Reconnecting Doctors and Patients

By Dr Melanie Billings-Yun (PhD)

"I didn't blame the doctors for what went wrong in there. But I blamed them for acting as if nothing had happened, for stonewalling, for worrying more about a possible lawsuit than about me."

This actual patient complaint is an example of a typical early stage doctor-patient conflict of the sort I introduced in my article in the October issue of the *SMA News*, "Practicing Medicine in an Age of Disconnection." What started out as an easily avoidable communication failure, quickly crossed into anger over "medical arrogance", and ended up as a complaint of improper treatment, harming the doctor's record and potentially leading to lawsuit.

According to the report by Dr Wong Chiang Yin, Chairman of the SMA Complaints Committee, presented at the recent SMA 8th Ethics Convention, the most common complaints lodged against doctors in Singapore are (1) overcharging, (2) poor attitude by the doctor, (3) wrong diagnosis, and (4) faulty treatment.[1] Judging from a plethora of studies from all over the world, however, at the root of nearly all of these complaints is poor communication and a sense that the doctor "doesn't listen", "never tells us anything" and "just doesn't care about me."[2]

In last month's article, I talked about the importance of moving beyond blame over what was causing the rise in complaints and lawsuit and, instead, working to improve doctor-patient relations as a vital component of medical treatment. This month, I will focus on the practical steps you can take to reduce or resolve conflict with patients, proactively and productively. The key, I believe, is to borrow the tools of a negotiator.

NEGOTIATING DOCTOR-PATIENT RELATIONS

In the early 1980s, a team at Harvard University developed a negotiating method that revolutionized the traditional concept of positional bargaining which, they showed, not only led to unwise outcomes, but badly damaged personal relations in the process. Their seven-step negotiation process started instead from open ***communication*** of ***interests*** in order to encourage the development of creative ***options*** to achieve solutions that were based on ***legitimacy*** rather than force, and therefore were more likely to preserve the parties' underlying ***relationship***.[3]

While all of these are equally important steps in conflict resolution, my experience over two decades of negotiating in Asia indicate that good doctor-patient relations must place particular emphasis on establishing good ***relationships*** and strong two-way ***communication***. Moreover, developing trust is an equally important consideration.

In Singapore, as in most of Asia, relationships are directly related to trust. People tend to give greater trust to those they know well while generally mistrusting strangers. As I discussed last month, one factor in the sharp

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rise in patient complaints is that doctors and patients are less likely to have long-term relationships nowadays. And as doctor-patient relationships grow shallower and more fleeting, trust decreases. A sense that "the doctor didn't answer my questions" can rapidly devolve into "he must be hiding something" or even "he's lying to me."

That was what happened in the case quoted above. A patient had a surgical procedure under a local anesthetic. During the operation, she suffered severe muscle spasms throughout her body, which audibly alarmed the doctors during the procedure. The experience was traumatic for the patient in any case, but was made more so when each attending doctor in turn dropped by her ward to tell her that, whatever had caused the reaction, he had not been at fault. When the husband heard the wife's story, he angrily called the orthopedist. His anger turned to rage – and the filing of an official complaint – when the doctor replied in what seemed a dismissive way: "It wasn't important; don't worry about it."

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RE-ESTABLISHING TRUST

What was going on? In all likelihood, the doctor truly did believe that it was a minor incident that should not worry the patient. Or he may have been offended into silence by the man's tone, or feared that if he expressed regret, he would open himself up to medical liability. Perhaps he simply did not know what had caused the spasms and so chose to keep quiet. But his diffidence created the very outcome he wished to avoid. The problem is that he was viewing the incident only from his own perspective.

From the perspective of the frightened and confused patient, however, the doctor's failure to openly express either concern or sympathy implied that he did not care about her at all and, worse, that he must be hiding something. The husband told me that he filed the complaint because he saw that as the only way of finding out what had really happened to his wife. He went on to say that, since the doctor acted as if he thought they would sue him, he and his wife were fully justified in not trusting him. The doctor, he reasoned, had undoubtedly "messed up" and was just trying to cover his tracks.

