how likely do you think the doctor would be to tell you?



Source: Kaiser Family Foundation/Agency for Healthcare Research and Quality/Harvard School of Public Health National Survey on Consumers' Experiences with Patient Safety and Quality Information, November 2004.

oroughly review the facts of the case and quickly notify the patient and/or families of the findings. If an error or mistake is found, the provider should apologize, offer answers and provide a fair settlement up front. The family should retain legal counsel to ensure their rights are protected and preserved throughout the process. Finally, patients and families should be allowed to participate to the extent possible in the effort to make sure the medical error does not happen again.

The movement is being heralded as a “middle-ground solution” to the medical malpractice crisis. “With Sorry Works,” says Dr. Kraman, “people are treated fairly and humanely, and the resulting response is they usually don’t want to file a lawsuit.” He says that the approach has reduced lawsuits and saved money at the VA Hospital.

When the Patient Is a Child

Delivering bad news can be especially difficult when the patient is a child. In an article in the February 2004 edition of *Journal of Clinical Oncology*, Drs. Jennifer Mack and Holcombe E. Grier review the literature and give physicians practical advice on how to break bad news to parents and children.

According to the article, there are three main points for families to hear and understand:

■ **Diagnosis.** “Parents’ understanding of their child’s condition influences their choices for therapy,” says Dr. Mack. She advises physicians to use the word “cancer” since some parents will not associate the terms “leukemia” or “tumor” with cancer.

■ **Treatment options and goals.** Some parents will want to hear numbers, such as “80 percent with this type of cancer are cured.” Others want just a general idea, such as “Most children with this form of cancer are cured.” Drs. Mack and Grier advise doctors to ask parents what their preference is.

■ **Cause.** Families may seek meaning or want something to blame, even if it is themselves. Parents may need reassurance that there are few known causes for childhood cancer.

From there, physicians can cover information that the family needs before treatment begins, such as the stage of the cancer and what parts of the body it has affected as well as the impact of treatment on

At the University of Michigan, administrators do not encourage “insincere” or across-the-board apologies, but they do support physicians as they try to communicate with disgruntled patients and try to work out a solution. As a result, claims—and malpractice costs—are down.

David Patton, malpractice attorney representing plaintiffs in Paradise Valley, Ariz., is also a Sorry Works board member. “The majority of people who visit my office are angry and simply looking for answers,” he says. “Unfortunately, doctors and malpractice insurers cut off communication with patients and families after bad or unanticipated outcomes, even when malpractice doesn’t happen.”

COPIC Insurance Company, a professional liability insurer based in Denver, promotes disclosure of unanticipated medical

daily life, side effects and other details of informed consent. The physician should point the family to other resources, such as support groups or educational materials.

“Finally, we tell parents that they are part of a team,” Drs. Mack and Grier write. “Our role is to teach them about their child’s disease and to plan and supervise the treatment. Their role is to teach us about their child and themselves, because this will help us provide better care. We remind families that we will be with them for as long as their child or they need us.”

Drs. Mack and Grier recommend including older children in this initial conversation when possible. If they are not included, they may think that information is being hidden from them. Younger children are usually best told separately by the physician with parents present. If parents feel uneasy about how the information will be presented, physicians can offer to role-play with the parents. In that conversation, physicians will need to go over basically the same information with children, letting their reactions and responses guide the discussion.

The most important point, say Drs. Mack and Grier, is keeping lines of communication open: “It’s crucial that the exchange of information among the patient, family, and physician continue as the shock of the initial diagnosis fades.”

Source: Mack, JW and Grier, HE, “The Day One Talk,” Journal of Clinical Oncology, Vol. 22, No. 3, Feb. 1, 2004.

outcomes through its “3Rs Program”—Recognize, Respond and Resolve. “The purpose of the program is to assist patients who have experienced an unanticipated medical outcome by facilitating candid, early communication between a physician and a patient, thereby preserving the relationship,” the company says. The program assists a physician in responding in a timely fashion to unanticipated medical outcomes that meet the program’s criteria; communicating with the patient in an empathetic manner, and arranging for additional care or services the patient might need as a result of the outcome

Under the no-fault program, patients can receive compensation for their loss of time at \$100 a day (capped at \$5,000) and reimbursement for out-of-pocket medical expenses related to the unanticipated outcome (capped at \$25,000), COPIC says.

The most frequent 3Rs cases involve hysterectomy, colonoscopy, laparoscopic cholecystectomy, complications of general anesthesia and delayed diagnosis of appendicitis. Cases that are ineligible for the program are those in which the patient died, an attorney is involved or a formal written demand for compensation is made.

Some 2,641 COPIC-insured physicians participate in the program, which the company says has dramatically reduced litigation and associated costs while preserving doctor-patient relationships. COPIC says that from the program’s inception in October 2000 through March 31, 2006, a total of 2,456 qualifying incidents have resulted in 588 reimbursements to patients totaling almost \$3.3 million (or an average of \$5,567 per paid incident). The company says that only a few cases that met 3Rs criteria have gone on to become formal claims.

Informed Consent

Good informed consent may go a long way toward warding off a communications crisis with your patients. Physicians are aware of the legal requirement to obtain written informed consent before a patient undergoes a medical procedure or treatment, but the process of obtaining consent can do more than offer legal protection—it can open up lines of communication.

