Communicate, don’t litigate: The Schwartz Center Connections Program

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Little is known about effective educational approaches intended to reduce malpractice risk by improving communication with patients and among multidisciplinary teams in outpatient settings in order to prevent diagnostic delays and errors. This article discusses a prospective, controlled educational intervention that aimed to open lines of communication among teams in two disciplines: identifying how and why communication lapses occur between disciplines and with patients, and articulating strategies to avert them.

INTRODUCTION

Although the majority of patient care now occurs in outpatient settings, the study of patient safety and quality improvement in these settings is just beginning to evolve.1,2 The total number of malpractice claims decreased between 2005 and 2009, but the proportion of paid claims for outpatient errors increased significantly to 43.1%. Diagnostic errors (diagnoses that are missed, incorrect, or delayed) were the most common reasons for these paid outpatient claims.3,4 Most diagnostic errors involve cognitive factors, but communication lapses between physician and patient, or among providers, have been implicated in many cases. Examples of these lapses include failure to obtain adequate medical history, poor communication between providers about referrals and follow-up, and other process breakdowns.5

We designed a new program, Schwartz Center Connections, to improve providers’ role clarity, care coordination, and communication with each other and with patients in outpatient settings. Our goals were to improve the safety of patients whose care is shared among multiple providers and to reduce malpractice risk.

BACKGROUND

Most errors do not result in malpractice claims, but patients and families decide to litigate when they perceive lack of caring, communication, and collaboration with and among clinicians.6,7 Levinson et al found that primary care physicians (PCPs) who had no malpractice claims used more effective communication skills (eg, orienting patients to the visit, soliciting opinions,
Effective communication increases in complexity when multiple clinicians and staff from different specialties in different locations are involved in a patient’s care. A large cross-sectional analysis of Medicare claims showed that the typical PCP coordinates care of patients with 229 other physicians in 117 practices in one year. As many as 15%-30% of a PCP’s patients may be referred to specialists yearly. Role clarity, care coordination, and communication during shared care, consultations, and transitions of care between PCPs and specialists is vitally important but often lacking. Despite hopes that electronic health records will provide a technologic solution, use of health information technology is not necessarily associated with improved communication outcomes.

**Intervention objectives**

We aimed to open lines of communication among team members across two disciplines, to provide opportunities for them to build collegial relationships to discover how and why communication fails during the care of their shared patients, and to identify opportunities for improvement. Because discussions addressed lapses that had resulted in significant harm to patients, we wanted to provide a safe venue to consider the emotional impact this has on patients, families, and professional caregivers. We also wanted to explore the program’s impact on quality and patient safety initiatives. In this pilot program, we included PCPs, who play a central role in continuity and coordination of care, and gastroenterologists (GIs) because failure or delay in diagnosing cancer is among the most common malpractice allegations, and colon cancer is among the most common types of cancer cited in malpractice claims.

**Educational intervention**

Educational program teams at each site included physician liaisons with responsibility for quality issues in their divisions of primary care and gastroenterology and a clinician-educator who facilitated each session. Five 60- to 90-minute case-based multidisciplinary, interprofessional discussions were conducted at each site over 9 months.

Each case was based on a closed malpractice claim that involved a patient shared by the 2 disciplines. We created 6 brief, deidentified clinical summaries, a patient or family member narrative, and a facilitation guide for each case. The fictionalized patient or family narratives, were created to reveal who the patient was as a person and to describe his or her emotions and experiences of care. The session facilitation guides included clear learning objectives, questions to evoke discussion of communication and relational lapses and potential solutions, and information or slides to help facilitators teach selected relevant communication skills.

Our educational strategies included interactive case- and narrative-based discussions with repetition of summarized learning points. We included the patient and family members’ stories to bring their voices and perspectives into the discussion and to enhance empathy and compassion for the patient and between colleagues, as we have seen occur in the context of Schwartz Center Rounds. The Schwartz Center Rounds, now taking place in over 300 sites across the United States and in England, are multidisciplinary forums that offer healthcare providers regularly scheduled opportunities to openly and honestly discuss together social and emotional issues that arise in caring for patients. In the Schwartz Center Connections program, too, we hoped to foster open dialogue while also counterbalancing the potential fear and distress engendered in healthcare providers during discussions of malpractice.

