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MEDICAL RESIDENT SOCIALIZATION & RISK-MANAGEMENT TRAINING: A SUMMARY REPORT

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THIS STUDY WAS SUPPORTED BY A GRANT FROM THE PROVOST'S INSTRUCTIONAL DEVELOPMENT FUND AT NORTHEASTERN UNIVERSITY AND THE FACULTY UNDERGRADUATE RESEARCH INSTITUTE, WHICH PROMOTES THE INVOLVEMENT OF UNDERGRADUATE STUDENTS IN FACULTY RESEARCH. THE AUTHORS WOULD LIKE TO ACKNOWLEDGE THE CONTRIBUTIONS OF THE STUDENTS IN TWO SECTIONS OF THE ADVANCED ORGANIZATIONAL COMMUNICATION CLASS (FALL 2003) WHO CONDUCTED AND TRANSCRIBED INTERVIEWS FOR THIS STUDY.



INTRODUCTION AND LITERATURE REVIEW

Earning respect in the position of “doctor” is a long and significant process requiring years of formal and informal training through lecture, demonstration, and actual experience. Communication skills and methods are important aspects of both the training process and one’s ability to understand and make sense of that training. While an impressive body of research has accumulated about the process of medical resident socialization (Beagan, 2001; Becker, 1977; Harter & Krone, 2001; Pomerantz, Fehr, & Ende, 1997), limited research has been conducted regarding a growing concern for many medical institutions: communication skills training specifically related to risk management situations. To address that gap, this exploratory study looked at how medical residents are trained to handle situations when a patient threatens a doctor with a lawsuit, and how they make sense of that training.

The actual content of training, whether it takes place formally in medical school, or informally in residency, is by no means uniform. Likewise, different people take away different things from the same experience. While some educational institutions may stress the importance of doctor-patient communication, others only offer a single course, or do not stress communication skills in interactions in hospital settings (Mishler, 1984; Brown, 1995). Some individuals faced with the prospect of communication skills training may believe that formal communication training can not be effective or that communication skills are innate and can not be taught, while others may consider communication training to be of significant importance (Burnard, 1996). Regardless of individual belief or institutional value, research clearly shows that communication skills are of primary importance in the development of trust in doctor-patient relationships, in the limiting of patient anxiety, and in the level of overall patient satisfaction—all factors which help to minimize the frequency of lawsuits (Valente, Antlitz, Boyd, & Troisi, 1988; du Pre, 2000). In addition to curriculum content, informal training occurs with one’s immersion in the social setting of the hospital, where real doctor-patient interactions begin to take place and the role-playing and experiences of being doctor become more of a reality (Beagan, 2001).

While past literature shows that patient dissatisfaction occurs most often in medical interactions where inadequate communication takes place (Evans, Stanley, and Burrows, 1992), and that the level of patient satisfaction is directly related to



the percentage of malpractice suits (Valente et al, 1988), the question that arises here is whether communication strategies necessary to promote patient satisfaction are taught in any capacity, including how they are taught and the overall perceived effectiveness of that instruction. While a significant amount of literature emphasizes the importance of communication skills to all levels of patient satisfaction (Evans et al, 1992; Street & Wiemann, 1988; Valente et al, 1988), less exists addressing the efforts that are made to foster the necessary communicative skill level of physicians in medical training. Little past research has addressed exactly how physicians are trained to handle communicating in risk-management situations and how socialization into the medical field ultimately teaches physicians what to do in a lawsuit situation, the topics which this particular study has sought to address.

METHODS AND PROCEDURES

This study was conducted in part by a grant from the Provost's Instructional Development Fund at Northeastern University, which promotes the involvement of undergraduate students in faculty research. Students in an Advanced Organizational Communication course read academic journal articles about medical professional socialization, communication skills training and risk management, as well as qualitative research methods in order to gain knowledge about the topic of study. Additionally, all of the undergraduate students were trained in interviewing skills and a number of the students conducted interviews for this study.

Participants in this study (n=27) were drawn from snowball sampling tactics, beginning with a small pool of contacts primarily from two Boston-area teaching hospitals. All participants had completed medical school and were in at least their first year of residency at the time of interview. A majority of respondents were in their second year of residency.

