MedPro Group
a Berkshire Hathaway company

Communication in the Diagnostic Process: Preventing Breakdowns and Missed Opportunities

Laura M. Cascella, MA, CPHRM

PEACE OF MIND | EXPERTISE | CHOICE | THE MEDPRO GROUP DIFFERENCE

Communication often is considered a "soft skill" in the workplace, but its value — particularly in patient care — should not be diminished. Communication breakdowns in healthcare are not uncommon, and they can result in anything from minor confusion to serious patient harm. In an analysis of more than 23,000 malpractice claims and lawsuits, Candello (formerly CRICO Strategies) identified communication failures as a risk factor in 30 percent of all cases. Further, 37 percent of all high-severity injury cases involved communication failures.[1]

> "Communication breakdowns in healthcare are not uncommon, and they can result in anything from minor confusion to serious patient harm."

Candello's findings about communication also apply to claims specifically related to diagnostic errors. For example, the analysis notes that the majority of communication breakdowns in general medicine occur during the diagnostic process. MedPro Group malpractice case data show that communication is the second most common contributing factor (after clinical judgment) in diagnosis-related cases. Communication issues occur in 47 percent of these cases — and these issues have remained persistent over the years.[2]

Generally, communication failures fall into two main categories: (1) communication among providers, and (2) communication between providers and patients/families. The former accounts for 69 percent of the communication issues noted in diagnosis-related cases, while the latter accounts for 41 percent.[3] (**Note:** The total exceeds 100 percent because some cases include lapses in both categories.) Although communication issues among providers are most prevalent, both issues are worthy of further discussion.

Communication Issues Among Healthcare Providers and Staff Members

Successful communication among healthcare providers and between providers and staff members has always been a critical element of patient safety. The emphasis on communication has become even more pronounced in recent years with the shifting focus toward collaborative and team-based care. Yet, even as these changes occur, communication still remains a top risk management concern for healthcare organizations as well as a common risk factor in malpractice claims.

> "In terms of diagnosis, certain elements of the patient care process are particularly vulnerable to communication missteps and errors . . ."

In terms of diagnosis, certain elements of the patient care process are particularly vulnerable to communication missteps and errors, such as transitions of care among multiple providers and clinical staff members. These individuals might be working in the same organization or coordinating care across multiple organizations. Additionally, the scenarios in which information is exchanged can vary. For example, a practitioner might be providing coverage for a colleague, ordering diagnostic procedures, referring a patient to a specialist (or receiving a referral), or participating in multidisciplinary care.

Regardless of the situation, care coordination and care transitions require careful communication among all members of the diagnostic team, accountability for assigned roles, ownership of established processes, and engagement with patients/families.[4] When evaluating organizational efforts to support continuity and coordination of care, consider whether policies are in place that:

- Specify the minimum requirements for what information to communicate during patient handoffs and care transitions.
- Clearly establish duty of care and clinical responsibilities for all providers. For example, who is responsible for reviewing diagnostic reports and communicating information to the patient?
- Support thorough and ongoing communication between doctors, advanced practice providers, and clinical/nonclinical staff (via phone calls, emails, periodic meetings, etc.).

- Define appropriate processes for referrals and consultations, such as how providers and staff should handle urgent communications, consultation reports, informed consent, and follow-up.
- Specify a process for managing pertinent clinical findings or critical test results.
- Establish requirements for using tools, checklists, and forms as part of the care coordination process.
- Define expectations for documentation in patient health records.

Because care coordination involves many components and individuals as well as complex logistical processes, providers might feel limited in their ability to manage all of the moving parts and effect change — especially when working with people and groups outside of the organization. However, taking proactive steps within the facility to address gaps in care transitions and improve policies for continuity of care can make a difference. Examples of potential strategies include formalizing inbound patient referral processes, focusing on the logistics of external referrals, and asking providers and staff members to offer suggestions on ways to improve collaboration.[5]

"Taking proactive steps within the facility to address gaps in care transitions and improve policies for continuity of care can make a difference."