A site-based clinician facilitated each case-based discussion. The facilitator reinforced the goals of listening and mutual respect at the beginning of each session and asked a participant to read the case summary. Another participant read the patient or family member narrative, after which the group discussed the emotional impact of the cases on them and the social and emotional aspects of the patient and family’s context and reactions. The facilitator then initiated a discussion of the communication lapses that led to diagnostic delay or failure, and, in the final portion of the session, strategies to prevent these lapses. After each session, the physician liaisons, facilitator, and Schwartz Center program developers summarized “key learning points” that emerged during the discussion and e-mailed them to all attendees.

**EVALUATION METHODS**

We evaluated the impact of our program using a prospective design with an intervention and comparison group, and thematic analysis of stakeholder interviews. Professional and administrative staff members in primary care and gastroenterology were invited to attend all...
educational sessions; however, the evaluation study included 56 professionals in the intervention group who attended 2 or more sessions and 56 professionals who attended none. Participant characteristics are shown in Table 1.

Intervention and comparison group members completed online baseline and postprogram surveys. Postprogram surveys were completed 2 to 7 weeks after the final program session. Intervention participants who attended the final session at each site were also invited to participate in focus groups (n = 26), and another subset was invited to take part in semistructured telephone interviews (n = 17). Thirteen stakeholders took part in telephone interviews; 2 additional people took part in hybrid stakeholder/participant interviews because they had attended sessions. Stakeholders included session facilitators, physician liaisons, representatives of the funder, PC and GI chiefs, and executives responsible for clinical quality and patient safety.

This study was approved by the Institutional Review Board of the Beth Israel Deaconess Medical Center, to whom the Institutional Review Board of Massachusetts General Hospital ceded review in accordance with joint agreements between these 2 institutions.

### Main measures

The primary outcome measure was a 10-item Communication Lapse Prevention Scale (CLPS). A review of the literature on safety climate and provider communication in medical settings did not yield any appropriate existing scales for assessing communication lapse prevention. Therefore, the evaluators, in conjunction with the program designer, developed a customized measure keyed to the specific learning goals of the intervention (see Table 2 for items). CLPS scores can range from 1 (not at all knowledgeable) to 6 (extremely knowledgeable). The scale was highly reliable, with Cronbach’s alpha of 0.92–0.94.

An additional outcome measure was a 5-item scale adapted from Makoul and colleagues’ Communication Assessment Tool (CAT). This measure used 5 of the 14 CAT items, focusing most specifically on communication (see Table 3 for items). The items were revised to reflect the provider’s rather than the patient’s point of view and the original 5-point “quality” scale (poor to excellent) was changed to a 6-point “satisfaction” (extremely dissatisfied to extremely satisfied). The scale was highly reliable, with Cronbach’s alpha of 0.81.

Other secondary outcomes, relevant only for the intervention group, included self-reported changes in knowledge, attitudes, and behaviors as a result of the program.

### Key results

Most intervention group members agreed that as a result of their participation, they had more strategies for communicating effectively with patients (91%), members of the other department (90%), and members of their own department (88%). Further, the Connections group reported behavior changes that they attributed to their participation in the program, including being more likely to intervene to prevent communication lapses (93%) and communicating more often with members of their own department (84%), members of the other department (78%), and patients (75%).

Comparing the results of the intervention group with those who did not attend any sessions, the intervention group had statistically significant improvements in 8 of the 10 items assessed by the CLPS (p < 0.05). Averaging across items, the number of session attendees who were very or extremely knowledgeable about the communication strategies increased by 19% in the treatment group, versus a 7% drop in the comparison group. These included provider-to-provider strategies (eg, to clarify and resolve any differences relating to follow-up) and provider-to-patient strategies (eg, for talking with patients about errors and adverse events and about follow-up). This also included knowledge about systems that support the sharing of information among multiple providers involved in a patient’s care (Table 2).