Data was acquired through a single 30-45 minute phone interview. Interviews followed a semi-structured protocol and were tape recorded and later transcribed. Open-ended questions asked participants to discuss their feelings concerning communication importance and communication training effectiveness and experiences; to convey ideals of patients and interactions between themselves and their patients; to discuss their feelings and views towards lawsuits; and to



discuss how they were trained, both formally and informally, to handle situations in which mistakes are made or lawsuits are threatened. Names and phone numbers of residents interested in or recommended for the study were collected by the principal researchers, and later each student in the organizational communication class was assigned an interviewee. In most cases, initial contact with the resident was made by the student researcher, who then set up a time to conduct the interview. All data collection took place within the course of the Fall 2003 semester at Northeastern University. Participants were compensated for their time with a \$25 electronic gift certificate to Amazon.com or Barnes & Noble.com.

Interview data was analyzed by a team of two communication studies professors and one student researcher using methods of inductive thematic analysis, first drawing out interview-wide themes and then breaking down data into various segments for question-by-question analysis. The themes discussed in this report are in response to the following three research questions:

- What type of training do medical interns and residents receive that addresses how to handle potential lawsuits?
- How do medical interns and residents make sense of their training and socialization experience regarding how to handle potential lawsuits?
- What communication strategies do medical interns employ in risk management situations?

RESULTS & ANALYSIS

Resident Training Regarding Lawsuits

Training about general communication and how to handle lawsuits varied greatly from person to person. In terms of general communication training, many residents remembered formal lectures or courses that they attended in medical school, often noting interactions with mock patients (n=14; 52%; see Appendix for a summary of responses to all questions). In many instances (n=12; 44%), residents felt that the mock patient interactions were a valuable part of their training. On the other hand, a dominant view among those who felt the training was effective was that as valuable or interesting the formal training may have been, the most effective learning experience was actually becoming immersed in the medical field and



experiencing things first hand.

When discussing formal training for handling mistakes, a very small number of residents (n=3, or 11%) mentioned risk management as a resource about which they were formally trained. 48% of the respondents did not remember receiving any formal training about how to handle mistakes. 22% of the respondents said that they had courses on the topic, while 15% were unsure or could not remember.

When discussing informal training about how to handle mistakes, respondents often noted learning about mistakes and strategies to deal with them from a superior or attending physician (n=13; 48%), possibly being pulled aside by a superior and taught on a case-by-case basis, or through hearing stories or discussions that take place as a part of the everyday interactions. Inherent in the medical hierarchy is the connection between resident and attending, therefore many respondents naturally assumed that, while they may not have had first-hand experience dealing with lawsuits, they would automatically seek out their attending or superiors if a mistake was ever made, or a lawsuit threatened.

Overall, there was a vague understanding about risk management and risk management processes by the residents in our study. While 41% of respondents noted that they would call the hospital council if threatened with a lawsuit, very few seemed to understand the function of risk management as a hospital entity, or the protocol for contacting risk management. Risk management was often discussed using terms such as “sort of” and “I think”. At best, a respondent noted:

Risk management does like a five minute blurb now that I think about it. Um, just about who they are and what their role is and give us their number. So, you hear about it the first day...they just said to call them.

Another stated:

I have heard that there is a risk management office in the hospital. I never contacted them or found out how.



Resident Sense-Making Regarding Lawsuits

Our second research question, “How do medical interns and residents make sense of their training and socialization experience regarding how to handle potential lawsuits,” was primarily addressed by the interview question that asked the medical residents about their feelings towards lawsuits. As the residents described their feelings towards lawsuits, they drew on a number of metaphors to help them make sense of lawsuits and their socialization into an environment of potential litigation. Lawsuits, in terms of their intensity or the rationale for them, can be placed on a continuum. On one end, lawsuits were discussed as a *recourse*, avenue, pathway, or means through which a patient has the ability to act. This end of the continuum represents a somewhat less intense use for lawsuits. More to the center of the continuum were lawsuits as a means of *compensation*, where lawsuits are more than recourse, but also have the purpose of obtaining financial compensation for pain or loss. On the other, more intense end of the continuum stood lawsuits as a means of *retaliation* or *retribution*. Residents who used this metaphor to discuss lawsuits were more likely to feel that lawsuits and patients’ ability to threaten them are a very negative aspect of the health care field. Additional metaphors that arose were lawsuits as a *right* of the patient, and lawsuits as a “*necessary evil*”—a sort of checks and balances for the medical system. A few respondents felt that, to patients, lawsuits were like a *game* spurred by greed. This lawsuit-as-game metaphor casts the players differently, in that it transforms the patient from a rational being interested in regaining or maintaining their health to a greedy individual interested in financial gain. The hospital or medical institution is cast as one of deep pockets, vulnerable to such attacks, and the entire system becomes the playing board.

