Lown Right Care

Reducing Overuse and Underuse

Poor Physician-Patient Communication and Medical Error

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Case Scenario

A 48-year-old patient presented with a history of major depressive disorder and mildly elevated blood pressure. After two separate blood pressure measurements of 155/90 mm Hg, the patient's physician prescribed daily hydrochlorothiazide (HCTZ) to lower blood pressure. The patient asked if there was anything important to know about the medication, and the physician said the patient should eat a banana daily to keep potassium levels up. The patient was advised to follow up in the future. The physician did not ask about any other medications the patient was taking or other health habits, and additional blood tests were not ordered.

The patient was taking escitalopram (Lexapro), which a psychiatrist prescribed, was an avid runner, and often fasted one day per week for health reasons. The patient took the HCTZ as prescribed and, over the next few weeks, began to feel weak and dizzy. The patient called his physician, who diagnosed acute labyrinthitis over the phone and prescribed meclizine for vertigo. The patient's symptoms worsened despite the new medication, and the patient passed out during a run one week later, on a day of fasting. At the emergency department, the patient's blood pressure was 75/50 mm Hg, potassium was 2.3 mEq per L (2.30 mmol per L), and sodium was 117 mEq per L (117.00 mmol per L). The patient was admitted to the hospital, and the HCTZ was immediately discontinued.

Clinical Commentary

Good communication between physicians and patients is essential to enable good outcomes and avoid medical errors. Sometimes patients cannot express their concerns and needs clearly. Conversely, physicians often overestimate their communication skills, and such skills have been shown to decline during a physician's career.[1] Breakdown in communication can lead to harm and suboptimal treatment. A previous article in *American Family Physician* highlighted the importance of involving the patient as a partner in the diagnostic process,[2] something that can only occur with good physician-patient discourse.

Poor communication can lead to a medical error when a patient does not report their allergies or health history to a physician, or when a physician does not correctly or thoroughly record a medical history or medication list, as in this patient's case. When clinicians do not communicate well with each other, errors can occur because of incorrect or missing information.[3] But harm may also occur when patients do not follow a prescribed course of care or physicians do not inform patients of potential risks of treatment.

Studies have shown that ineffective clinician communication can reduce patient adherence to care. One study found that when patients believed communication was optimal, 70% followed recommendations, whereas when communication was deemed poor quality, only 50% did. Patients with lower adherence had worse outcomes and a substantially higher cost of care.[4] In 71% of cases

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This series is coordinated by Kenny Lin, MD, MPH, deputy editor.

A collection of Lown Right Care published in *AFP* is available at https://www.aafp.org/afp/rightcare.

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Author disclosure: NEEDED

in which patients did not follow a physician's care plan, they did not agree with what the physician recommended, or they did not fully understand the physician's instructions. This can occur when a physician does not explain the recommendations adequately and does not allow patients to ask questions or voice their beliefs or concerns.[5] When patients are allowed to tell their story and physicians explain information in a way that patients understand, adherence and quality of care improve without increasing the patient visit time.[6] Good communication has been associated with higher patient satisfaction, increased adherence to therapy, better control of blood glucose and blood pressure, fewer medical mistakes, and increased symptom resolution.[7]

What constitutes effective physician-patient communication? Often it is spending time listening to a patient's needs and wants and understanding each patient's circumstances. A short discussion of the patient's health habits would have impacted medication choice for this patient. Studies suggest that listening, explaining, and having empathy are the three most important factors in increasing patient satisfaction and outcome.[5] Studies show that poor communication leads to a poor sense of physical and mental health compared with more optimal communication.[4] When physicians do not sufficiently explain interventions, do not respect the health beliefs of their patients, and do not try to reach consensus, the likelihood of therapeutic failure and error increases.

Poor communication can lead to a nocebo response, in which patients feel they are not being heard, do not convey all their health information to the physician, and tend to ignore advice.[8] For this patient, the physician's limited questioning created a breach where the patient did not convey important information to the physician and impeded the physician from recognizing symptoms that were caused by a medication the physician prescribed.