Connections participants also made statistically significant (p < 0.05) gains on the scale constructed from the adapted CAT items, reflecting improved satisfaction with their ability to communicate in ways patients can understand.
and to provide emotional support. Averaging across items, the number who were extremely satisfied with their ability to communicate with patients in various ways increased by 13% in the treatment group, as compared with 3% in the comparison group (Table 3).

We inspected graphs of the relationships between how many sessions participants needed to attend before these positive outcomes occurred. These graphs suggested that there was maximal benefit at the end of 3 sessions, at least in terms of the quantitative outcomes assessed by the surveys.

“Key Learning Points” (summaries of each session distributed to Connections participants) revealed heightened awareness of how poor communication can precipitate errors. One participant said, “(The most important thing I learned was) recognizing how potential lapses in communication can occur. It also increased my awareness of the importance of communication and potential ways of avoiding lapses in communication.”

Participants also highlighted the importance of self-awareness. For example, clinicians recognized how their assumptions and unconscious biases about patients’ lifestyles, personal choices, and other factors affected their care. They also attested to knowledge of new patient-centered communication strategies; for example, eliciting and responding to patients’ concerns, and exploring their personal and social reasons for nonadherence. After attending Connections, a participant said, “I don’t assume patients are aware of reasons for tests; I try to uncover reasons for noncompliance—poor understanding, fear, not informed about (the) reason for (a) test.” Another said, “Connections made me realize how often our patients don’t understand what we are telling them … I (now) go back and check their level of understanding and how comfortable they are with what we’ve just discussed.”

Another “Key Learning Point” reflected participants’ insight that communication is an individual and community responsibility. One of the most striking and consistent themes throughout the interviews and open-ended survey responses was how unusual it is for providers from different specialties to have a chance to sit down and talk to each other in a neutral, safe space and the great value of such interactions. A PCP commented: “Hearing that we have shared values and goals is a powerful product. I feel it … That personalization enhances information flow and thus translates to improved patient care, and particularly our relationships with our patients.”

Several participants mentioned that providers typically work in “silos” in which providers in different specialties rarely interact in person or by telephone. Providers described having long-term referral relationships with specialists whose faces and voices she would not recognize and whose personalities—and sometimes even genders—she did not know. Connections fostered a sense of
teamwork. As one participant said, “(I am) more respectful of the perspective of my colleagues—they are no longer ‘faceless’ entities, but part of a team to which I belong.”

Finally, stakeholders reported during interviews that the Connections program helped refine or energize existing quality initiatives at both hospitals. Examples include (1) revising colonoscopy preparation instructions to be more patient friendly, (2) partnering across departments to increase colonoscopy screenings, (3) refining and implementing initiatives to schedule patient follow-up after colonoscopies, (4) entering recommendations by GI about colonoscopy follow-up and return intervals in a standardized location in the electronic medical record, (5) consistently including reasons for GI referral by PC, (6) clarifying whose responsibility it is to ensure that recommended follow up occurs, and others.

DISCUSSION

Effective communication with patients and among providers is essential for compassionate, coordinated, safe care that is consistent with patients’ preferences. Nevertheless, such communication is inconsistent and educational programs to improve it across patient care settings and disciplines are largely lacking.11,20,21 The Connections program addressed this gap and had a significant effect on session participants’ strategies for communicating with