Despite the existence of various feelings towards lawsuits, as the continuum of metaphors illustrates, there was an overall sense from the respondents that, while some felt a fear towards lawsuits—keeping it in the back of their mind as they practiced—the attendings, and not the residents interviewed, are ultimately the ones who would be involved in a lawsuit. Because of this, there was an undertone of distance accompanying nearly all responses concerning feelings about or experiences with lawsuits. Residents may know of someone who had been threatened by a lawsuit, but it was not likely that they themselves had been threatened by a lawsuit. Because of this, responses varied from showing a fairly thorough understanding of lawsuits and what should be done if a lawsuit is



threatened, as illustrated by this excerpt:

If the resident feels that they might be implicated in a lawsuit, they should speak with their attending immediately. And um, they should speak to the hospital council, like an attorney or a lawyer...for both if the doctor feels that they are going to be sued individually, or if the, um, hospital will be sued.

to a very superficial knowledge and sense of responsibility towards the possibility of a lawsuit:

Um, I think I've heard of them, but I haven't...it's very vague, so I don't even, I don't really know that much about them.

While different levels of training may raise the level of awareness in residents, socialization into the medical field may ultimately teach residents little about lawsuits. At best, residents are likely to gather through observation that lawsuits are something their superiors must deal with. The most visible or explicit reference to this perception was the following comment made by one resident:

Well, I'm a little removed from it, as a resident, to some degree, um, because, we don't get actively sued, because it's not our, not our ass so to speak. Ya know, there while we have a lot of responsibility, we always- we have, people over us who maintain the ultimate responsibility for the care of the patient.

Communication Strategies Used in Risk-Management Situations

Medical residents identified a number of communication strategies to use in risk management situations. The most common strategy was to be open, honest, and forthcoming in one's communication interactions (n=11; 41%). The second most commonly discussed strategy, to admit or tell of one's mistake (n=5; 19%), is directly related to this method of being open and truthful. Many residents acknowledged that keeping things from a patient, or not being truthful about the patient's care, is more likely to lead to future problems (potentially lawsuits) than if the residents use honest, open, and forthcoming communication strategies in all communication interactions. One stated that "complete disclosure is...the rule, not the exception."



Along with the idea of honest and open communication, residents stressed the importance of maintaining a good relationship or positive rapport with their patients throughout the interview. In some cases, residents acknowledged that a good relationship could be the most important aspect of the doctor-patient dyad, whether or not potential lawsuit situations arise. For example, the following resident noted:

I've always learned from people from med school as well as where I am now that if you keep communication lines open and you have a good relationship, kind of like a therapeutic bond with your patient, lawsuits are less likely if honest mistakes are made.

It was acknowledged that personal dislike for a physician may make a patient more likely to threaten a lawsuit, and that a good relationship is often related to open and honest communication channels. Therefore, the medical residents seemed to suggest that it was important not to underestimate the power of communication and maintaining good rapport with patients.

While the residents spoke of the importance of communication and doctor-patient relationships, they also cited institutional pressures, most notably the issue of time, which can often make the use of these communication strategies a difficult task to achieve. As one resident said,

I think there's a bit of a notion that physicians are that way because they're cold or that they prefer not to explain things in more detail, that they don't want to take the time to do it. And the truth is, they don't want to take the time because they don't have the time and that's really the unfortunate part.

The statements regarding the importance of open communication and building rapport with patients, as well as the institutional pressures regarding time, seem to refute the stereotypical view that doctors are naturally cold people and poor communicators.



CONCLUSION

The depth and breadth of the responses to our research questions varied greatly among participants, a phenomenon that could be due to a number of factors. Residents lead busy lives, and some were pressed for time during the interview (were on call at home, for example). Others were interviewed by novice interviewers who did not have the expertise to use follow-up questions when necessary. Some residents were just better at answering questions in the interview format than others. Finally, many residents were extremely open and prolific in their answers.

