Communication as a Contributing Risk Factor in Diagnostic Errors

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Providing coordinated, competent patient care involves precision at many points in the clinical process, but particularly in sending and receiving information. Yet, “the increasingly complex healthcare environment can complicate the communication process and hinder the information exchanges necessary for optimum care.”

Communication breakdowns in healthcare are not uncommon, and they can result in anything from minor confusion to serious patient harm. When evaluating diagnostic errors, communication issues are the second most common contributing factor in malpractice claims, based on MedPro Group claims data.

Although MedPro Group’s data show that communication issues have decreased over time, they still remain a persistent factor in claims and occur at a palpable rate (see Figure 1).

Figure 1. Trends in Diagnostic Error Contributing Factors Over a 10-Year Period

In a broad sense, communication failures can be broken down into two main categories: communication issues among providers (and their staff members) and communication lapses between providers and patients. This article will examine both and will discuss various ways in which practitioners can implement safeguards in their communication processes.

**Communication Issues Among Healthcare Providers and Staff Members**

Successful communication among healthcare providers and between providers and their staffs has always been a critical element of patient safety. The emphasis on communication has been even more pronounced in recent years, with the shifting focus toward collaborative and team-based care. For example, the Institute of Medicine lists communication as one of the five core principles guiding new models of care delivery.²

However, even as the demand for collaborative care increases, communication still remains a top risk issue in healthcare practices. Further, “legal dangers appear to be on the rise as team-based care grows and patients are handed off to a wider scope of health professionals.”³

In terms of diagnosis, certain elements of the patient care process might be particularly vulnerable to communication missteps and errors, such as coordination of care or transitions of care among multiple providers and medical staff. These providers and staff members might be working in the same practice or coordinating care across various organizations. Further, the scenario in which information is exchanging hands can vary. For example, a provider might be

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**Case Example**

**Overview:** A 45-year-old male presented to his primary care doctor complaining of a headache of 2 weeks duration. The patient was morbidly obese, had a family history of cerebral aneurysm and migraine headaches, and was a heavy smoker. The primary care doctor ordered an MRI and MRA of the brain, which were read by a neuroradiologist at a teleradiology service. The neuroradiologist reported a 3 millimeter aneurysm of the anterior communicating artery. Based on this information, the primary care doctor referred the patient to a neurosurgeon.

When the patient presented to the neurosurgeon, he brought hard copies of both the MRI and MRA. The neurosurgeon 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, a CT angiogram confirmed a hemorrhage in the brain, most likely caused by a 5 millimeter aneurysm. Despite treatment, the patient was diagnosed as brain dead and he died shortly thereafter.

**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 would have indicated 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.
providing coverage for another clinician, 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 providers and healthcare facilities, accountability for assigned roles, ownership of established processes, and engagement with providers and patients.4 When evaluating your practice’s efforts to support continuity and coordination of care, consider whether policies are in place that:

- Define the specific types of information to communicate during care coordination or transitions of care, such as the patient’s medical history, family history, known conditions, allergies, medication list, and treatment information.
- Clearly establish duty of care and clinical responsibilities for all providers. For example, who is communicating information to the patient?
- Support thorough and ongoing communication between doctors, advanced practice providers, and clinical staff (through electronic mediums, regularly scheduled meetings, etc.).
- Define appropriate processes for referrals and consultations, such as how the practice intends to handle urgent communication, consultation reports, informed consent, and follow-up.
- Outline a plan for communication of 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 the patient record.

Because care coordination involves many components and individuals, as well as complex logistical processes, healthcare providers may feel limited in their ability to manage all of the moving parts and effect change — especially when working with individuals and groups outside of their practices.

However, taking steps within the practice to address gaps in, and enhance policies related to, care transitions and continuity of care can make a difference. A 2014 Medical Economics article notes that practitioners can “build a rigorous transition of care process”5 within their organizations by implementing proactive strategies. Examples of these strategies include formalizing inbound patient referral processes, focusing on the logistics of external referrals, and finding opportunities to improve collaboration with other providers.
Communication Issues Between Providers and Patients

Communicating well with patients is vital in establishing a culture of safety, creating a successful provider–patient partnership, and engaging patients in shared responsibility for their care.

Failures or gaps that occur in provider–patient communication may increase the likelihood of errors, including diagnostic errors. Further, some malpractice studies suggest that providers who are poor communicators are more likely to be sued. A study in Florida showed that the way in which patients perceive doctors’ “interest, accessibility, and communications ability was more important than the technical quality of care as a predictor of the physician’s malpractice claiming experience.”

