

From the Editor

- Learning to Talk and Listen** 535
Audiey C. Kao

Vignettes

- Vignette 1: **Physician-to-Patient Communication** 537
Disclosing Error to a Patient
Commentary by Geoffrey H. Gordon

- Vignette 2: **Physician to Patient in Clinical Trials** 541
Hoping for the Best, Preparing for the Worst
Commentary by Frederic W. Platt

- Vignette 3: **Colleague-to-Colleague Communication** 547
Frame Feedback to Improve Professional Performance
Commentary by Barbara F. Sharf

- Vignette 4: **Physician-to-Nurse Communication** 551
Following the Golden Rule toward Respectful Relationships
Commentary by Richard Sheff

- Vignette 5: **Physician-to-Drug Rep Communication** 554
Finding the (Right) Time
Commentary by Michael E. Roloff and Rachel Malis

- Vignette 6: **Resident to Patient's Family and Attending** 559
Physician Responding to Insensitive Remarks about a Patient
Commentary by James T. Hardee

- Vignette 7: **Resident-to-Student Communication** 564
Giving Honest Feedback
Commentary by Benjamin Blatt

Upcoming Issues of *Virtual Mentor*

September: Ethical Challenges in Organ Donation

October: Ethical Decision Making in the Diagnosis and Management of STDs

November: Ethical Issues in Endocrinology

Virtual Mentor

Ethics Journal of the American Medical Association
August 2005, Volume 7, Number 8

From the Editor

Learning to Talk and Listen

Good communication is the solution, or part of the solution, in nearly every difficult interpersonal situation, whether between husband and wife, supervisor and employee, student and teacher, or patient and physician. In medicine, good communication is necessary for the establishment of a therapeutic alliance between patient and physician. Through good communication, physicians come to appreciate patients' values and expectations, which, in turn, inform treatment recommendations that are better understood by patients, and that understanding ultimately contributes to greater adherence to treatment and improved health outcomes. This is not to say that such conversations are easy, even for experienced physicians, or that they come naturally to most medical students and residents—communication skills must be learned and practiced. The need to practice—to *use*—communication skills is, in part, why the educational technology of the standardized patient (SP) is a common feature of today's medical school curriculum and has slowly gained acceptance in residency training and beyond.

In this special issue of *Virtual Mentor* on Difficult Conversations in Medicine, we feature vignettes and practical commentaries that aim to support the educational goal of helping students and physicians become better talkers and listeners. Of the 7 vignettes, 3 concern difficult conversations between physicians and patients or patients' families. The remaining 4 present situations that are not routinely, if ever, used as the basis for SP educational modules—perhaps simply because they do not involve patients. Nevertheless, the SP model can be employed in helping medical students and physicians learn to handle difficult situations that require good communication with a non-patient. One of the non-patient-based vignettes, for example, deals with how a radiologist should speak to a colleague about her concern that the colleague has misread several radiographic studies in the last 6 months. How does one even begin such a conversation without creating more tension in an already difficult situation? Read the commentary from our expert contributor, as well as a “mini-script,” designed to help readers handle this situation in real life. Other non-patient-based vignettes concern conversations between physician and nurse, resident and medical student, and physician and pharmaceutical company representative. We hope these vignettes will serve as catalysts for developing “standardized person” educational modules in medicine.

As always, and maybe especially for this issue, talk to us and tell us what you think about this special issue, because we listen and will make changes to *Virtual Mentor* that will help doctors help patients.

Sincerely,

A handwritten signature in black ink, appearing to read 'AK', with a long horizontal flourish extending to the right.

Audiey Kao, MD, PhD

Theme Issue Editors

Abraham P. Schwab, PhD, senior fellow, Institute for Ethics, American Medical Association

Phil Perry, MSJ, assistant editor, *Virtual Mentor*

The viewpoints expressed on this site are those of the authors and do not necessarily reflect the views and policies of the AMA.

Copyright 2005 American Medical Association. All rights reserved.

Virtual Mentor

Ethics Journal of the American Medical Association
August 2005, Volume 7, Number 8

Vignette 1: Physician-to-Patient Communication

Disclosing Error to a Patient

Commentary by Geoffrey H. Gordon, MD

You are halfway through a busy clinic afternoon and seeing Mr Osler, a middle-aged man with hypertension. His blood pressure diary indicates that he is above your therapeutic target, and you decide to add a new antihypertensive drug to his regimen. You write a prescription, the nurse faxes it to the pharmacy, and you move on to the next patient.

Two days later you are called by the emergency room about Mr Osler, who became dizzy while getting his morning paper. He fell on his porch, sustaining a forehead laceration. A careful evaluation showed only postural hypotension, and his laceration was closed. You arrive to say hello to him and see his medication bottles at the bedside. You are shocked to find that the hospital pharmacy dispensed the new drug at 10 times the dose you intended. You step out of the room to collect yourself and decide what to do.

Commentary

Medical errors are the eighth leading cause of death in the US, and medication errors alone cause more than 7000 deaths per year. Error can be generally defined as the flawed execution of a sound plan or the wrong plan to achieve a particular aim. Not all errors result in adverse outcomes (for example, a patient with a recorded medication allergy tolerates an erroneous dose without difficulty), and not all adverse outcomes are the result of error (for example, a pneumothorax as a known complication of subclavian vein catheterization, discussed during informed consent). A “near miss” is an error that is caught before it harms the patient.

Errors are ubiquitous and, even though we are all accountable for our performance, no one is perfect 100 percent of the time. Errors arising from one individual’s action (or inaction) are normally caught by safety checkpoints designed to identify and stop them. Errors can slip undetected, however, through “holes” in the checkpoints, such as faulty information technology, diffusion of responsibility, or poor communication. Learning when and how our patient safety systems *don’t* work is critical. This requires open communication of information, without “shame and blame” and with the goal of reducing preventable harm due to error.

Error: The Human Experience

Physicians typically respond to error with anger, shame, and fear. Mostly they fear a malpractice suit, in which patients accuse them of medical negligence and substandard

care in order to be compensated for economic losses. As a result of this fear, physicians may avoid or hide the error, become defensive, or blame others. In the long term they can experience sadness, self-doubt, and guilt.

Patients want to know that an error occurred, what happened, and how. They want the physician to express concern or offer an apology and, if appropriate, compensation for economic losses. Patients and attorneys cite communication breakdown and loss of trust, rather than substandard care, as the most common cause of a lawsuit.

Rationale for Disclosure

For decades, professional societies have endorsed disclosing errors to patients and families. This is based on the ethical principles of honesty and integrity. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) adopted error disclosure as a standard in 2001. Paradoxically, error disclosure may reduce overall malpractice costs, probably because patients often sue when they feel their physicians are avoiding them or hiding information. In Oregon, a 2003 “apology law” states that a general apology or expression of regret cannot be construed as an admission of guilt or error, and a few states are enacting laws mandating medical error disclosure.

On the other hand, disclosing errors makes patients more aware of problems and could increase the number of malpractice claims. Causality may be hard to assess. Also, it’s a difficult conversation to have.

Steps in Disclosing and Reporting an Error

1. *Make sure the patient is stable and ensure optimal care.*
2. *If you are under supervision, notify the attending physician immediately.*
3. *If the harm is severe (a patient death or wrong surgery) report it immediately to a quality assurance team or administrative official.*
4. *Gather the basic facts available at the time.* What happened and why? How did it affect the patient? What was done? What is the patient’s current condition?
5. *Consider getting help talking with the patient or family.* If you are worried, angry, or defensive it will help to have someone with you. Ideally this person would be able to speak on behalf of the hospital to offer sincere regret, support, and services.
6. *Disclose the error to the patient, his or her family, or both.* State the facts without blame or conjecture. That is, give an account of what happened, the consequences, what treatments are being given to correct the error, and the results of treatment. Let them know that you will update them as you learn more.
7. *Express empathy.* Patients are normally frightened, angry, and distrustful if harmed by a medical error. Your behavior and response to the error affects their perception of what happened. Explain that the event was not expected or intended, that their feelings are understandable given the circumstances, that they are doing the right thing by seeking information, and that you are there to support them. Express regret for what happened and offer a personal apology if appropriate.

8. *Let the patient know that your goal is to make sure that he or she gets the very best care possible.* Tell the patient that you are doing everything you can to learn how the error happened and to make sure it doesn't happen again to him or her or to anyone else.

9. *Express a desire to continue providing care* and hope that the patient can trust you and your team to do so.

10. *Report the error to your quality management department* (usually with an incident report). If this was not a severe harm case, this can take place in the first 24 hours. The result may be a critical event review, or "root cause(s) analysis," to find and repair the "holes" in the patient safety system. Unfortunately many still view these as disciplinary actions rather than as means to improve patient safety.