Other typical limitations of qualitative research were also present in the study. In qualitative research the data is not normally generalizable to large groups; we can just interpret data for the small group that was involved in this study. Also, many residents were from the same institution, and were therefore greatly influenced by the overall institutional culture of their shared medical setting. Nevertheless, much valuable information about medical socialization, communication, and lawsuits was obtained through this research study, and will serve as the basis for publication in scholarly journals.

Moreover, this research project and its incorporation into the coursework for an Advanced Organizational Communication class allowed undergraduate students to participate in a real life research project, gaining indispensable first-hand experience. Overall, students reported that they enjoyed participating in the project, which allowed them to learn a great deal about research and interviewing as well as socialization and medical culture. Most reported that the most exciting part was conducting the actual interview.

Thank you to each and every participant for contributing to this research project as well as to the education of undergraduate students. If you have any questions or comments about this summary report, or would like to learn more about further publication of the results in scholarly journals, please contact one of the two principal investigators: Dr. Walter Carl (w.carl@neu.edu) or Dr. Carey Noland (c.noland@neu.edu).



REFERENCES

- Beagan, Brenda L. (2001). "Even if I don't know what I'm doing I can make it look like I know what I'm doing": Becoming a doctor in the 1990s. The Canadian Review of Sociology and Anthropology, 38.3, 275-292.
- Becker, Howard S., Geer, Blanche, Hughes, Everett C., & Strauss, Anselm L. (1961). Boys in white: Student culture in medical school. Chicago: University of Chicago Press.
- Brown, J.S. (1995, May 15). Rethink how medical schools pick 'best' students. American Medical News, 19, 29.
- Burnard, Philip. (1996). Acquiring interpersonal skills: A handbook of experiential learning for health professionals. London: Singular Publishing Group.
- du Pre, A. (2000). Communicating about health: Current issues and perspectives. Mountain View, CA: Mayfield.
- Evans, Barry J., Stanley, Robb O., & Burrows, Graham D. (1992). Communication skills training and patients' satisfaction. Health Communication, 4 (2), 155-170.
- Harter, Lynn M., & Krone, Kathleen J. (2001). Exploring emergent identities of future physicians: Towards an understanding of the ideological socialization of osteopathic medical students. Southern Communication Journal, 67 (1), 66-83.
- Mishler, E.G. (1984). The discourse of medicine: Dialectics of medical interviews. Norwood, NJ: Ablex.
- Pomerantz, Anita, Fehr, B.J., & Ende, Jack. (1997, June). When supervising physicians see patients: Strategies used in difficult situations. Human Communication Research, 23 (4), 589-615.
- Street, Richard L. Jr., & Wiemann, John M. (1988, Summer). Differences in how physicians and patients perceive physicians' relational communication. The Southern Speech Communication Journal, 53, 420-440.
- Valente, Carmine M., Antlitz, Albert M., Boyd, Marlyn D., & Troisi, Angelo J. (1988). The importance of physician-patient communication in reducing medical liability. Maryland Medical Journal, 37 (1), 75-78.



APPENDIX

NOTE: Arrowed statements refer to additional comments made by participants.

Q1: What year are you in your residency?

First: 5; 18.5%

Second: 14; 52%

Third: 2; 7.5%

Fourth: 2; 7.5%

Fifth: 2; 7.5%

Senior: 1; 3.5%

Chief: 1; 3.5%

Q2: What area is your residency in, if you've declared one? If not, what area(s) are you considering?

Internal Medicine: 11; 41%

Radiology: 4; 15%

Physical Medicine and Rehabilitation: 2; 7.5%

Emergency: 2; 7.5%

Pathology: 1; 4%

Neurology: 1; 4%

Oncology: 1; 4%

Family: 1; 4%

Infectious Disease: 1; 4%

Dermatology: 1; 4%

Vascular Surgery: 1; 4%

Otolaryngology/head and neck surgery: 1; 4%

Q3: When you think about the relationship between doctor and patient, how important, on a scale of one to ten, do you think communication is, if at all? Ten is the most important, one is the least important.

Ten: 19; 70%

Nine: 5; 18.5%

Eight: 3; 11%

→ doctor/patient trust

→ gauging patient comprehension

→ language barriers, loss of communication through translators



Q4: How important do you think your attendings consider communication skills?