In fact, studies have shown that people are quick to take retribution against those who appear to betray their trust.[4] In a negotiation game I have developed and played with hundreds of MBA students in Korea, Thailand and Singapore, "The Rice Market," I find pretty consistent results: participants tend to enter relationships warily, then cautiously begin to offer trust when they see it is to their advantage. Teams that are shown trust most often reciprocate – but they respond with genuine anger, often extending several rounds (even beyond class time!) if the other side fails to return their trust or is "disloyal". It normally takes a face-to-face conflict-resolution meeting – and a number of concessions by the "betrayer" – to return the relationship to equilibrium. In short, showing trust, though not always immediately reciprocated, is a necessary step in creating a relationship, while demonstrating mistrust is almost certain to achieve immediate distrust, even retaliation, in return.

In cases of doctor-patient conflict, a first step in re-establishing trust is to show "selfless" concern for the other. This does not mean making confessions whenever things go wrong. But it does mean being willing to express genuine empathy and interest in order to show the patient you care – and thereby to alleviate the rising mistrust that can balloon into accusations of negligence. The doctor in the above incident, for example, could have said: "I know it must have felt frightening, but let me explain what was going on and why you have no reason to be worried." If he did not know the cause of the problem, he might still have shown his concern for the patient by explaining: "We can't say at this point what caused those spasms, but I want to assure you that it did not affect the successful outcome of the operation. We are looking into it, but in the meantime, I have already noted it in your wife's record so that future doctors will be prepared if she undergoes another surgical procedure some day." Or he might simply have encouraged her to talk about her fears, responded thoughtfully, then asked her how she would like to proceed. Any of those responses would have been better than dismissing the patient's concerns without explanation ("There's nothing to worry about"; "That's not important") or refusing to talk about it altogether.

FOCUSING ON PATIENT INTEREST

The second case, which involved a friend of mine in Korea, primarily involves communication and the importance in any conflict of focusing on interests rather than positions. The woman underwent a very painful back operation and spinal fusion on a Friday, after which she was given a "morphine ball" (a self-regulating drip) that she was to squeeze whenever the pain got too intense. Initially, all went well. But on Saturday, the drip stopped working. When the patient called the nurse, she was told that the morphine drip had run out and they could not replace it because the hospital pharmacy was closed for the weekend. Tempers

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flared along with the pain. By the time the weekend duty doctor arrived, the patient and her sister were threatening to sue the hospital for malpractice. The doctor tried to ease tempers by asking everyone to calm down and apologizing for "the inconvenience," but that only seemed to make matters worse, especially when he agreed that there was nothing to be done until the pharmacy reopened on Monday.