More information about improving communication among healthcare providers and staff members is available in the following MedPro resources:

- *Breaking Down Communication Barriers in Collaborative and Team-Based Care*
- *Collaborating With Advanced Practice Providers*
- *Risk Q&A: Handoffs and Signouts*
- *Risk Resources: Handoffs and Care Transitions*
- *Speaking Up for Patient Safety: Techniques to Support Assertiveness*

Case Example

Overview: A 45-year-old male visited his primary care provider (PCP) after having a headache for 2 weeks. The patient was morbidly obese, had a family history of cerebral aneurysm and migraine headaches, and was a heavy smoker. The PCP ordered magnetic resonance imaging (MRI) and magnetic resonance angiography (MRA) of the brain. A neuroradiologist at a teleradiology service read the results and reported a 3 mm aneurysm of the anterior communicating artery.

Based on this information, the PCP referred the patient to a neurosurgeon. The patient brought hard copies of both the MRI and MRA results to his visit with the neurosurgeon. The specialist reviewed the patient's hard copies, but never looked at the full motion source images. Based on the still images, the neurosurgeon concluded that the patient did not have an aneurysm.

About 18 months later, the patient woke with an abrupt, severe headache. At the hospital, computed tomography angiography confirmed a brain hemorrhage, most likely caused by a 5 mm aneurysm. Despite treatment, the patient was diagnosed as brain dead and died shortly after.

Discussion: When multiple providers are involved in a patient's care, the opportunity for miscommunication increases, particularly when the providers are in different locations. In this case, the neurosurgeon potentially missed signs of the aneurysm because he did not have access to all of the images that were available to the neuroradiologist.

However, the neurosurgeon did have access to the neuroradiologist's report. A careful review of the report should have signaled a difference of opinion in the diagnosis. At that point, the neurosurgeon could have arranged a call with the neuroradiologist to discuss and reconcile their differing opinions about the test results.

Better communication between these specialists may have ultimately led to a different course of action and possibly a different outcome for the patient.

Communication Issues Between Providers and Patients/Families

Just as thorough communication among members of the diagnostic team is vital to patient safety, so too are effective interactions between providers and patients/families.

One of the key recommendations in the National Academies of Sciences, Engineering, and Medicine's (NASEM's) pivotal report titled *Improving Diagnosis in Health Care* is for providers to include patients/families as members of the diagnostic team and to engage them in the care process in ways that align with their needs, values, and preferences.[6]

Communicating well with patients can help support a culture of safety, create a successful provider–patient partnership, and engage patients in shared responsibility for their care. Conversely, failures or gaps in provider–patient communication may increase the likelihood of errors. "When information falls through the cracks, diagnoses are confounded, procedures are complicated, and subsequent care is compromised."[7] Thus, the ability to effectively interact with patients is essential in all steps of the care process — from initial encounter through follow-up.

"The ability to effectively interact with patients is essential in all steps of the care process — from initial encounter through follow-up."

Communication Policies

To help mitigate the risk of poor communication with patients, develop comprehensive policies related to verbal, electronic, and written interactions. These policies should:

- Establish expectations for courteous and respectful communication that is reflective of a patient-centered and service-oriented culture.
- Describe the purpose and accepted use of each type of communication and explicitly note the preclusion of certain activities (e.g., diagnosing over the phone or email).
- Set forth standards and criteria for telephone triage that (a) support scheduling based on patient needs, (b) establish the use of boilerplate responses and scripts (when appropriate), and (c) assign roles for clinical and nonclinical staff.

- Define the appropriate use of email, texting, and social media for communicating with patients. Policies should cover management of social media and email accounts, development of disclaimer language for digital media, and staff expectations and accountabilities.
- Establish appropriate timeframes for clinician and staff responses to verbal and electronic inquiries and concerns from patients.
- Outline steps for managing patient complaints and measuring patient satisfaction (e.g., through the use of written or online surveys).
- Develop a process and appropriate timeframes for following up with patients about test results and missed or canceled appointments.
- Define specific requirements for documenting patient interactions.
- Educate and train providers and staff on communication policies and techniques.

Provider–Patient Encounters

A *JAMA* study that focused on the types and origins of diagnostic errors in primary care found that more than 75 percent of the process breakdowns that led to diagnostic errors involved the provider–patient encounter.[8] What goes wrong during these interactions? It's not always clear, but various factors can play a role, such as:

- Ongoing distractions and interruptions in the care setting.
- Discomfort on the part of patients in reporting their symptoms or medical histories.
- Circumstances in which providers prematurely cut off patients while they're talking. A recent study suggests clinicians interrupt patients after a median of just 11 seconds.[9] Older studies have suggested that clinicians will interrupt or redirect patients within the first 18–23 seconds of telling their stories.[10]
- Situations in which patients/families feel that healthcare providers are devaluing their views or failing to understand their perspectives.

