

# INSURANCE

## It's Not What You Say, but How You Say It

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Poor communication skills appear to be the primary catalyst for malpractice claims. Many practitioners have lost sight of what used to be called “bedside manner.” However, anyone who has experience in evaluating or managing malpractice litigation will tell you that the depersonalization of communications before, during, and after an adverse outcome of treatment tends to lead to lawsuits. Conversely, a sympathetic relationship with a patient makes legal action less likely. So, in the wake of the recent malpractice insurance crisis, why not encourage a return to the concept of an effective bedside manner?

For one thing, modern life is not conducive to investing sufficient time and attention in each patient. Rather than house calls, a physician may be hard-pressed to spend more than a few minutes with a patient, barring any evident need for critical care. The good news is that PAs can fill this gap by providing the patient with contact time the physician cannot spare. This assumes that you, the PA, are not equally as hard-pressed and that you have the requisite communication skills. Otherwise, you can make a not-so-good situation worse, and the patient's wrath may transfer from the physician to you.

A recent article in the November 30,

2005, issue of the *New York Times*, entitled “When the Doctor Is In, but You Wish He Wasn't,” relates the story of a patient presenting with low back pain. The examining PA reviewed x-rays and recommended spinal injections. When the patient insisted on discussing the treatment plan with a physician, the PA explained that the doctor was busy seeing patients. “Well, I'm a patient,” said the patient, but got no reply.

Never mind that the physician may have quickly corroborated your diagnosis; not convincingly explaining the need for the injections and appearing to the patient that you have created a barrier between her and the physician sets a bad stage in the event that something subsequently goes wrong.

Medical groups are becoming increasingly sensitive to this, and some are employing scientific methods to survey patient satisfaction. Some are even basing physicians' compensation on their survey performance. However, if the surveys are accurate, this should be a good thing. Higher patient satisfaction should mean fewer lawsuits.

But what if there is an error that leads to a serious adverse outcome? Won't the patient still sue? The September 30, 2005, issue of *AAPA News* provided a striking example in the article “Patient Safety Law Promises Freer Discussion of Errors.” An 18-month-old was admitted to the hospital with burns. After a medication mix-up, the

little girl died. The hospital and the parents reached a unique settlement: they cooperatively founded, and the hospital funded, a pediatric patient safety program in the child's name.

The mother, who lectures on this issue across the country, summed up her feelings in the following quote: “Hopefully, after these people hear me, they'll realize the importance of disclosing medical errors, apologizing, and doing the right thing. It's not about the money. It's about apologizing. If [the hospital] hadn't apologized to us and said that they'd fix the problem, it would have been a bloodbath, and nothing good we've done with [the hospital] would have come about.”

Recent evidence points to this being a common response to adverse outcomes even as tragic as this example. Litigation can be avoided by merely saying, “I'm sorry.” It also has the advantage of being the right thing to do in human terms.

However, patient communication before, during, and after treatment requires specialized knowledge to be effective. The *Times* article gives an interesting example. A doctor who scored low on his patient satisfaction survey sought advice from a colleague. The colleague said, “Everyone thinks they're listening to patients. But one method does work. Use continuers. As you're working with people, say ‘Uh-huh’ three times. If the patient says, ‘I've been hav-

ing chest pains,” instead of jumping in and suggesting tests, say, ‘Uh-huh.’ Then the patient says, ‘I've also been having headaches.’ Then you say, ‘Uh-huh.’ So then the patient says, ‘It all started when my brother died of an aneurysm in the brain. And I wonder if it's related.’”

The doctor said that he looked at his colleague “like I'm a little nuts,” but he agreed to try. He later returned elated, saying, “I can't believe how different it is. I hear things I don't usually hear.”

In other words, it's sometimes just a matter of technique. That's why AAPA endorses the on-line course Patient Communication and Adverse Outcomes. It provides many such techniques and helps you do the right thing, the right way. It qualifies for two hours of Category I CME credit as well as a 10 percent premium discount if you participate in the AAPA-endorsed professional liability insurance program.

You can access the course at [www.professionallriskadvisor.com/aapa](http://www.professionallriskadvisor.com/aapa) or call AAPA Insurance Services at 877/356-2272 for more information. The cost for the course is \$39 for AAPA members and \$69 for nonmembers.

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