11. *Write a note in the medical record documenting what happened, the impact on the patient, treatment provided, and results.* You can include who was told about it, what they were told, and when. The clinical record is the wrong place to guess what happened or to blame others.

12. *Items that should not be disclosed or documented in the clinical record include names of individuals or disciplinary actions taken, results of critical events or peer reviews, and consultations with attorneys or insurers.*

A primary goal of error disclosure and reporting is preventing future harm to future patients. Patient safety is an ethical duty, as important as duty to individual patients. However, fear of blame and malpractice suits often suppresses error reporting and disclosure and drives it underground. National and regional efforts are under way to remove blame from considerations of patient injury and compensation [1, 2].

Coda

You call the pharmacy, and hear that they dispensed the dose that was on the prescription, and they fax back the prescription to prove it. You see that you wrote a decimal point that you think is clear, but the pharmacist and ER nurse disagree. You are angry that no one questioned the prescription or called you about it. You call the patient advocate for advice.

The patient advocate arrives, empathizes with you about the situation, and says Mr Osler should be told what happened. She offers to help with the conversation and accompanies you to the bedside. When you return to Mr Osler's room, he is relaxed and comfortable, and his blood pressure is normal. You tell him that you wrote a prescription that some people were unable to read, and that, as a result, he received more of the medicine than you intended. Mr Osler is furious and blames you for almost killing him. You tell Mr Osler that his dizziness and fall were most likely side effects of the higher-than-intended dose but that no further side effects are anticipated. There are no long-term consequences of the unintended high dosage, you say. You apologize and tell him that you didn't intend for this to happen.

The patient advocate empathizes with Mr Osler, reassures him of your good intentions, and asks what other concerns he has now. He is worried about his dogs that are home alone and about the bill for the ambulance ride. The patient advocate

says that she will call a neighbor to care for the dogs and promises to see if the hospital can help with the bill. You explain to Mr Osler that what happened to him has shown the hospital it must speed up implementation of computer-entry orders, which should reduce these kinds of errors. When Mr Osler is calm, you express interest in continuing to be his physician. He thanks you for being honest and says he will give you another chance. You carefully rewrite his prescription, explaining the new dose and follow-up.

References

1. S.544 – A bill to amend title IX of the Public Health Service Act to provide for the improvement of patient safety and to reduce the incidence of events that adversely effect [sic] patient safety. *Bill Summary & Status for the 109th Congress*. Available at: <http://www.congress.gov/cgi-bin/bdquery/z?d109:SN00544:@@L&summ2=m&>. Accessed July 25, 2005. Congress passed S 544 on July 27 and sent it to the President to sign into law.
2. SorryWorks, for example, is an Illinois initiative to provide compensation for patients injured by care without resorting to lawsuits. Available at www.victimsandfamilies.com/Sorry.phtml. Accessed July 26, 2005.

Suggested Readings

Beckman HB, Markakis KM, Suchman, AL, Frankel RM. The doctor-patient relationship and malpractice: lessons from plaintiffs' depositions. *Arch Intern Med*. 1994;154:1365-1370.

Elder NC, Dovey SM. Classification of medical errors and preventable adverse events in primary care: a synthesis of the literature. *J Fam Pract*. 2002;51:927-932.

Gallagher TH, Waterman AD, Ebers AG, Fraser VJ, Levinson W. Patients' and physicians' attitudes regarding the disclosure of medical errors. *JAMA*. 2003;289:1001-1007.

Kraman SS, Hamm G. Risk management: extreme honesty may be the best policy. *Ann Intern Med*. 1999;131:963-967.

Wu AW, Cavanaugh T, McPhee SJ, Lo B, Micco G. To tell the truth: ethical and practical issues in disclosing medical mistakes to patients. *J Gen Intern Med*. 1997;12:770-775.

Geoffrey H. Gordon, MD, is an associate professor of medicine and psychiatry and director of the John Benson Program on Professionalism at Oregon Health and Science University in Portland, Oregon.

The viewpoints expressed on this site are those of the authors and do not necessarily reflect the views and policies of the AMA.

Copyright 2005 American Medical Association. All rights reserved.

Virtual Mentor

Ethics Journal of the American Medical Association
August 2005, Volume 7, Number 8

Vignette 2: Physician to Patient in Clinical Trial

Hoping for the Best, Preparing for the Worst

Commentary by Frederic W. Platt, MD

A patient of yours with prostate cancer has been given a prognosis of 4-6 months and has enrolled in a Phase II clinical trial. In discussing the research protocol with him, you have repeatedly emphasized there is no guarantee of therapeutic benefit. The patient, however, discusses the potential for long-term plans, now that he's "part of the study." How should you, as his clinician, communicate that the study may not change the prognosis?

Commentary

One can imagine the conversation:

Patient: I'm really glad you got me on this new medicine, Doctor. After I do the first 6 months, I'm going to go on an elderhostel trip to the Greek Isles. I've sent them my payment.

Doctor: Oh my, I'm not sure that's so good an idea, John.

Patient: Oh, don't you worry, Doctor. I'm going to do just fine.

We want to have our cake and eat it too, don't we? We want our patients to be hopeful enough to enlist for research protocols and yet "realistic" enough to accept our limited expectations for them. We mourn when our patient loses hope but when he has hopes that exceed ours, we say he is in denial. So how can we approach this patient whose expectations differ so greatly from ours? We must prepare ourselves to address this divergence of opinion.

First, look inward.

In preparing for all difficult encounters, our first task is to look inward, to consider our own ideas and feelings [1,2]. My self-analysis of this situation would sound something like this: I am concerned that my patient has unrealistic expectations about the benefit of this research protocol. I am worried: worried that the actual outcome will not please my patient or his relatives; worried that my patient may reject proven treatment because of inflated hopes for an experimental treatment with low probability of success; worried that I will have to tell him some bad news, hence threatening his hope; worried that I may have to endure his anger, should his disease continue to progress, at what he could perceive as a betrayal by me or the medical system. I surely don't want to replace his hopefulness with despair or anger. Perhaps I am also angry—angered that this study or perhaps that my research colleague has led

the patient on; angry that now my interchanges will take much more time. I may be sad, already grieving this patient's death. Yet I am glad that the patient is here, still coming to me, willing to work with me.

Besides my feelings, my picture of reality may include the observation that even our pessimistic estimates of life expectancy are often still far too optimistic. Physicians tend to overestimate time-left by a factor of 2 to 5 [3]. And our patients are often even more optimistic. Disappointing and unanticipated outcomes for patients often stem from the misalignment of expectations between physician and patient [4]. The unrealistic expectations that patients hold probably explain more unanticipated outcomes than do other phenomena such as biological variability, rare outcomes, and even errors of the individual clinicians and of the systems in which we work.

Ask the patient.

Once I have sorted out my own feelings, I want to learn more about the nature of my patient's hope. I know it is important and therapeutic to make efforts to understand my patient and to let him know that I have heard and understood him. So I will have to begin my response to his surge of hopefulness with acknowledgement of his feelings [5-7], I may say, for example, "Sounds like you're feeling a lot more hopeful since we discussed this research study." Only after demonstrating that I have observed his state of mind will I proceed to my concerns, and then I want to inquire about his specific hopes, beginning with, "Can you tell me more about your hopes for the future?"

Doctor: So John, can you tell me more about your hopes for the future?

Patient: What do you mean, Doctor?

Doctor: Well, I hear that you have a trip planned to the Greek Isles.

Patient: Yeah, me and my wife have always wanted to do that.

Doctor: I see. And you've probably got some other things you want to do.

Patient: Like what?

Doctor: Well, even though we're hoping that you have a lot of time left, what if your life were a matter of a few months? Are there people you'd want to talk to? Things you want to accomplish?

Patient: Oh, I see what you mean. Yeah, there's my sister in New York. I haven't talked to her for years.

Doctor: So maybe talking with your sister, going to Greece. What else?

Patient: Well, you know if this was the end, mostly I'd like to be at home with my wife.

Doctor: Those all sound reasonable. Any other hopes?

Patient: No, Just to be comfortable and not in a lot of pain.

Doctor: OK. I think I understand now.

I often recommend a policy of hoping for the best while preparing for the worst [8,9]. In this case I will recommend this policy to my patient and the person he has designated to make medical decisions for him if he is incapacitated, the person with “durable power of attorney for health care.” Using the “educational sandwich”—Ask, Tell, Ask—I will ask my patient to describe the scenarios he foresees and how he sees his options in all those situations. I will inquire about what other sources of comfort and hope he has. Maybe I will have little to tell him after I discover the various scenarios he envisions. If I do give him information about the course of his disease, I will ask him and his companion what they understood of my explanations and suggestions. I might phrase my post-explanation question like this: “I am not sure I explained my ideas very clearly. Can you tell me what you heard so I can clarify [10,11]?”