These issues, alone or in combination, can lead to communication breakdowns, problems with data collection and synthesis, patient dissatisfaction, and — ultimately — diagnostic mistakes.

Tackling provider–patient communication issues can be tricky due to the somewhat nebulous nature of these problems. However, practitioners can employ various techniques and strategies to enhance interactions, build better partnerships, and engage patients/families in the diagnostic process. For example:

- Allow adequate time for dialogue, and repeat important information to confirm understanding of the patient's reason for visiting, their concerns, and their point of view.
- Make an effort to allow the patient to fully voice their concerns without interruption.
- Determine what the patient hopes to achieve as a result of the visit.
- When possible, sit down with the patient while taking their medical history or reviewing clinical information.
- Ask open-ended questions to generate more thorough responses. For example, "So, you're having pain?" becomes "Can you tell me more about your pain?"
- Create an atmosphere that encourages questions, clarification, and open dialogue. Often, patients need to hear the same information more than once to absorb it.
- Use eye contact in face-to-face conversations. Eye contact is particularly important when using a computer or tablet during patient care because these devices might seem to depersonalize the interaction.
- Consider your body language and how a patient might perceive it. For example, fidgeting, constantly looking at a screen, or hanging on the door knob might be construed as dismissive. Certain facial expressions might seem judgmental or condemning, which may lead to reticent behavior or patient reluctance, particularly if patients are sharing sensitive information.
- Before the patient encounter ends, encourage patients to ask questions about any other potential issues. It is not uncommon for patients to wait until the end of an appointment to bring up the issues that actually are most worrisome to them.

Although these strategies will not eliminate the potential for miscommunication, they may help (a) improve processes for gathering information, (b) build patient trust, and (c) reinforce a culture of safety — critical elements for improving the diagnostic process, reducing the risk of errors, and reducing liability exposure.

Healthcare providers also can use patient-friendly tools and resources to help patients/families become more active partners in the diagnostic team. Two examples of patient-friendly tools are included in NASEM's *Improving Diagnosis in Health Care: Resources for Patients, Families, and Health Care Professionals*.

Additionally, more detailed information and tips about communicating with patients is available in MedPro's *Guideline: Communicating Effectively With Patients to Improve Quality and Safety* and *Risk Tips: Engaging Patients to Improve Diagnosis*.

Case Example

Overview: A doctor on call for his group practice received an after-hours call from a male patient in his sixties. The patient was complaining of weakness and reported that he had started a new blood pressure pill (hydrochlorothiazide) 3 days earlier. He also reported taking lisinopril daily for more than a year.

The doctor quickly attributed the patient's weakness to the new medication; he told the patient to stop taking the hydrochlorothiazide and to check his blood pressure using a home blood pressure cuff.

The doctor instructed the patient to seek immediate care if his systolic pressure went above 180 mmHg, but to otherwise make an appointment to see his regular doctor to get a different blood pressure medication.

Three days later, the patient was hospitalized with sudden onset of right arm and leg weakness as well as difficulty speaking. He was diagnosed with atrial fibrillation. Based on the patient's symptoms and medical history, the admitting physician determined that the patient's weakness was a result of the arrhythmia, rather than a side effect of hydrochlorothiazide. The findings on neuroimaging strongly suggested an embolic stroke.

The patient was treated with warfarin for the atrial fibrillation and received rehabilitation while in the hospital; however, he was still experiencing weakness and some word-finding difficulties 6 weeks later.

Case Example (continued)

Discussion: This case demonstrates several communication problems. Because the doctor was conversing with the patient over the phone, he did not have the benefit of performing a complete physical exam or gathering visual evidence of the patient's condition. Thus, taking the patient's history became the most crucial aspect of the encounter. However, once the patient reported his new blood pressure medication, the doctor focused on that information and terminated the data-gathering process — a cognitive bias known as premature closure.

Further, when speaking with the patient, the doctor did not ask open-ended questions about the patient's symptoms — e.g., "How would you describe the weakness?" This strategy might have revealed further information about the patient's condition, which potentially could have indicated the severity of the situation.