<table>
<thead>
<tr>
<th>Knowledge of or Strategies For…</th>
<th>Mean Change</th>
<th>p Value</th>
<th>Percentage Who Were Very or Extremely Knowledgeable about the Communication Lapse Prevention Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resolving differences of judgment among providers</td>
<td>+1.04</td>
<td>-0.06</td>
<td>&lt; 0.01</td>
</tr>
<tr>
<td>Roles in communicating diagnostic findings across departments</td>
<td>+0.98</td>
<td>+0.10</td>
<td>&lt; 0.01</td>
</tr>
<tr>
<td>Communicating with patients about sharing information with providers</td>
<td>+0.78</td>
<td>-0.16</td>
<td>&lt; 0.01</td>
</tr>
<tr>
<td>Systems that support the sharing of information among multiple providers</td>
<td>+0.74</td>
<td>-0.36</td>
<td>&lt; 0.01</td>
</tr>
<tr>
<td>Clarifying who discusses abnormal findings with patients</td>
<td>+0.73</td>
<td>-0.21</td>
<td>&lt; 0.01</td>
</tr>
<tr>
<td>Clarifying provider responsible for follow-up</td>
<td>+0.72</td>
<td>-0.20</td>
<td>&lt; 0.01</td>
</tr>
<tr>
<td>Helping patients take responsibility for diagnostic testing and follow-up</td>
<td>+0.61</td>
<td>-0.18</td>
<td>&lt; 0.01</td>
</tr>
<tr>
<td>Discussing adverse events/medical errors with patients</td>
<td>+0.55</td>
<td>+0.09</td>
<td>&lt; 0.05</td>
</tr>
<tr>
<td>Roles in communicating diagnostic findings within departments</td>
<td>+0.42</td>
<td>+0.01</td>
<td>NS</td>
</tr>
<tr>
<td>Breaking bad news to patients</td>
<td>+0.26</td>
<td>-0.06</td>
<td>NS</td>
</tr>
</tbody>
</table>

Note: The maximum change from baseline to postprogram survey is ±5.00. Table shows estimated marginal means from univariate ANOVA, controlling for covariates: hospital, specialty, profession, gender, and age. NS is not significant.
colleagues and patients. Further, several important initiatives to prevent lapses in communication and improve the quality and patient safety of the care of patients shared between the participating disciplines ensued after the program.

The goals of the Patient-Centered Medical Home, the chronic care model, and other initiatives are to provide “whole person” coordinated, effective, and safe care.\textsuperscript{22,23} Shared electronic medical records (EMRs) may help attain these goals. However, some clinicians and patients find that EMRs detract from interpersonal communication.\textsuperscript{24,25} Clinicians also report barriers, including lack of standardization of key elements required for information exchange and information overload. Electronic referral systems may help with information exchange, but may not address clinicians’ concerns about how to improve the process of shared interdisciplinary decision making for mutual patients.\textsuperscript{26,27}

Systems-mediated communication may support but cannot replace interpersonal communication. It simply works better when people talk to each other. Relational coordination of care—strategies to resolve differences in judgment among providers.

This study has limits in generalizability, including its implementation in two US academic teaching hospitals, and its basis in self-report. Women outnumbered men in the sample although we controlled for this in the analysis. More than half of the intervention group had been in their profession for more than 20 years, as compared with about a third of the comparison group. It may be that the pilot program was somewhat more attractive to healthcare providers with more experience in the field, or perhaps it was simply easier for more senior providers to make time to attend more sessions.

This study suggests that educational programs can open lines of communication and improve communication and care coordination strategies across disciplines to prevent lapses in care that lead to malpractice claims in outpatient settings. Longitudinal research is needed to assess its impact on diagnostic errors that result in actual adverse events and malpractice claims. Nevertheless, interventions like the Connections program, that bring together “silo’d” providers to build relationships, communication, mutual understanding, respect, and trust, may be a powerful catalyst to improve the quality and safety of patient care and reduce malpractice risk while providing support to those who participate. These benefits are integral to compassionate, patient-centered care.