Doctor: John, perhaps it would help for me to tell you how I like to think about situations where we can’t be 100 percent sure, like yours.

Patient: Sure, Doc. Go ahead.

Doctor: Well, I like to suggest hoping for the best, like doing that Greece trip, while preparing for the worst, like if you were too sick to go on the trip.

Patient: Yeah, I can understand that. But are you telling me that I won’t last that long?

Doctor: No, I sure don’t know that. But it is really hard to predict the future. It could go either way.

Patient: I see. Well, OK, I’ll hope for the best and make plans but I will also contact my sister and talk to my wife about how I’d like to be taken care of if things get worse.

Doctor: Sounds like a good plan! So thinking about how things might go if they weren’t so good, what about talking with someone from our Hospice department so you and your wife would know what they had to offer just in case you needed their help in the future.

Patient: Yeah, I could do that. But I think I’m going to surprise you. I’ll send you a picture of the Parthenon yet!

Doctor: I sure hope so! And I’ll do whatever I can to make that happen.

Patient: Thanks, Doc. I’m really glad you’re my doctor.

Doctor: Me too. Oh, and there is one more thing that I don’t think we’ve discussed yet. If you are ever in a position where you couldn’t tell me your wishes, whom should I turn to to best represent your wishes?

Patient: Oh, that would be my wife. She’s my agent. She signs the checks, decides what we’re going to eat, everything.

Doctor: OK. Well, that's about all I've got on my mind. Can you sum all this up so I see if I said things that made sense?

Patient: Sure. You want me to hope for the best but plan for the worst. So I can plan the trip but better talk with my sister. You want us to talk with the hospice people and if I'm ever out of it, my wife will tell you what I would have wanted. Is that it?

Doctor: Perfect!

Breaking the News

Are we obliged to make efforts to “correct false hope?” I think not. I think our task is to hear the patient, understand the patient, communicate evidence of understanding, and ask the patient for his thoughts about our task, about what he would most like from us. But if we think he is expecting something from us that we clearly cannot deliver, we may have to tell him that, in the style of giving bad news. Most doctors are quite accustomed to the task of giving bad news. When asked how they do it, they frequently mention these strategies [12,13]:

1. Prepare yourself—gather the needed information, get your own feelings under control, be ready to be present when the patient expresses strong feelings. Make sure you have time and will not be interrupted (turn off electronic interrupting devices like cell phones.) Fire a “warning shot” to prepare the patient for upcoming bad news. Find a quiet, private place to have the conversation. Ask the patient if he would like someone else in on the conversation.

2. Sit down. Eye contact helps. Be able to touch the patient.

First ask the patient what he already knows and what his concerns are. Then deliver the news bit-by-bit and ask the patient for his understanding of what you said. (Use the ask-tell-ask model.)

3. Listen and watch for emotions, ideas, and the patient's values. Then try to let the patient know you heard and understood what he or she has said. Empathic communication requires not only that we listen, watch, and understand, but also that we reflect that understanding so that the patient knows it.

4. Recognize that the communication of bad news is not a one-time-event. Your patient will likely retain little of what you told him, and the conversation will have to be held again and perhaps several times. It is not done when the conversation ends.

Reassurance

Finally, we can reassure our patient. Not the false reassurance that suggests that things are not as bad as the patient thinks, or that they are not as bad as the patient is making them out to be. But we can reassure our patients that we will be back, that we will be present with them, that we will be available, and that we will not abandon them if their disease progresses. The promises we make must be those we can deliver on. If our patient is helping us in our research studies, we can repay him with our availability. We can provide our cell phone number, our home phone number, and a promise to

respond to him when he needs us. That promise may be all we can offer, but it is worth a great deal.

Doctor: John, of course I'm not sure of exactly what the future will bring.

Patient: No, of course not, Doctor.

Doctor: So what I'd like to promise you is that I'll be with you. In fact, I'd like to give you my phone numbers so you can get hold of me if you need to—my home number and my cell phone number.

Patient: That's kind of you, Doctor. I won't bother you unless I need you.

Doctor: I know. Here they are. Meanwhile, let's have you come back as this research protocol asks, in 2 weeks.

Patient: OK, Doctor. See you then.

References

1. Epstein R. Mindful practice. *JAMA*. 1999;282:833-839.
2. Novack DH, Suchman AL, Clark W, Epstein RM, Najberg E, Kaplan C. Calibrating the physician: personal awareness and effective patient care. *JAMA*. 1997;278:502-509.
3. Christakis NA, Lamont EB. Extent and determinants of error in doctors' prognoses in terminally ill patients: prospective cohort study. *BMJ* 2000;320:469-473.
4. O'Connell D, Kemp White M, Platt FW. Disclosing unanticipated outcomes and medical errors. *J Clin Outcome Manage*. 2003;10:25-29.
5. Barrett-Lennard GT. The phases and focus of empathy. *Br J Psychol*. 1993;66:2-14.
6. Coulehan JL, Platt FW, Egener B, et al. "Let me see if I have this right"—words that help build empathy. *Ann Intern Med*. 2001;135:221-227.
7. Platt FW, Gordon GH. Building rapport: empathy, the universal tool. In: Platt FW, Gordon GH, eds. *The Field Guide to the Difficult Patient Interview*. 2nd ed. Philadelphia: Lippincott, Williams and Wilkins. 2004:21-29.
8. Back AL, Arnold RM, Quill TE. Hope for the best, prepare for the worst. *Ann Intern Med*. 2003;138:439-443.
9. Platt FW, Gordon GH. Hope. In: Platt FW, Gordon GH. *Field Guide to the Difficult Patient Interview*. 2nd ed. Philadelphia; Lippincott, Williams and Wilkins; 2004:131-133.
10. Silverman J, Kurtz S, Draper J. Exploring and planning. In: *Skills for Communicating with Patients*. 2nd ed. Oxford: Radcliffe Publishers; 2005:158-159.
11. Gordon GH, Duffy FD. Educating and enlisting patients. *J Clin Outcome Manage* 1998;5:45-50.
12. Baile WF, Buckman R, Lenzi R, Glober G, Beale EA, Kudelka AP. SPIKES—a six-step protocol for delivering bad news. *Oncologist*. 2000;5:302-304.
13. Quill TE, Townsend P. Bad news: delivery, dialogue, dilemmas. *Arch Intern Med*. 1991;151:463-468.

Suggested Reading

American Medical Association. *Code of Medical Ethics*. Opinion 8.0315. Managing Conflicts of Interest in the Conduct of Clinical Trials. Available at: http://www.ama-assn.org/apps/pf_new/pf_onlinef_n=browse&doc=

policyfiles/HnE/E8.0315.HTM&&s_t=informed+consent&st_p=0&nth=1&catg=AMA/HnE&catg=AMA/BnGnC&catg=AMA/DIR&prev_pol=policyfiles/HnE/E-7.05.HTM&nxt_pol=policyfiles/HnE/E-8.01.HTM&. Accessed July 25, 2005.

Frederic W. Platt, MD, is clinical professor of medicine at the University of Colorado and was director of communication training for first-and second-year medical students during the past 6 years. He is a regional consultant for the Bayer Institute for Health Care Communication.

The viewpoints expressed on this site are those of the authors and do not necessarily reflect the views and policies of the AMA.

Copyright 2005 American Medical Association. All rights reserved.

Virtual Mentor

Ethics Journal of the American Medical Association
August 2005, Volume 7, Number 8

Vignette 3: Colleague-to-Colleague Communication

Frame Feedback to Improve Professional Performance

Commentary by Barbara F. Sharf, PhD

You are a radiologist in a hospital-based group practice. While one of your partners is on vacation, an internist calls you because your partner read a head MRI for one of his patients a short while ago. The internist is concerned because his patient's headaches are becoming worse, and she is now developing visual field deficits. Before considering a second MRI, the internist would like you to review the first one. When you get off the phone, you pull the patient's (Mrs Kirk's) MRI; there is a suspicious "spot" in the pituitary gland that you think called for further evaluation. This difference of opinion has happened twice before with radiographic studies that were originally read by your partner and reviewed by you over the last 6 months. You think he is making some obvious omissions in his readings, and you recognize that something must be done. Patient safety could be at risk. You decide that the best course of action is to talk to your partner as soon as he returns from vacation. What do you say to him and how do you say it?