Finally, other than noting that the patient should seek immediate care if his systolic blood pressure rose above 180 mmHg, the doctor did not provide the patient with any further instructions, such as what to do if the weakness continued or worsened, how to respond if new symptoms occurred, or when to schedule the follow-up appointment.

Health Literacy and Patient Comprehension

A major obstacle in provider–patient communication is ensuring patient comprehension of both verbal and written health information, including clinical explanations, recommendations, instructions, educational materials, and more.

Health information and services often are unfamiliar and confusing. People of all ages, races, cultures, incomes, and educational levels struggle with health literacy, and many adults have trouble understanding and using the health information that is routinely available in healthcare facilities.[11]

Additionally, other issues — such as language barriers; cultural issues; and auditory, visual, or speech disabilities — can affect health literacy, hindering the communication process and patient understanding.

Because the ability to "find, understand, and use information and services"[12] is a key component of making informed health-related decisions, gaps in these areas can have serious implications for informed consent/refusal, patient follow-up, and patient adherence. Thus, taking steps to ensure patient understanding and awareness is critical to organizational communication strategies.

For more information about addressing health literacy and patient comprehension, see MedPro's *Checklist: Strategies to Support Patient Comprehension* and *Risk Resources: Health Literacy and Cultural Competence*.

In Summary

Effective communication among healthcare providers, between providers and staff members, and between providers and patients/families plays a fundamental role in risk management and patient safety. Although changes in technology and workforce models have affected the process of communication, they have not tempered its significance. This sentiment holds true when examining the ways in which communication gaps or failures contribute to diagnostic errors and subsequent malpractice cases.

Analysis of malpractice cases shows that communication lapses represent a consequential risk for healthcare organizations and providers. However, this risk can be mitigated through development of policies to address communication gaps and enhance communication efforts, careful evaluation of collaborative processes among providers, and review and refinement of communication processes between providers and staff and providers and patients.

Endnotes

[1] CRICO Strategies. (2015). *Malpractice risks in communication failures: 2015 annual benchmarking report*. Retrieved from www.candello.com/Insights/Candello-Reports/Communications-Report

[2] MedPro Group diagnosis-related cases, opened 2013–2022.

[3] Ibid.

[4] Medical Economics. (2014, March). *Seven steps for managing transitions of care.* Retrieved from www.medicaleconomics.com/view/seven-steps-managing-transitions-care

[5] Ibid.

[6] National Academies of Sciences, Engineering, and Medicine. (2015). *Improving diagnosis in health care*. Washington, DC: The National Academies Press.

[7] CRICO Strategies, *Malpractice risks in communication failures: 2015 annual benchmarking report*.

[8] Singh, H., Giardina, T. D., Meyer, A. N., Forjuoh, S. N., Reis, M. D., & Thomas, E. J. (2013, March 25). Types and origins of diagnostic errors in primary care settings. *JAMA Internal Medicine*, *173*(6), 418-425.

[9] Phillips, K. A., Ospina, N. S., & Montori, V. M. (2019). Physicians interrupting patients. *Journal of General Internal Medicine*, *34*(10), 1965. doi: https://doi.org/10.1007/s11606-019-05247-5

[10] Phillips, K. A., & Ospina, N. S. (2017). Physicians interrupting patients. *Journal of the American Medical Association*, *318*(1), 93-94. doi:10.1001/jama.2017.6493

[11] U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (2010). *National action plan to improve health literacy*. Washington, DC: Author. Retrieved from https://health.gov/our-work/health-literacy/national-action-plan-improve-health-literacy; Nielsen-Bohlman, L., Panzer, A. M., & Kindig, D. A. (Eds.). (2004). *Health literacy: A prescription to end confusion*. Institute of Medicine. Washington, DC: The National Academies Press; Centers for Disease Control and Prevention. (2013). *The state of aging and health in America 2013.* Atlanta, GA: Author. Retrieved from www.cdc.gov/aging/pdf/state-aging-health-in-america-2013.pdf

[12] The Centers for Disease Control and Prevention. (2023, July 11 [last updated]). Health literacy basics: What is health literacy? Retrieved from www.cdc.gov/healthliteracy/learn/index.html