Ten: 8; 29.5%

Nine: 6; 22%

Eight: 6; 22%

Seven: 3; 11%

Six: 2; 7.5%

- depends on the field
- training
- patient comprehension
- problems with time
- person to person variables

Q5: To what factors do you attribute poor interaction between doctors and patients?

Lack of time: 19; 70%

- doctor to patient ratio: 6; 22%
- doctors are overworked: 4; 15%

Language factor: 10; 37%

- language and cultural barriers: 7; 30%
- technical terms and jargon: 3; 11%

Doctors' lack of communication skills: 4; 15%

Patients' comprehension or level of understanding: 2; 7.5%

Patients' education level: 4%

Patients' response to choices presented by the doctor: 1; 4%

General distractions in the hospital: 1; 4%

Q6: What are the characteristics of your ideal patient?

A patient who is understanding: 16; 59%

- understanding of their problem: 8; 29.5%
- understanding of the doctor: what the doctor is saying, what the doctor's limitations are, what's going on and why the doctor is doing what s/he is doing: 8; 29.5%

A patient who has an open mind/wants to improve his or her health: 8; 29.5%

A patient who is compliant: 8; 29.5%

A patient who trusts me: 5; 18.5%

A patient who asks questions: 5; 18.5%

A patient who is proactive and researches his or her condition: 2; 7.5%

A patient who is personable: 2; 7.5%

A patient who communicates/explains well: 2; 7.5%



Q7: Describe your ideal communication interaction with a patient.

Mutual, open conversation where patient and doctor listen and disclose: 12; 44.5%

Interaction where there are many questions: 4; 15%

Interaction with no time constraints: 3; 11%

A succinct, focused interaction, where only related topics are discussed: 3; 11%

An interaction that feels like friends: 3; 11%

An interaction that takes place in a calm setting, with only the doctor and patient present: 2; 7.5%

An interaction where both participants speak the same language: 1; 4%

A one-way interaction, with doctor dictating: 1; 4%

An ideal interaction would always depend on the unique circumstances: 1; 4%

Q8: How would you describe your feelings towards lawsuits brought by patients against doctors?

Good if valid: 10; 37%

→ mistakes do happen: 3; 11%

→ there are bad doctors: 1; 4%

→ a way to stop mistakes: 1; 4%

→ a “necessary evil:” 1; 4%

→ for compensation/retribution: 1; 4%

Against it: 3; 11%

→ people think doctors are like God: 1; 4%

→ stem from greed: 2; 7.5%

Depends on circumstances: 3; 11%

Good communication avoids/is needed: 5; 18.5%

Can hinder care/affect way practice: 3; 11%

Better documentation avoids/is needed: 3; 11%

Consciously avoid/worry about: 2; 7.5%

Scared: 2; 7.5%

Good relationship/therapeutic avoids/is needed: 2; 7.5%

Would be avoided if doctor admitted mistake: 2; 7.5%

Patient’s rights: 1; 4%

Removed from issue because resident: 1; 4%

Normal in our culture: 1; 4%

Few actually follow through: 1; 4%

Don’t fear: 1; 4%



Q9: Why do you think most patients sue doctors?

- Poor communication: 8; 29.5%
- Someone to blame: 5; 18.5%
- Unhappy with care/treatment/outcome: 5; 18.5%
- Mad at doctor and situation/want compensation: 4; 15%
- Monetary retribution: 3; 11%
- Bad relationship/rapport: 3; 11%
- Doctor did something wrong: 2; 7.5%
- Feel wronged/hurt: 2; 7.5%
- Lack of understanding (of patient): 2; 7.5%
- Physician tries to cover-up: 2; 7.5%
- Negligence: 1; 4%
- Unrealistic expectations: 1; 4%
- No trust in doctor: 1; 4%
- Cultural trend: 1; 4%

Q10: Is there anything else I should know about your feelings about lawsuits?

- Compensation is disproportionate to issue/limit compensation: 3; 11%
- Some deserve compensation: 2; 7.5%
- Some patients will sue whether something was done wrong or not: 1; 4%
- Mistakes do happen—they don't have to result in death: 1; 4%
- Lawsuits are anxiety provoking: 1; 4%
- People sue a lot more now, and they're not afraid: 1; 4%
- Lawsuits make people more careful in what they do/detracts from patient care: 1; 4%
- Scary to the point where it makes some reluctant to enter medicine, or predisposed towards leaving: 1; 4%
- Most doctors get sued in their lifetime no matter what they do: 1; 4%
- Patient may not be well educated: 1; 4%

Q11: Describe an example of a doctor-patient interaction that you feel went very well.