Commentary

There's no getting around it—this is an unpleasant interpersonal situation, and one of ethical concern for patient well-being. Typically, physician colleagues enact a professional relationship of co-equal status and power. You have no authority to monitor your partner (Dr M), nor do you have any desire to regulate your fellow physicians. On the other hand, the practices of clinical consults and second opinions have developed to provide a system of checks and balances in patient care so that the judgment of one practitioner is open to scrutiny, questioning, and feedback from others. The hoped-for result is the best care available for the patient. This situation with your partner is functioning like a second opinion. It is not unusual for physicians to differ in their judgments, thereby triggering dialogue and reconsideration of options. It *is* unusual to discover a pattern of obvious clinical errors; and, in this case, you feel ethically obliged to do something about this problem before it is repeated with other patients. But what constitutes "doing something"? Calling your peer to task looms as a distasteful event.

Define goals.

The first knotty question to be considered is: what is the goal of this conversation? Put another way, what do you hope to accomplish by confronting your colleague? An overarching goal is to get Dr M's full attention and to mutually negotiate a constructive response. Examples of constructive responses might include a promise from Dr M to conduct a supervised review of his work and to contact treating

physicians if they've been given incorrect information. You may also have concerns about your colleague. While you have no more desire to be his therapist than his police officer, it would be useful to know to what he attributes this pattern of errors; if there is a difficulty beyond carelessness (eg, incompetence, depression, substance abuse, unusual stress, etc.), then it will become important to urge Dr M to seek help for himself.

Such goals assume 2 willing participants engaged in civil conversation. What if Dr M is defensive, angry, in denial, or otherwise unwilling to talk? The intimidating tape of a tense phone interchange between Dr M and Dr Y (alias, you) keeps playing in your head:

Dr Y: Dr M, this is Dr Y. I'd like to talk with you about your findings on Mrs Kirk, a patient whose MRI we both reviewed recently.

Dr M: OK, shoot. What's on your mind?

Dr Y: I was hoping we might be able to talk in person about this matter. Should take about 20 minutes or so.

Dr M: (*beginning to sound annoyed.*) Sorry, I'm really booked today. If you have something to say, let's hear it.

Dr Y: (*also a bit annoyed.*) Well, to be honest, when I reviewed your report on Mrs Kirk, I found a spot on her scan that you had overlooked. The internist who ordered the MRI called me to discuss further testing. And, unfortunately, this isn't the first time I've found similar errors in your work.

Dr M: (*abruptly*) Fine, Dr Y. I'll take a second look at Mrs Kirk's MRI. But in the future, I'd appreciate your concentrating your efforts on your own work. I'm perfectly capable of overseeing my write-ups, thanks!

What steps can be taken to avoid this type of hostile exchange and to facilitate as productive an encounter as possible? There are no guarantees, of course, when it comes to dealing with individual personalities, but there are well-established guidelines for communicating feedback, including critical constructive or corrective feedback. Though these guidelines have been developed primarily in the context of educational and managerial settings [1, 2], the practice of medicine has often been framed as a lifelong educational venture. Thus, it's helpful to realize that even seasoned practitioners can benefit from peer commentary and advice, if provided in a sensitive and thoughtful manner. So how can critical feedback be communicated constructively?

- *Effective feedback is timely, but not sprung on the recipient as a surprise attack.*
- *It is communicated in an environment conducive to an undisturbed and private interpersonal exchange.*
- *It is framed as problem-solving between allies with common goals, as opposed to one person attempting to condemn or control the actions of another.*

In the preceding imagined dialogue, Dr Y had an appropriate instinct to meet with Dr M personally to talk about Mrs Kirk's case; a planned face-to-face meeting would have been preferable to an off-the-cuff phone conversation, which lacks many nonverbal, relational cues (an even bigger problem in e-mail messaging). However, Dr Y didn't

realistically assess the difficulty of setting up such a meeting, especially with the opening gambit of discussing “your” (Dr M’s) findings, which does not connote conjoint problem-solving. Timeliness was out of Dr Y’s control, since Dr Y had already been contacted by the treating physician.

- *Feedback should be conveyed in descriptive, rather than evaluative, language.*
- *It should be anchored in firsthand specific data, limited to a few key points, rather than vague generalizations or overwhelming amounts of information.*
- *The person offering feedback may include subjective reactions, as long as these are acknowledged as personal feelings and not statements of fact.*

Even in this brief interchange, there is a good deal of evaluative language, in which Dr Y labels Dr M’s work as error-prone. Had this meeting occurred in person, there would have been opportunity for these 2 to jointly examine the MRI (the firsthand data). Dr Y may also have been more successful in engaging Dr M had she expressed her personal concerns for both the well-being of Mrs Kirk and Dr M.

- *The recipient should have adequate opportunity to respond and contribute to problem-solving.*
- *It should be focused on remediable behaviors, resulting in improved decisions and outcomes.*

After having been negatively evaluated, rather than engaging in problem-solving for the benefit of the patient, Dr M is focused on exiting this conversation—not on addressing potentially serious problems. There’s been no discussion about making future positive changes.

Using these guidelines to inspire a dialogue that doesn’t arouse defensiveness, let’s imagine another possible exchange between Dr Y and Dr M:

Dr Y: Thanks for agreeing to meet with me to discuss our differing interpretations of Mrs Kirk’s MRI. I’m glad we could find a mutually agreeable time.

Dr M: Yeah, I appreciate the heads up. I’ve had a chance to compare our 2 reports. I agree there’s a spot that probably bears further investigation. I’ve called the treating physician to discuss my revised assessment and to let him know that you and I concur.

Dr Y: I see. Well, that relieves a large part of my concern.

Dr M: OK.

Dr Y: Something else is nagging at me.

Dr M: OK, shoot.

Dr Y: Well, I’ve noticed that our readings have differed in 3 of the last 4 images we’ve both examined. It concerns me because these differences raise questions about optimal patient care.

Dr M: Really? What cases? Were they like what we’ve been discussed about Mrs Kirk’s case?

Dr Y: Yes, roughly the same kinds of things.

Dr M: I don't know what to say.

Dr Y: In the past, we've agreed upon our readings quite well. I'm wondering whether something out of the ordinary is going on with you recently.

Dr M: Well, I have to admit that, lately, I've had some major stress at home with a very sick child. I like to think of myself as a very careful reader, and I don't want to put anyone at risk.

Dr Y: I wonder if it would help to go through the previous 2 images together and see if we can come to agreement on them as well? Also, we should discuss if there's anything I or other folks in the department can do to help while you're having this extra stress at home.

Dr Y: That would be a great help. I appreciate your taking the time to talk to me about this.

Even though this conversation went very well, what should you do if Dr M continues to make clinical errors? Reporting him to a quality assurance committee is always a final resort, but needn't be the first course of action. This case reveals a real and important tension between a physician's ethical obligation to ensure accuracy in patient diagnosis and treatment while providing corrective feedback to colleagues in a constructive, collaborative manner. Thoughtful communication that does not put colleagues on the defensive is most likely to result in improved performance.

References

1. Ende J. Feedback in clinical medical education. *JAMA*. 1983;250:777-781.
2. Gibb JR. Defensive communication. *J Commun*. 1961;11:141-148.

Barbara F. Sharf, PhD, is a professor in the Department of Communication at Texas A&M University, College Station, Texas.

The viewpoints expressed on this site are those of the authors and do not necessarily reflect the views and policies of the AMA.

Copyright 2005 American Medical Association. All rights reserved.

Virtual Mentor

Ethics Journal of the American Medical Association
August 2005, Volume 7, Number 8

Vignette 4: Physician-to-Nurse Communication

Following the Golden Rule toward Respectful Relationships

Commentary by Richard Sheff, MD

An ICU nurse consistently informs, you, the junior resident, that he would have handled a particular problem or conversation with a patient differently, often explaining what he would have done instead. This morning, he started to correct you in front of a patient but was interrupted by the entrance of the patient's primary care physician.

Commentary

Communication between a doctor and a nurse should be simple. Both are highly trained professionals. Both share a commitment to providing excellent care to the same patient. Both need each other to make this happen. Then why does it go wrong so often?

This clinical vignette may help us answer this question. The first thing that should strike you about this scenario is that it is unusual. Why? Because most nurses are not comfortable telling a physician, even a junior resident, that he or she would have handled a problem differently. Not that nurses don't think physicians should do things differently. Just ask them. You'll get an earful, and it will probably be enlightening. Yet physicians almost never ask nurses for input or feedback. In fact, lesson number 1 from this scenario is that developing physicians should ask nurses for input more often than we do. As young physicians we too often believe we are supposed to be all-knowing. We are afraid that asking for input or feedback, especially from a nurse, will undermine our authority or will tarnish our persona. We are not all-knowing, not as medical students and residents, and not even as senior physicians. Willingness to listen to others, especially experienced nurses who are part of our patient care team, is a sign of a mature physician.