Physician-patient discourse should occur in a language and at a health literacy level that patients understand. Using relative numbers (e.g., 50% reduction in stroke, as in this patient's case) is confusing to patients and does not help them understand actual risks and benefits. The use of absolute numbers or the number needed to treat is more comprehensible and accurate.

Good communication does not take more time; it only requires a physician to consider it important and be adequately trained. Good communication has been shown to be as important as many prescribed therapies, possibly contributing to the beneficial effects of antidepressants and dementia drugs.[7]

Patient Perspective

Good communication and good patient care are closely intertwined in primary care, as this patient's case illustrates. The physician presumably had access to the patient's medication list and possibly to information about the patient's dietary and exercise habits. That the physician did not take these factors into account suggests that the patient's electronic health record had not been reviewed or that the physician was unaware of the documented interaction between escitalopram and diuretics. The patient's subsequent phone report of a well-known adverse effect was attributed to a new and unrelated disease process (labyrinthitis), which suggests the same casual attitude toward the patient's history. Did the physician not remember the prescription for HCTZ? Should the physician have asked about the patient's current blood pressure readings? In both instances, asking the patient a couple of simple questions would have elicited the necessary information even if it were unavailable from other sources.

To say that the patient did not convey important information to the physician misses the point. The patient's actions indicate that the patient was a health-conscious and conscientious individual. The patient exercised regularly, paid attention to diet, followed the physician's recommendations, and called about new symptoms when they appeared. The patient asked the physician the key question that should have opened up the shared decision-making process: "Is there anything I need to know about this medication?" The physician deflected the question with a suggestion to eat bananas.

A patient would rarely persist in light of such a response. Patients have been acculturated to believe that physicians should not be questioned, and most patients might assume there is nothing to be concerned about if a physician does not mention it. This patient had probably filled out forms documenting medications and health habits and reasonably assumed these were considered. It is incumbent on clinicians to be familiar with the possible adverse effects and interactions of the medications they prescribe and share that knowledge with their patients.

TAKE-HOME MESSAGES FOR RIGHT CARE

- Listening, explaining, and having empathy are the three most important factors in increasing patient satisfaction and outcome.
- When physicians do not sufficiently explain interventions or attempt to understand patients and respect their individual health beliefs, the likelihood of therapeutic failure and error increases.
- Good communication leads to the right care and better adherence to that care, higher patient satisfaction, fewer diagnostic errors, and fewer medical mishaps.
- Communication should occur in a language and at a health literacy level that patients understand, and benefits and harms should be presented as absolute rather than relative numbers.

The interactions between this patient and physician raise further concerns. It may be premature to prescribe an antihypertensive medication after only two blood pressure measurements without considering the possibility of white coat hypertension. Asking the patient to take their blood pressure at home would have provided a layer of protection against adverse events and would, in all likelihood, have prevented the alarming experience of passing out and going to the emergency department.

The misdiagnosis of labyrinthitis is troubling because it was made without the patient being examined. This is a serious diagnostic error mediated by poor communication that may be replicated many times as medical care shifts to more virtual visits. It is the physician's responsibility to know when a virtual assessment is sufficient and when it is not.

Resolution of Case

By not taking time to thoroughly discuss the patient's medications, health habits, and exercise routine, the physician prescribed a medication that was not optimal and potentially dangerous. The physician did not arrange a follow-up appointment and laboratory tests, adequately discuss the possible risks of the medication they prescribed, or take the correct actions when the patient called and reported dizziness.

Before discharge, the hospital team contacted the patient's physician to determine a blood pressure medication that would work well based on the patient's lifestyle and comorbidities. They chose low-dose lisinopril. The physician spoke with the patient at the time of discharge to discuss why the previous medication caused a severe reaction and possible adverse effects of the new medicine. They both agreed to be more forthright in their communication. A follow-up appointment was arranged for one week after discharge.

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