Table 3: Mean and Percentage Changes in Participants’ Satisfaction with Patient Communication from Baseline to Postprogram Survey

<table>
<thead>
<tr>
<th>Increased Satisfaction</th>
<th>Mean Change</th>
<th>Percentage Who Were Extremely Satisfied</th>
<th>( p ) Value</th>
<th>Pre</th>
<th>Post</th>
<th>Change</th>
<th>Pre</th>
<th>Post</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check to make sure patients understand everything you tell them</td>
<td>+0.25</td>
<td>-0.02</td>
<td>NS</td>
<td>Intervention</td>
<td>30%</td>
<td>43%</td>
<td>13%</td>
<td>Comparison</td>
<td>28%</td>
</tr>
<tr>
<td>Understand patients’ main health concerns</td>
<td>+0.23</td>
<td>+0.08</td>
<td>NS</td>
<td>Intervention</td>
<td>36%</td>
<td>55%</td>
<td>19%</td>
<td>Comparison</td>
<td>47%</td>
</tr>
<tr>
<td>Discuss next steps, including any follow-up plans with patients</td>
<td>+0.20</td>
<td>+0.02</td>
<td>NS</td>
<td>Intervention</td>
<td>46%</td>
<td>57%</td>
<td>11%</td>
<td>Comparison</td>
<td>40%</td>
</tr>
<tr>
<td>Provide emotional support to patients</td>
<td>+0.16</td>
<td>-0.11</td>
<td>&lt; 0.05</td>
<td>Intervention</td>
<td>38%</td>
<td>50%</td>
<td>12%</td>
<td>Comparison</td>
<td>54%</td>
</tr>
<tr>
<td>Talk to patients in terms they can understand</td>
<td>+0.14</td>
<td>-0.12</td>
<td>&lt; 0.05</td>
<td>Intervention</td>
<td>52%</td>
<td>64%</td>
<td>12%</td>
<td>Comparison</td>
<td>64%</td>
</tr>
</tbody>
</table>

Note: The maximum change from baseline to postprogram survey is ±5.00. Table shows estimated marginal means from univariate ANOVA, controlling for covariates: hospital, specialty, profession, gender, and age. NS is not significant.
FUNDING
This study was funded by a grant from the Risk Management Foundation of the Harvard Medical Institutions, Inc. (CRICO) to the Schwartz Center for Compassionate Healthcare. The funder provided the researchers with access to closed malpractice claims in the public domain and provided continuing education credits to physicians who attended the sessions. Members of the funder’s education staff attended each session and provided valuable input and feedback.

CONFLICTS OF INTEREST
Dr. Lown is an employee of the Schwartz Center for Compassionate Healthcare and Mount Auburn Hospital. She has received honoraria in the past from the National Board of Medical Examiners. Drs. Kormos, Kriegel, Leffler, Richter, and Ship received honoraria for participating in the Connections project. Drs. Gareis and Manning are employed at Goodman Research Group, Inc., a for-profit company that was contracted by the Schwartz Center for Compassionate Healthcare to conduct an external evaluation of the Connections program. Dr. Leffler reports paid consultancies with Shire Pharmaceuticals, Alba Therapeutics, Alvine Pharmaceuticals, Boston Clinical Research Institute; honoraria from National Foundation for Celiac Awareness, Healthy Villi; grants/research support from Shire Pharmaceuticals, Prometheus Laboratories, Glutenpro Diagnostics, National Institute of Health, BIDMC Center for Healthcare Delivery. Dr. Richter reports a paid consultancy with Policy Analysis Inc.

This work was presented in part as a poster at the Society of General Internal Medicine meeting, Orlando, Florida, May 2012, and at the IMAC Conference in Grand Cayman, November 2012.

CONTRIBUTORSHIP AND GUARANTORSHIP
Dr. Lown (the guarantor of this work) created the curricular materials, drafted and revised the article, contributed to the conception and design of the intervention and interpretation of data, and provided final approval of the version to be published. Drs. Gareis and Manning contributed to the conception and design of the intervention, collected and analyzed the data, contributed to drafting and revising the article, and provided final approval of the version to be published. Dr. Leffler served as the principal investigator on behalf of the study group for the Beth Israel Deaconess Medical Center Institutional Review Board. Drs. Kormos, Kriegel, Leffler, Richter, Ship, and Weil participated in the conception and design of the intervention and revision of the article for important intellectual content, and provided final approval of the version to be published. No person has been omitted who contributed substantially to the conception and design, or analysis and interpretation of data or drafting and critical review of this article.

REFERENCES


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