Respectful Relationships

If the nurse and the ICU junior resident have an effective, collegial relationship, then, although it's unusual, the frank feedback may be welcomed as part of an exchange between 2 knowledgeable clinicians. In this case, the nurse made the mistake of carrying out the clinical exchange in front of the patient. Should you, the junior resident, address this in front of the patient as well? Of course not. You didn't appreciate it when the nurse did this to you, so why do you think the nurse would feel any different? If you let your ego get in the way, you may have an impulse to embarrass the nurse in front of the patient with some sort of public dressing-down. All too often physicians act this way. Whether striking back to defend their stature as physicians or in a misguided effort to "teach the nurse a lesson," physicians sometimes criticize, humiliate, and embarrass nurses in front of patients.

Do Unto Others

Instead, this is a moment to treat the nurse exactly as you would want to be treated. Complete the clinical interaction with the patient and leave the patient's bedside. Then, in a quiet and collegial manner, ask to speak with the nurse alone. If this is a first-time event, it is appropriate to begin this interaction with a question from one colleague to another, such as:

Junior resident: You began to correct me in front of that patient just now. This is unusual, so I was wondering why you did that.

You may be surprised to hear something like:

Nurse: "I was concerned you were about to make a mistake that would have led to a patient injury. Our patient safety protocol requires us to speak up when this occurs."

If this is the response, you could say the following:

Junior resident: Thanks for speaking up, but should a similar situation arise in the future, please ask to speak to me away from the patient.

You may want to develop a code phrase the nurse could use that would alert you to his concern and trigger an immediate pause in the clinical interaction to obtain the nurse's input before proceeding.

To this day, nurses often do not feel empowered to address physicians directly when they see a medical error unfolding. Instead, all they feel comfortable doing is "hinting and hoping." The patient safety movement is changing this, providing structured communication tools between doctors and nurses that reduce errors. As physicians, we should welcome this change, not be threatened by it.

Dysfunctional Relationships

So far we have assumed this scenario represents a collegial, respectful relationship between doctor and nurse. But it is also possible that we are catching a glimpse into a dysfunctional doctor-nurse relationship. If this is the case, then we should ask why the nurse feels a need to consistently tell you, the junior resident, what he would have done differently. Sometimes physicians and nurses get into power struggles. Sometimes personalities clash. Whatever the underlying cause, a mature physician should still treat this nurse as he or she would want to be treated. This means asking to speak to the nurse privately and raising the concern as colleagues. Listen to the feedback thoughtfully. You may agree with it or disagree, and either is OK. You should then take this opportunity to state clearly that a disagreement like this should never be carried out in front of a patient. As previously mentioned, you may need to arrange a signal that allows the nurse to keep you from making an error and provides the 2 of you an opportunity to step into a private location for an exchange about the best way to proceed.

If this approach does not work, meaning either the nurse does not accept the feedback professionally or the nurse's behavior continues, it is important for the physician to recognize that this nurse has a boss, and it is not the ICU junior resident. So you

should work through the nursing chain of command, beginning with the nurse's immediate boss, who is usually a unit manager or supervisor. You should speak directly to this person, reporting either the individual event or the pattern of behavior and ask the manager or supervisor to help solve the problem with the nurse. If this exchange fails to resolve the issue, the physician should go either to the manager or supervisor's boss or to the chief resident and ask that person to address the problem. (If it had happened to an attending physician, he or she would report it to the department chair.) In each of these exchanges, the physician should maintain a professional demeanor, without the need to raise his or her voice.

So why do doctors and nurses fail to communicate well? The answer is failure to follow the golden rule. If someone else doesn't follow this principle, that doesn't justify your throwing it aside. Always treat others in the clinical setting as you would want to be treated, and you will be respected, appreciated, and effective.

Suggested Reading

American Medical Association. *Code of Medical Ethics*. Opinion 9.045 Physicians with Disruptive Behavior. Available at: http://www.ama-assn.org/apps/pf_new/pf_online?f_n=browse&doc=policyfiles/HnE/E-9.045.HTM&&s_t=&st_p=&nth=1&prev_pol=policyfiles/HnE/E-8.21.HTM&nxt_pol=policyfiles/HnE/E-9.01.HTM&. Accessed July 25, 2005.

Richard Sheff, MD, is chairman and executive director of the Greeley Company, a division of HCPro, Inc. in Marblehead, Massachusetts. The Greeley Company is a physician-led, national consulting and education company serving hospitals, medical staffs, and physician organizations across the country.

The viewpoints expressed on this site are those of the authors and do not necessarily reflect the views and policies of the AMA.

Copyright 2005 American Medical Association. All rights reserved.

Virtual Mentor

Ethics Journal of the American Medical Association
August 2005, Volume 7, Number 8

Vignette 5: Physician-to-Drug Rep Communication

Finding the (Right) Time

Commentary by Michael E. Roloff, PhD, and Rachel Malis, MA

A pharmaceutical company representative drops off samples at Dr Mann's office about every 2 weeks. Dr Mann uses the samples and wants to keep receiving them. The rep always asks to talk with Dr Mann in person and lingers in the office until Dr Mann makes time between patients to shake hands and chat for a few minutes. Dr Mann wants the drug company rep to know that he does not want to talk with him each time he visits; the rep's lingering presence in the office is, at best, distracting and, at worst, annoying to the staff and reduces the time Dr Mann has to spend with patients.

Commentary

This scenario is not uncommon. In a study regarding physicians' perceptions of the pharmaceutical industry, almost 40 percent of the physicians indicated that they found pharmaceutical reps too pushy and aggressive [1]. The key question in this case is how Dr Mann should confront the rep about his behavior. We first focus on how Dr Mann should prepare for the confrontation and then we discuss how he should carry it out.

Preparation

After observing an inappropriate behavior, individuals often begin by thinking about how to confront the other party. Those who engage in prefrontation planning report a number of benefits including that they are better able to fluently present their position, stay in emotional control, and respond to the transgressor's statements than are those who do not rehearse [2]. When planning how to confront the drug rep, Dr Mann must focus on how to achieve 2 interaction goals. First, he must express his concerns clearly and efficiently, and second, he must do so in a socially appropriate manner [3]. Unfortunately, the manner in which he tries to achieve 1 goal may reduce the likelihood that he will accomplish the other. Efficiency is often achieved by speaking directly to the issue at hand. Dr Mann may speak with certainty about his perspective on the rep's behavior and tell him to stop. Such behavior achieves clarity but appears to attack the transgressor's image and therefore is perceived to be socially inappropriate. Indeed, confrontations often lead to destructive argument cycles wherein one person demands that the other change, and the other stonewalls by becoming nonresponsive, or one person's complaints prompt the other to countercomplain [4]. The net result of such cycles is that no agreement is reached and relationships are damaged. Therefore, to avoid a negative cycle, Dr Mann needs to think about efficiency and social appropriateness when preparing an opening line and constructing arguments.

Opening Line

What Dr Mann initially says to the rep can set the tone for the remainder of the confrontation. Research indicates that Dr Mann will be most effective if he follows 5 rules:

1. He should begin the conversation by being assertive, but not accusatory. Assertive language takes the form of “I” statements that indicate that Dr Mann takes responsibility for his views or feelings about the situation (eg, “I am falling behind in my appointments.”) whereas accusatory language is expressed through “you” statements wherein he blames or demeans the rep (eg, “You are causing me to fall behind in my appointments.”). Confrontations that begin with “you” statements cause others to feel greater anger, defiance, irritation and alienation, and less sympathy than do “I” statements [5].
2. Dr Mann should be willing to share responsibility for the problem (eg, “We have been meeting too much.”) rather than shifting the responsibility solely onto the rep. (eg, “You have been meeting with me too much.”) Statements in which the speaker expresses shared responsibility with another are viewed as more effective and socially appropriate than are those that attach all of the blame to the other [6].
3. Dr Mann should avoid using strong emotional descriptions (eg, “You are really making me angry.”) to describe how he feels about the rep’s behavior. Research indicates that the use of the term “anger” in an opening line causes another to feel greater anger and defiance than simply stating that one feels distressed [5].
4. Dr Mann should clearly indicate in his opening statement (a) the problematic behavior, (b) the consequences of the behavior, and (c) his feelings about it (eg, “Our meetings are distracting me from meeting with patients, and that bothers me.”). These 3 statements capture the core of Dr Mann’s concerns, and research shows that including all 3 make another more open to the complaint and willing to change [7].
5. Finally, Dr Mann should be empathic (eg, “I know you are trying to provide me with updated information about your products, but our meetings are getting in the way of helping my patients.”). Often others have a legitimate reason for their behavior and expressing concern for that viewpoint leads to a less negative view of the confronter [8].