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

Communication Policies

To help mitigate the risk of poor communication with patients, healthcare providers should consider developing comprehensive policies related to verbal, electronic, and written communication with patients. These policies should:

- Establish expectations for courteous, respectful communication that is reflective of a patient-centric, service-oriented culture.
- Describe the purpose and accepted use of each type of communication and explicitly note the preclusion of certain activities (such as 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 and social media for communicating with patients, including management of accounts, development of disclaimer language, and staff roles.
- Establish appropriate timeframes for clinician response to verbal and electronic inquiries and concerns.
- Outline steps for managing patient complaints and measuring patient satisfaction (for example, through the use of surveys).
- Delineate a process and appropriate timeframes for following up with patients about test results and missed or cancelled appointments.
- Define specific requirements for documenting patient interactions within the patient’s record.
- Support staff education and training on communication procedures and techniques.
Provider–Patient Encounters

A 2013 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.\(^7\)

What goes wrong during these interactions? Although it’s not always clear, various office-, practitioner-, and patient-related circumstances can play a role, such as:

- Environmental factors, e.g., ongoing distractions or interruptions.
- Situations in which patients do not feel comfortable reporting their symptoms or medical histories.
- Circumstances in which providers prematurely cut off patients while they’re talking. Research has shown that, on average, doctors will interrupt patients within the first 18 seconds of telling their story.\(^8\)
- Situations in which patients or their family members feel that their 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, various techniques and strategies can be employed to enhance interactions with patients, build better provider–patient partnerships, and engage patients in the diagnostic process.

Although these strategies will not eliminate the potential for miscommunication, they may help providers (a) improve their 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 preventing liability claims.

Strategies to Enhance Communication During the Provider–Patient Encounter

- Allow adequate time for dialogue, and take the time to understand the patient’s/family’s concerns and point of view.
- Make an effort to allow patients to fully voice their concerns without interruption.
- Repeat key information back to the patient after he or she has finished explaining the chief complaint or reason for the visit.
- Determine what the patient hopes to achieve as a result of the visit.
- Whenever possible, sit down with the patient while taking his or her history or reviewing clinical information.
• Ask open-ended questions to generate more thorough information. For example, “So, you’re having pain?” becomes “Can you tell me more about your pain?”

• Create an atmosphere that encourages questions and open dialogue. Specifically ask whether the patient has questions or would like to offer any additional information before the appointment concludes.

• Use eye contact in face-to-face conversation. Eye contact is increasingly more important as technologies, such as electronic health records (EHRs), are used in the office practice environment.

• Consider your body language and how a patient might perceive it. For example, fidgeting or constantly looking at a computer screen might be construed as dismissive. Certain facial expressions might be considered judgmental, which may cause the patient to withhold information.

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**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 the side effects 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.

**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 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.

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 may have revealed further information about the patient’s condition, which potentially could have indicated the severity of the patient’s situation.

Finally, other than noting that the patient should seek immediate care if his systolic 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.
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, and people of all ages, races, cultures, incomes, and educational levels may struggle with health literacy. In fact, the Institute of Medicine says that nearly half of all American adults have trouble understanding and acting on health information.10

Further, the CDC explains that almost 90 percent of adults have difficulty using the everyday health information that is routinely available in healthcare facilities.11

In addition to limited health literacy, other issues — such as language barriers and auditory, visual, or speech disabilities — can hinder the communication process and patient understanding.

Because “obtaining, communicating, processing, and understanding health information and services are essential steps in making appropriate health decisions,”12 gaps in these areas can have serious implications for informed consent/refusal, patient follow-up, and patient compliance.

Thus, taking steps to ensure patient understanding and awareness is critical to your practice’s communication strategies. The checklist on the next page can help you identify patient comprehension strategies already at work in your practice and target areas for improvement.

Note: As with other aspects of the patient care process, activities related to informed consent discussions, consultative advice, clinical recommendations, and patient education should be documented in the patient record.
What We Have Here Is a Failure to Communicate

Verbal and written health information and instructions are provided in lay language, and medical terms are explained. (For example, “shortness of breath” is used instead of “dyspnea,” or “tooth decay” instead of “caries.”)

Patient forms and educational materials adhere to the principles of plain language (see box on previous page).

The quantity of information provided is reflective of “need to know,” essential facts. Information does not include extraneous details that could distract the reader and potentially inhibit understanding.

When possible, and with the patient’s permission, family members and significant others are included in discussions about the patient’s care.

The patient’s overall capacity to understand, language barriers, cultural beliefs, and disabilities are considered as part of communication strategies.

Access to language services, interpreters, and assistive technology is available to meet patients’ diverse needs.

Instructions for follow-up care are provided verbally and reinforced in writing. Written versions are updated as changes occur.

The informed consent process is tailored to the specific patient and the complexity of the proposed intervention.

The practice’s philosophy on informed consent reinforces that, for the patient to be truly “informed,” he or she must understand the information that the healthcare provider has disclosed.

“Teach-back” or “repeat-back” techniques are used to gauge patient understanding and reduce the risk of miscommunication.

Questions are encouraged, and time for questions and review of materials is allotted during patient appointments.

Conclusion

Dr. Jerome Groopman, in his book titled *How Doctors Think*, states that although "modern medicine is aided by a dazzling array of technologies . . . language is still the bedrock of clinical practice." This sentiment holds true when examining the ways in which communication gaps or failures contribute to diagnostic errors and subsequent malpractice claims.

Although MedPro Group data show that communication considerably trails clinical judgment as a contributing factor in diagnosis-related claims, it nonetheless represents a consequential risk. Healthcare practices can potentially mitigate that risk by evaluating collaborative processes among providers, carefully considering communication processes between providers and staff and providers and patients, and developing policies to strengthen and safeguard communication efforts.
Endnotes

5. Ibid.
12. Ibid.

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