“Simply stated, the very act of disclosure results in less anxiety, increased trust in the integrity of the physician, a smoother

clinical course and better patient understanding should anything go awry,” says The Doctors Company, a physician-owned medical malpractice insurance provider based in Napa, Calif. “Ideally, the informed-consent process should be viewed as an opportunity to dispel uncertainty, allay anxiety and help fill the gap between patient ignorance and supposed physician omnipotence. By sharing uncertainty, you can transform a potentially adversarial relationship into a therapeutic alliance.”

The American Medical Association says that informed consent

Patients Worry About Overtreatment: Poll

Nearly three-quarters (72 percent) of U.S. adults think that patients who have medical conditions experience problems because of being overtreated (i.e., getting too many treatments or getting more aggressive treatment than is appropriate), according to a 2005 Wall Street Journal Online/Harris Interactive Health Care Poll. Half (50 percent) of the survey respondents said that they are somewhat or very concerned, personally, about being overtreated when they are sick or in need of medical care.

More than half (52 percent) told researchers that they have chosen to question or forego recommended care because they felt it was unnecessary or too aggressive. Specifically, the poll's findings include the following:

- Nearly a third (32 percent) did not fill a prescription that their doctor gave them because they felt it was unnecessary.
- About one-fifth (21 percent) got a second opinion from another physician because they thought their doctor's recommendations were too aggressive.
- Sixteen percent did not get a diagnostic test that their doctor recommended because they felt it was unnecessary.
- One in 10 did not get a surgical procedure that their doctor recommended because they felt it was unnecessary.
- Nine percent changed doctors because they felt their doctor's approach was too aggressive.

The public has several theories as to why doctors may overtreat patients. Doctors' concerns about malpractice lawsuits (53 percent) and the desire to make more money (45 percent) and meet patients' demands (45 percent) are the reasons most cited by adults as to why they think overtreatment occurs.

is more than simply getting a patient to sign a written consent form. “It is a process of communication between a patient and physician that results in the patient’s authorization or agreement to undergo a specific medical intervention,” the AMA says.

COPIC Insurance Company says that it is the physician’s responsibility to obtain patient consent. “The physician may obtain assistance from others, such as nurses, health educators, physician assistants, etc. However, the final discussion about the risks and benefits, and the answering of questions must be done by the physician,” the company says.

The AMA lists the following items that need to be disclosed and discussed during the communications process:

- The patient’s diagnosis, if known.
- The nature and purpose of a proposed treatment or procedure.
- The risks and benefits of a proposed treatment or procedure.
- Alternative treatment options, regardless of their cost or the extent to which the therapies are covered by health insurance.
- The risks and benefits of the alternative treatment option.
- The risks and benefits of not receiving or undergoing a treatment or procedure.

The conversation should be documented in the patient’s chart. Once the patient understands the treatment, then he or she can be given a consent form to sign. Your malpractice insurance carrier may have requirements that written consent be obtained for specific treatments. For example, COPIC requires its policyholders to obtain written consent for any procedure requiring general or regional anesthesia and a number of diagnostic procedures such as endoscopy, flexible sigmoidoscopy, coronary angiography and needle biopsies. The insurer also requires written consent for allergy treatments, long-term steroid treatments and long-term anticoagulant therapy.

The AMA says that consent forms should be tailored to the specific procedure; the

simple assertion that “all material risks have been explained to me”

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may not provide adequate legal protection. “At the other extreme, listing all of the risks may not be wise either,” the AMA states. “A comprehensive listing will be difficult for the patient to understand and any omission from the list will likely be presumed undisclosed.”

The Doctors Company offers an on-line library of sample informed-consent documents for a variety of general and specialty specific procedures. These are available by logging on to www.thedoctors.com/consent.

No News Can Be Bad News

Sometimes physicians have to deliver “no news,” which can also feel like bad news to the patient. A CT scan that shows no tumor leaves the patient with no explanation for his or her debilitating headaches. While the patient knows that he should be happy that there’s no sign of cancer, he is frustrated that the physician doesn’t have a clear answer—and a cure for the pain he’s feeling.

Dr. Frankel says for physicians, “The three hardest words are ‘I don’t know,’ but they can be extremely powerful if followed up by ‘But I’ll make every effort to find out.’”

It’s important to remember that even if there is no obvious medical cause for a patient’s symptoms, they are still very real to the patient. The biopsychosocial approach to the medical interview can be helpful in determining if stress or other factors in the patient’s life may offer an explanation of the symptoms.

For example, a patient with unexplained symptoms may reveal that he is having marital difficulties or that his son is in trouble with the law. Of course, there’s no medical treatment for these problems, but once the patient has disclosed the information, the physician’s “fix-it” mentality may kick in. Dr. Frankel recommends asking the patient, “How did you hope I could help you with this problem?”

“One-fourth to one-third will say ‘I don’t expect you to do something, I just needed to tell you,’” says Dr. Frankel.

The best solution, he continues, may be to listen. “One of the greatest goods that a physician can do for a patient is to listen to their distress,” Dr. Frankel says.