Having described some guidelines, how should Dr Mann initiate the confrontation? Here is an example: “I have been meaning to talk to you about a problem I have in my office that you can help me resolve. Lately, my staff and I have had difficulty getting through our scheduled patient visits and this really bothers me. So many other meetings are happening during the day, it is hard for us to efficiently give our patients the attention they need. For the sake of our patients, I must do something to insure time for their appointments. Although our meetings are often helpful, we can’t meet each time you stop by the office. Even our brief conversations throw off the schedule. I would be grateful if from now on you check with my receptionist about our appointment schedule and whether there is available time for us to talk. If we are completely booked, then we won’t be able to meet—even for a short time. I have to get the office back on schedule.”

Notice that the statement clearly identifies the problem, consequences, and solution. It does not hold the rep personally responsible for the problem and indicates that, at certain times, such meetings are appropriate and enjoyable.

Constructing Arguments

A confrontation typically does not end with the opening statement and sometimes the other person chooses to argue the point. Hence, Dr Mann needs to anticipate possible replies and to prepare responses that acknowledge the rep's point of view while maintaining Dr Mann's initial stance.

Based on research on confrontations, here are potential responses from the rep with possible replies [2].

1. The drug rep may indicate that he had no idea that his visits were disruptive and that he did not intend that to be the case.
Dr Mann's reply: "I know that you did not mean to create this problem and by checking ahead, we can prevent it from occurring in the future."
2. The rep may attempt to justify his frequent contact by noting the importance of passing along new information about products.
Dr Mann's reply: "You are a valuable resource to me and I appreciate that. Many of our discussions, however, have little to do with medicine and we cannot afford to continue them."
3. The rep may attempt to minimize the problem by noting that he only "pops in to say hello for a little while."
Dr Mann's reply: "Most of our conversations start that way but more often than not, we talk for much longer."
4. The rep may try to deflect personal responsibility by explaining that such contacts are encouraged by his supervisor and that to keep his job, he must do them.
Dr Mann's reply: "I understand that you have a job to do but you would have more of my attention if we talked at more appropriate times."
5. The rep could try to "turn the tables" by either chastising Dr Mann for not raising this issue sooner or by insisting that Dr Mann encouraged such visits. This is the most difficult since the rep is now blaming Dr Mann. In such a case.
Dr Mann's reply: "I enjoyed our discussions and I saw no reason to raise this issue until they became a problem. Now they are and we must do something about them."

When anticipating reactions and preparing responses, Dr Mann should create clusters of arguments that can be used flexibly once the conversation begins rather than articulated in a scripted sequence [10]. In other words, he should not prepare as though he will say "x," the rep will respond with "y," and then he will counter with "z." Confrontations are rarely that predictable. It is better to prepare for a variety of sequences.

Confronting

Research suggests that Dr Mann should be mindful of a number of things as he approached the conversation with the drug rep. First, he should avoid negative start-ups. Often individuals will initiate a confrontation when they are angry, which increases the likelihood that they will be too forceful, causing the other person to feel under assault and prompting defensive behavior [11]. Hence, he should avoid initiating this discussion on days when he is stressed or when the rep's behavior has been especially annoying. Second, once the discussion begins, it is important for Dr Mann to stay in emotional control. That means he should avoid reciprocating the other person's negative emotional behavior and, instead, enact behaviors to help assuage the person's negative emotional reactions [12]. For example, if the rep raises his voice, Dr Mann should continue to discuss the issue in a calm tone. Third, Dr Mann must manage the process. Indicate to the rep when the conversation is getting out of hand and suggest more appropriate approaches to discussing the problem [13]. "We aren't getting anywhere by arguing. Let's stop, think about some solutions and meet later to discuss them." Finally, stay focused on finding a mutually acceptable solution rather than on parsing blame for the problem. For example, "We aren't getting anywhere by blaming each other. We both want to help patients and I think we can find a way to do our jobs so that can happen. I am willing to listen to your solutions." Blaming is a *destructive* sequence whereas finding a solution is *constructive* [14].

Clearly, confrontations are risky endeavors, but when done skillfully they can effectively prevent or stop problematic behavior.

References

1. Creyer EH, Hrsistodoulakis I. Marketing pharmaceutical products to physicians. *Mark Health Serv.* 1998;18:34-38.
2. Stutman RK, Newell SE. Rehearsing for confrontation. *Argumentation.* 1990;4:185-198.
3. Kellermann KA. Goal-directed approach to gaining compliance: relating differences among goals to differences in behaviors. *Communic Res.* 2004;31:397-445.
4. Gottman JM, Markman HJ, Notarius CI. The topography of marital conflict: a sequential analysis of verbal and nonverbal behavior. *J Marriage Fam.* 1977;3:461-477.
5. Kubany ES, Richard DC, Bauer GB, Muraoka MY. Impact of assertive and accusatory communication of distress and anger: a verbal component analysis. *Aggressive Behaviour.* 1992;18:337-347.
6. Benoit WL, Benoit PJ. Aggravated and mitigated opening utterances. *Argumentation.* 1990; 4:171-183.
7. Remer R. The effects of interpersonal confrontation on males. *American Mental Health Counselors Association Journal.* 1984;6:56-70. See also Watson JJ, Remer R. The effects of interpersonal confrontation on females. *Personnel and Guidance Journal.* 1984;62:607-611.
8. Kern JM. Predicting the impact of assertive, empathic-assertive, and nonassertive behavior: the assertiveness of the assertee. *Behavior Therapy.* 1982;13:486-498.
9. Baumeister RF, Stillwell AM, Wotman SR. Victim and perpetrator accounts of interpersonal conflict: autobiographical narratives about anger. *Journal of Personality and Social Psychology.* 1990;59:991-1005.

10. Roloff ME, Putnam LL, Anastasiou L. Negotiation skills. In: Greene JO, Burleson BR, eds. *Handbook of Communication and Social Interaction Skills*. Mahwah, NJ: Erlbaum; 2003:801-834.
11. Gottman JM, Coan J, Carrere S, Swanson C. Predicting marital happiness and stability from newlywed interactions. *J Marriage Fam.* 1998;6:5-22.
12. Gottman JM. *What Predicts Divorce? The Relationship Between Marital Processes and Marital Outcomes*. Hillsdale, NJ: Lawrence Erlbaum; 1994.
13. Brett JM, Shapiro DL Lytle AL. Breaking the bonds of reciprocity in negotiations. *Academy of Management Journal.* 1998;41:410-424.
14. Roloff ME, Tutzauer FE, Dailey WO. The role of argumentation in distributive and integrative bargaining contexts: seeking relative advantage but at what cost? In: Rahim MA, ed. *Managing Conflict: An Interdisciplinary Approach*. New York, NY: Praeger; 1989:109-120.

Michael Roloff, PhD, is a professor in the Department of Communication Studies at Northwestern University, in Evanston, Illinois. He conducts research on interpersonal influence with a special emphasis on interpersonal conflict and on bargaining and negotiation. He is co-editor of Communication Research.

Rachel Malis, MA, is a graduate student in the Department of Communication Studies at Northwestern University, in Evanston, Illinois. She conducts research on interpersonal relationships with a focus on interpersonal conflict and health.

The viewpoints expressed on this site are those of the authors and do not necessarily reflect the views and policies of the AMA.

Copyright 2005 American Medical Association. All rights reserved.

Virtual Mentor

Ethics Journal of the American Medical Association
August 2005, Volume 7, Number 8

Vignette 6: Resident to Patient's Family and Attending Physician

Responding to Insensitive Remarks about a Patient

Commentary by James T. Hardee, MD

An attending physician uses disrespectful nicknames and makes remarks that you, the resident, find inappropriate. You are uncomfortable because he often refers to the HIV/AIDS clinic as death row, the nurses as little helpers, the pharmacists as Rex, and transfer to palliative care as the long walk. In the most recent incident, he made a derogatory remark about a comatose patient ("deadhead") that the patient's family heard.

When you tell the attending that the family overheard the insensitive comments, he suggests dismissively that you can discuss it with the family "if that will make you feel better."

Commentary

Derogatory and demeaning language has unfortunately been a part of medicine for generations. The disclosure that physicians used insensitive language regarding those in their care gained worldwide exposure in the novel *The House of God*, which has sold over 2 million copies in the past 25 years [1]. More recently, popular television shows such as *ER* and others have propagated the concept that health care providers continue to use cold and callous words to describe their patients. Whether said for humor, out of fatigue and frustration, or even arrogance, derogatory descriptors of patients have no place in medicine. It is well established that poor communication on the part of physicians leads to diminished health outcomes [2], decreased patient satisfaction [3], decreased compliance with treatment recommendations [4], and increased malpractice risk [5]. One can only imagine the harm done by intentionally derogatory language.