- Reach out to family about sick/dying patient: 4; 15%
- Talk to family—being open and honest: 3; 11%
- Take the time to learn the goals of the patient: 3; 11%
- Make the patient comfortable: 3; 11%
- Time for relational component—open, friendly exchange: 3; 11%
- Make sure patient understands what is going on: 2; 7.5%
- Regiment followed and understood → positive outcome: 2; 7.5%



Led to accurate diagnosis: 2; 7.5%

Patient comes prepared: 1; 4%

Respectful of my time: 1; 4%

Explained that patient should ask questions of his regular doctor: 1; 4%

Working well with a difficult patient: 1; 4%

Patient was happy because doctor seemed concerned: 1; 4%

Q12: Describe an example of a doctor-patient interaction that you feel did not go well.

Not taking time to talk with patient/not giving patient a chance to interact: 3; 11%

Psychological disorder or drunkenness: 3; 11%

Cultural barrier: 2; 7.5%

Use lots of medical terms: 2; 7.5%

Patient wants to dictate treatment: 2; 7.5%

Patient demands more time than doctor has/ not enough time to discuss: 2; 7.5%

Patient refuses/ resistant to treatment: 2; 7.5%

Patient begins conversation aggressively/defensive: 2; 7.5%

Couldn't tell patient what patient wanted to hear: 1; 4%

Doctor not personable, bad communication skills: 1; 4%

Language barrier: 1; 4%

Demand unreasonable things from doctor: 1; 4%

Female patient thought male doctor was inappropriate: 1; 4%

Patient showed up late, doctor didn't take time for interaction: 1; 4%

Long wait makes patient frustrated/upset: 1; 4%

Patient unhappy with care, hostile: 1; 4%

Doctor messed up and wouldn't admit it: 1; 4%

Q13: Did you ever receive any formal training or courses about general communication?

Mock patient interactions: 14; 52%

Lectures/scheduled courses: 10; 37%

Don't remember: 2; 7.5%

None: 2; 7.5%

Small group tutorials: 2; 7.5%

Risk management presentation: 1; 4%



Q14: What did you think of the training?

Effective: 8; 29.5%

May be helpful, but you actually have to do it: 6; 22%

Very effective: 4; 15%

Not effective: 3; 11%

Medical school interviews weed out the bad communicators: 1; 4%

Q15:

Q15a: Have you ever received any formal training regarding how to handle a situation when you make a mistake when interacting with a patient?

No: 13; 48%

Yes, through courses: 6; 22%

Don't remember, but think so: 4; 15%

Yes, risk management: 3; 11%

Yes, retreat with lectures: 1; 4%

Q15b: What specific communication strategies did they provide, if any?

Honesty/truthfulness/forthcoming/up front: 11; 41%

Admit/tell of mistakes: 5; 18.5%

Apologize: 4; 15%

Good relationship: 2; 7.5%

Good documentation: 2; 7.5%

Never argue: 1; 4%

Find out why patient is mad: 1; 4%

No interaction: leave everything to lawyers: 1; 4%

Q15c: Did you ever think, "I would not feel comfortable interacting with a patient in this way?"

No: 10; 37%

Yes: 1; 4%

Q16:

Q16a: Have you ever received any informal training about how to handle a situation when you make a mistake interacting with a patient?

Yes: 17; 63%

→ 13; 48% specifically note learning from a superior

No: 6; 22%

Q16b: What communication strategies have you learned from watching others or in your experience?

Honesty: 7; 26%

Acknowledge mistake: 6; 22%



Don't bring up the mistake, apologize that things went badly: 1; 4%

Dealing with death and dying: 1; 4%

Talk about complicated things in person: 1; 4%

The more information you give the patient, the better: 1; 4%

Give patients the chance to talk—and listen/spend the time: 1; 4%

Don't let language/culture be a barrier: 1; 4%

Breaking bad news: 1; 4%

Asking the right questions: 1; 4%

Don't belittle patients: 1; 4%

Q17:

17a: What is a resident supposed to do if they feel like a patient might threaten a lawsuit?