In an effort to enhance awareness and sensitivity of students and residents, many medical schools have developed curricula focusing on patient-physician communication, ethics, and professionalism. One such example is the Foundations of Doctoring program at the University of Colorado Medical School. Unfortunately, it can often be difficult for these programs to "undo" poor role modeling witnessed by trainees on the teaching wards and in the clinics. In an inspiring commentary, JA Barondess writes that "professionalism" means treating patients with dignity, warmth, and empathy and using effective communication [6]. It is awkward and confusing when trainees observe senior physicians using derogatory terminology in reference to

patients. Certainly such language cannot be condoned. But is it simply part of the culture?

The Insensitive Attending Physician

In the scenario of an attending physician who uses inappropriate and disrespectful nicknames for patients, there are at least 2 difficult conversations that the resident must decide how to approach. First, upon realizing that the family of a comatose patient probably heard the attending use the term “deadhead,” the resident will presumably decide to meet with the family. This will be an emotionally difficult, yet necessary and healing, conversation. Second, the resident must grapple with whether to approach the attending physician regarding his chronic use of derogatory language. This conversation will be difficult for reasons such as the inherent risk in providing constructive critical feedback to someone in a higher position, embarrassment on part of the attending, and, maybe more decisively, the fear of backlash from the attending physician on the resident’s evaluation.

Approaching the Family

After hearing such a callous term used to describe a loved one, especially by a health care professional, the family probably feels disappointment, hurt, anger, and mistrust. Approaching the family with openness and humility is essential. Making excuses and performing superficial “damage control” on behalf of the attending benefits no one. The use of open-ended questions and empathic communication is important in fostering understanding and restoring trust. Empathy is the emotional appreciation of another’s feelings. It is an attempt to understand another person’s experience from within that person’s frame of reference. Simply stated, empathy is the ability to put oneself in another’s shoes. As outlined by Platt and Keller [Z], key steps to effectively conveying empathy include:

1. Recognizing the presence of a strong feeling in the clinical setting (ie, fear, anger, grief, disappointment);
2. Pausing to imagine how the patient or family may be feeling;
3. Stating our perception of the patient’s or family’s feeling;
4. Legitimizing that feeling;
5. Respecting the patient’s or family’s effort to cope with the situation;
6. Offering support and partnership.

This framework of empathic communication will be helpful as the resident broaches the topic with the family. The conversation should begin with a statement of acknowledgement:

Resident: Thank you for meeting with me today during what must be a difficult time for your family.

The subject of the attending’s derogatory comment could then be brought up using an open-ended question such as:

Resident: I thought I saw you react this morning after Dr Jones’s use of inappropriate and hurtful language to describe your wife’s condition. I wanted the opportunity to

discuss this with you. I know that would have upset me. Can you tell me how this made you feel?"

At this point, the resident must pause and listen to the family's reaction, which could range from stunned silence or sadness and grief to overt anger and hostility. After hearing the family's feelings, the resident should restate what he hears. This empathic loop demonstrates understanding. Supposing the family responds with disappointment at the attending's comments, the resident might reply:

Resident: "It certainly sounds as though you're upset with this inappropriate language. I suspect that hearing it from a doctor you trust makes it even more difficult."

With this statement, the resident expresses empathy, by recognizing that the family feels disappointment and that they value trust and professionalism from physicians.

By using an empathic response, the resident does not fuel the family's anger or make excuses for the attending physician. Statements such as "Dr Jones was really busy this morning and we've had a tough week on the wards. He doesn't usually say things like that," demonstrate no willingness to understand the family's feelings or values. This type of excuse does little to build trust or promote healing.

After completing the conversation, which was framed with open-ended questions, listening, and empathic responses, the resident may wish to conclude by saying,

Resident: "I really appreciate your taking the time to speak with me and sharing your feelings so openly. I also thank you for the opportunity to learn from this situation. I want to assure you that the team is committed to the respectful care of your wife throughout her hospital stay."

Approaching the Attending

The issue of whether the resident should confront the attending about the chronic use of derogatory comments presents opportunities as well as potential pitfalls.

Unfortunately, due to the difficulty and awkwardness of such a conversation, most residents would probably choose not to bring up the subject directly to the attending. For better or worse there is a long-standing hierarchical culture in medicine where certain boundaries are rarely crossed. One such boundary is a trainee's providing specific feedback to an attending physician regarding quality of care or quality of communication. In most instances, if a resident were to register a complaint, it would probably be done in the setting of an anonymous or confidential message to the dean, program director, or department chair. Whether real or imagined, the threat of backlash from the attending (eg, a poor evaluation, loss of a fellowship position, reputation as a troublemaker, etc) is a strong dissuader.

However, the "gift" of direct feedback, provided in the context of a trusting, professional relationship seems to have a good chance of encouraging sustained behavior change. General guidelines for giving constructive feedback include:

1. Giving the feedback as close in time to the behavior as possible.
2. Being as specific as possible.
3. When offering constructive feedback, which could be potentially embarrassing for the attending physician, hold the conversation in a private setting.

A commonly used framework for communicating feedback that the resident might consider has 3 parts [8]:

1. Identify the behavior that is problematic.
2. State your feeling or reaction to that behavior.
3. Clarify why the behavior is a problem.

Focusing on one's own reaction to someone else's behavior minimizes accusatory statements ("You should know better than to call patients 'deadheads.'") and the defensive reactions such statements are likely to provoke. Assuming that the resident and attending physician have a relationship built on trust and respect, the conversation might begin,

Resident: Dr Jones, as you know, I respect you as a physician and have really been learning a great deal on your teaching rounds. I have a concern that I'd like to mention to you. On occasion I've noticed that you use demeaning language to describe certain patients.

After a brief pause, the resident may continue,

Resident: Knowing how much you care about our patients, it makes me uncomfortable when I hear terms such as "deadhead." As you know, Mrs Smith's husband overheard that comment yesterday and was upset by it. Also, I'm concerned that the medical students are starting to feel that it's OK to use such language around patients."

In these few sentences, the resident has followed the feedback framework and has succinctly stated the problem (derogatory language), his reaction to it (discomfort), and the reason (it hurt the family and had an impact on impressionable students). Presented in this way the information is difficult for the attending physician to ignore.

It has been said that "old habits die hard," but, with timely and direct feedback focusing on the behavior, the attending can consider his language and the effect on those around him.

Summary

In the difficult scenario of an attending physician who habitually uses derogatory terminology, the resident has the opportunity to restore trust with the family as well as provide feedback to the attending physician. Neither of these conversations is simple. In fact, the easy thing to do would be to do nothing. However, a mature, sensitive, and skilled resident can have a huge, if not life-changing, impact on both the family and attending physician if the conversations are held. The use of empathic communication and feedback focused on behavior should help facilitate these discussions.

References

1. Shem S. *The House of God*. New York, NY: Bantam Dell; 1978.
2. Stewart MA. Effective physician-patient communication and health outcomes: a review. *CMAJ*. 1995;152:1423-1433.
3. Brody DS, Miller SM, Lerman CE, Smith DG, Lazaro CG, Blum MJ. The relationship between patients' satisfaction with their physicians and perceptions about interventions they desired and received. *Med Care*. 1989;27:1027-1035.
4. Stewart MA. What is a successful doctor-patient interview? A study of interactions and outcomes. *Soc Sci Med*. 1984;19:167-175.
5. Beckman HB, Markakis KM, Suchman AL, Frankel RM. The doctor-patient relationship and malpractice. Lessons from plaintiff depositions. *Arch Intern Med*. 1994;154:1365-1370.
6. Barondess JA. Medicine and professionalism. *Arch Intern Med*. 2003;163:145-149.
7. Platt FW, Keller VF. Empathic communication: a teachable and learnable skill. *J Gen Intern Med*. 1994;9:222-226.
8. Course Syllabus. *Medicine and Management: Leadership in a Complex Environment*. Oakland, Calif: The Permanente Federation; 2000.

Suggested Reading

American Medical Association. Opinion 9.045. Physicians with disruptive behavior. *Code of Medical Ethics*. Available at: http://www.ama-assn.org/apps/pf_new/pf_online?f_n=browse&doc=policyfiles/HnE/E-9.045.HTM&&s_t=&st_p=&nth=1&prev_pol=policyfiles/HnE/E8.21.HTM&nxt_pol=policyfiles/HnE/E-9.01.HTM&. Accessed July 25, 2005.

James T. Hardee, MD, is a physician with Kaiser Permanente in the Department of Internal Medicine in Denver, Colorado. He is an assistant clinical professor in the Department of Medicine at the University of Colorado, also in Denver.

The viewpoints expressed on this site are those of the authors and do not necessarily reflect the views and policies of the AMA.

Copyright 2005 American Medical Association. All rights reserved.

Virtual Mentor

Ethics Journal of the American Medical Association
August 2005, Volume 7, Number 8

Vignette 7: Resident-to-Student Communication

Giving Honest Feedback

Commentary by Benjamin Blatt, MD

A resident consults with you about a third-year medical student assigned to her internal medicine team. He is always prepared, has read the patient charts, and has researched the management of the diseases and complications for which they are hospitalized. Yet his answers to specific questions—"What do these test results suggest?" or "What should be our next step?" are sometimes off the mark. In the interest of moving rounds along and making sure the others on the medical rotation have accurate information, she has not addressed this student's performance head on.

The resident tells you, "I'm afraid I am not doing right by this student. In fact, I feel like I am repeating the behavior of some of my residents when I was a student. They seemed unwilling to correct my errors on rounds. They wrote "excellent student" or "good job" on my evaluations even when I knew I had made mistakes. Not that I minded the praise. I just didn't feel I deserved it or learned much from it. So now I find myself saying "good" or "fine" to this student. What can I say to him that's more helpful without making him feel crushed?"

Commentary

This case brings up a disturbing trend: as a medical student, you received meaningless praise from your residents; now that you're a resident you find yourself repeating the pattern.

Your experience with feedback is not unique. In a survey performed in an academic medical center [1], 80 percent of the residents reported never or infrequently receiving negative, corrective feedback; 17 percent, never or infrequently receiving positive, reinforcing feedback. Fewer than 30 percent reported receiving *any* kind of feedback often. Teachers avoid giving feedback—especially when critical—and students avoid soliciting it. Neither teacher nor student wants to risk an awkward confrontation. As a result, there is no constructive feedback [2], or it morphs into half-hearted compliments. When negative feedback does occur, however, it may be dysfunctionally critical. If asked, most medical students can effortlessly offer a story or 2 of humiliating feedback encounters. Further exposing this dark side of the learning experience is a considerable literature on student abuse [3, 4].

What's wrong with giving only compliments or criticisms? Feedback is meant to be a guidance system that keeps its subject on course. It really *is* rocket science, which is where the term *feedback* originated. What's the problem with uncritical, undeserved

compliments? They don't guide—they don't reinforce specific behaviors. They provide some "feel good" motivation, but, as you yourself discovered, this is neutralized if the compliments are undeserved. Criticisms, on the other hand, may be behaviorally specific. However, if harsh and unbalanced by positive feedback, criticisms precipitate defensiveness. When attacked, students channel their energy to self-defense, not learning.

A culture in which feedback disappears or is too critical fosters an anxiety-ridden educational climate. Students don't know if they are learning and teachers don't know if their teaching is effective. Ultimately, patients bear the brunt of it; they may not get the care they need. As Ende puts it,

The goal of clinical training is expertise in the care of patients. Without feedback, mistakes go uncorrected, good performance is not reinforced, and clinical competence is achieved empirically at best, or not at all [2].

An effective feedback method is vitally important, then, for learners, teachers, and their patients—present and future. As you discovered, patterns in our academic medical culture, as in any culture, tend to get repeated. Establishing a more effective feedback method means passing on a better heritage than the one that was passed on to you.

How then can you avoid the compliment-criticism trap and give effective feedback? Let me summarize some strategies based on expert opinion, research, and personal experience [5, 6].

General Support Strategies

- 1. Prepare the learner:** Make appointments for individual feedback sessions at the beginning of a rotation. Identify specific goals (eg, feedback on clinical skills).
- 2. Create a supportive learning climate:** Treat the learner with respect, as a partner; approach difficulties as mutual problems (as in problem-based learning), be nonjudgmental, introduce humor, make risk-taking safe.

SOAP Paradigm for Giving Feedback

The Subjective/Objective/Assessment/Plan (SOAP) paradigm commonly used to structure clinical notes can also be used to guide you through the feedback interaction. (No great surprise: there are strong parallels between the teacher-student and doctor-patient relationship). Begin with the "subjective," eliciting the student's agenda as you would elicit a patient's agenda; proceed to the "objective"—your observations; and then go to assessment and plan as indicated below. Keep in mind, however, that the SOAP approach is a simplification; alter your course in response to teachable moments if they present themselves; be flexible when using the SOAP paradigm [5].

Let's apply the SOAP paradigm to this situation:

S Ask the learner for a subjective self-assessment: Begin the interaction by asking the learner, "How did it go? Anything you felt went especially well? Anything you were concerned about?" Make the process learner-centered: Ask the learner to help set the

agenda and goals for the session, to share past experiences, and partner with you to problem-solve. Adults learn best when they are motivated by the involvement characteristic of this sort of experiential learning [6].

O. Give objective feedback—balanced (reinforcing as well as corrective), descriptive feedback. Describe your observations and encourage the learner to reflect, thereby helping him to synthesize his own feedback (“You seemed to become a bit uncomfortable when you began the sexual history—can you tell me what was happening?”). Whenever possible, suggest choices rather than directing the learner. Keep the feedback points to a reasonable number.

A. Assess and summarize learning: Ask the learner to state 1 or 2 “take-home” points.

P Formulate an action plan: Ask the learner, “What new things will you try? What will you do differently? What research will you do?” Arrange for a follow-up to evaluate how the new strategies are working.

Finally, using the above strategies, let’s perform a hypothetical feedback session with the student who concerned you:

Strategies for Resident-Student Interchange **Prepare the Learning Climate**

Resident: This is our first of 2 feedback sessions you and I had arranged at the beginning of the rotation. My goal is to focus on clinical care and for us to work together to identify what is working well for you and what isn’t.

Does that sound OK to you? Any special goals you have?

Student: Sounds fine.

Subjective

R: So how have things been going?

S: OK, I guess.

R: Any examples?

S: Well, I have been working hard to know my patients really well, keep up with their charts, and read up on them.

R: I’ve noticed and am impressed! Anything else?

S: No, that’s about it.

Objective

R: Let me try to give you some of my observations.

Your hard work is paying off. You always know your patients cold, lab work and everything.

Tell me about your thinking process when it came to Joe Tolliver with the pleuritic chest pain.

S: Well, I guess I'm a little upset about that—I just didn't think of a pulmonary embolism. He had fever, so I was sure he had pneumonia.

R: Thinking back on the month, has that sort of thing happened before?

S: Yes, with several patients. Sometimes I get so involved that I just go with the diagnosis that first pops into my mind.

R: Agreed. This is an area you should work to improve. It's really perceptive of you to have picked up on it. Any strategies you can think of to help?

S: Slowing myself down could help—maybe just sitting down and writing out the differential, and then reflecting on what I might have missed.

R: Sounds good.

Assessment

R: So what's your take away from this feedback session?

S: Keep on top of my patients the way I have been; slow down, write and reflect when it comes to differential.

Plan

R: Let's meet again in 2 weeks and re-evaluate your plan. That OK? Also, it might help to do a few of the computerized clinical reasoning cases.

References

1. Isaacson JH, Posk LK, Litaker DG, et al. Resident perceptions of the evaluation process. *J Gen Int Med.* 1995;10(suppl):89.
2. Ende J. Feedback in clinical medical education. *JAMA.* 1983;250:777-781.
3. Elnicki DM, Linger B, Asch E, et al. Patterns of medical student abuse during the internal medicine clerkship: perspectives of students at 11 medical schools. *Acad Med.* 1999;74(10 suppl):S99-101.
4. Lubitz RM, Nguyen DD. Medical student abuse during third-year clerkships. *JAMA.* 1996;275:414-416.
5. Hewson M, Little M. Giving feedback in medical education: verification of recommended techniques. *J Gen Int Med.* 1998;13:111-116.
6. Kurtz S, Silverman J, Draper J. *Teaching and Learning Communication Skills in Medicine.* Abingdon, UK: Radcliffe Medical Press; 1998.
7. Knowles, MS, *The Modern Practice of Adult Education.* San Francisco: Jossey-Bass Publishers; 1980.

Benjamin Blatt, MD, is an associate professor of medicine at George Washington University School of Medicine, Washington, DC. He is also director of the Office of Education and Clinical Skills Center in Washington, DC.

The viewpoints expressed on this site are those of the authors and do not necessarily reflect the views and policies of the AMA.

Copyright 2005 American Medical Association. All rights reserved.