Speak to attending/superior: 16; 59%

Call hospital council: 11; 41%

Find root of problem/ smooth things out and see where the patient was coming from: 2; 7.5%

Discuss with patient/ use communication to better the situation: 2; 7.5%

Let others know: 1; 4%

Be straightforward: 1; 4%

Depends on situation : 1; 4%

Be accommodating: 1; 4%

Treat people as you would treat your family: 1; 4%

Document everything: 1; 4%

Let them yell and explain your stance: 1; 4%

Find lawyer if necessary (doesn't seem to mean risk management): 1; 4%

17b: How did you learn this?

Risk management presentation: 3; 11%

Formal training/lectures: 2; 7.5%

Informal/observation: 2; 7.5%

Common sense: 1; 4%

Learn to go to your attending for everything: 1; 4%

Through experience: 1; 4%

Remember from med school course: 1; 4%

Understood: 1; 4%

Told by attendings: 1; 4%



Q18:

18a: Have you or any doctor you've known made a mistake? What happened and how was it dealt with?

Wrong meds ordered: 9; 33%

Wrong dose of meds: too much/too little: 6; 22%

Medication wasn't discontinued/stopped too early: 3; 11%

Risk of procedure or of taking medication occurred: 3; 11%

Wrong diagnosis: 2; 7.5%

Not picking something up in exam or history: 2; 7.5%

Not ordering right test/doing best treatment: 2; 7.5%

Patient was sent to floor without orders and therefore got meds very late: 1; 4%

Keeping diagnosis from patient: 1; 4%

Reading wrong report: 1; 4%

Has not been involved in mistake: 1; 4%

18b: Did they talk to anyone about it?

attending: 9; 33%

patient/patient's family: 6; 22%

chief/senior resident: 4; 15%

other residents: 3; 11%

entire program: 2; 7.5%

nurses: 2; 7.5%

Q19:

19a: Were they concerned about being threatened with a lawsuit?

No: 15; 55.5%

→ complication of the procedure

→ routine error

→ outcome was fine

→ not a major error

→ never disclosed to the patient

Yes: 6; 22%

19b: If not, what would have to happen for the doctor to be concerned about a lawsuit?

→ wrong medicine actually given and not caught

→ wrong dose of meds given

→ a specific mistake that is serious

→ doesn't matter what mistake is, has more to do with relationship

→ wrong meds/missing lab value/missing something that is standard of care

→ kill somebody/ chop off wrong leg



Q20: Have you or any doctor you've known been in a position where a patient has threatened a lawsuit?

Yes: 5; 18.5%

Yes, but none that were credible: 4; 15%

Yes, but don't want to discuss: 1; 4%

Not sure: 2; 7.5%

No: 8; 29.5%

Q21: Are there any questions that I should have asked but didn't, or anything else you would like to share?

→ Should be a way for patients to have dialogue with their patients when they need it./ Continuity of care is important for how patients feel about their care.

→ Interesting to see how much our decisions are based on avoiding a lawsuit instead of just taking care of a patient. And how much that costs on the community.

→ I think there's a bit of a notion that physicians are that way because they're cold or that they prefer not to explain things in more detail, that they don't want to take the time to do it. And the truth is, they don't want to take the time because they don't have the time and that's really the unfortunate part.

→ Full disclosure in care or not debate—how much choice should patient have. (Thinks this depends on patient's level of education.)

→ Communication is difficult to teach.

→ A huge portion of patient-doctor communication depends on doctor-doctor communication.

→ I think you were pretty through you know um again lawsuits are pretty scary and I think it is something that kinda eats away in the back of our minds and I think it does affect how we practice medicine.

→ Good doctors who have better communication with their patients are less likely to get in trouble.

→ One thing that I think is going on in medicine is that there is a huge shift from like medical school, from what I've heard, use to be really focused on just the science of medicine...And, ya know, not so much the relationship and ahh the communication and I think that as- well I'm not sure for the reasons but I speculate that maybe now that we have so much more knowledge you can't really learn everything in medical school and yo- you need to learn a lot of like the scientific knowledge as well as you go along in your training in addition I don't know why there's a lot more training now in communication and the doctor patient relationship...And I think that's a GREAT thing and it's good, but I just don't know exactly why that started.

→ ...and if you've a good communication with your patient you'll have a good relationship and as long as you're open and up front about your mistakes I don't think that- I think of lawsuits can be avoided, you know, completely.