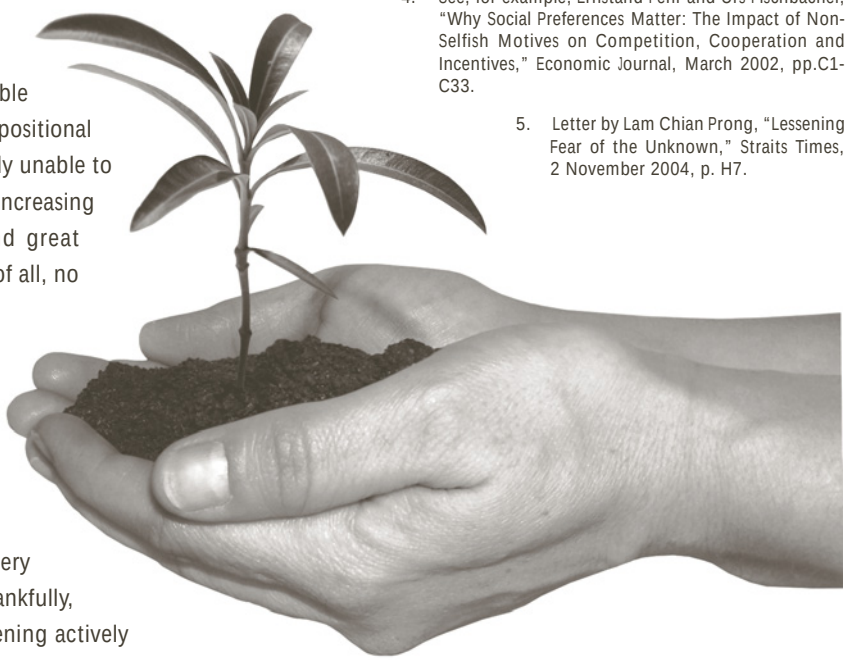
About then, the patient's brother-in-law, who had studied negotiation, arrived. After listening to the argument for a few minutes, he stopped everyone in their tracks. "It really doesn't matter if she has a morphine drip," he told the doctor. "My sister just needs something to relieve the pain. Is there anything else you could give her?" Astonishingly, a nurse spoke up at once: "Well, we could give her a morphine shot." It was that simple. Within half an hour, the patient was once again comfortable.

The point of this story is not that the medical staff at this hospital were negligent, but that they may have contributed to the patient's feeling that they were, through communication failings that progressively worsened as the situation became more conflictual. The doctor's apology was no doubt well-intentioned, but because it was not matched by any effort to rectify the situation, it came off as insincere – and the reference to the patient's suffering as "inconvenience" actually crossed over into insensitive. Moreover, the suggestion that the patient and her sister "calm down" merely increased their anger, as it made them feel that he was rebuking them for being upset rather than listening to their justifiable complaints.

However, the greatest error was to argue over positions ("Give me a morphine drip!" / "You can't have a morphine drip!"), rather than to listen closely to the interests of the patient ("I am in pain! I need ***help***!") and to communicate a range of options for achieving that interest in a medically justifiable way. By getting stuck in a yes / no positional battle, the parties were completely unable to reach a resolution, resulting in increasing anger, stress, recrimination, and great discomfort to the patient. Worst of all, no one could win such a positional argument without the other side losing.

Positional thinking is what leads many in the medical profession to believe that there are only two options: insisting on patient submission or letting every squeaky wheel run over you. Thankfully, nothing is ever so simple. By listening actively to your patients, finding out about their needs, wants and fears, and not just their medical symptoms – even when their feelings are communicated in angry tones – you can achieve both a greater understanding of and a closer bond with those under your care. By communicating your concerns, beliefs and judgments in a clear and reasonable, yet sensitive manner – neither defensive nor over-conciliatory – you increase both patient trust and compliance.

Strong two-way communication at the level of interests rather than positions opens the door to finding creative solutions that actually improve medical care. While, admittedly, this is easier said than done – especially given doctors' already overstretched schedules – communication and negotiation skills can and should be developed just as surely as any other skill in the physician's medical bag, through a training program followed by dedicated practice. While some might argue that it is not necessary in Singapore's still largely paternalistic culture, those on the front lines know that patient expectations are changing fast. A recent letter to the editor of the *Straits Times* spoke more eloquently than I, when he urged hospitals to be more open in providing information, because medicine is not just about disease and injury: "Healthcare, ultimately, is all about the patient, his fears, struggles and subsequent recovery."[5] ■



References:

1. "Introductory Remarks," Symposium on Conflict Resolution, SMA 8th Ethics Convention, Singapore, 24 October 2004.
2. See, for example, Gerald B. Hickson et al., "Patient Complaints and Malpractice Risk," Journal of the American Medical Association, 287(22):2951-7; Marlynn L. May and Daneil B. Stengel, "Who Sues Their Doctors? How Patients Handle Medical Grievances," Law and Society Review, 24:106-120.
3. Roger Fisher and William Ury, "Getting to Yes: Negotiating Agreement Without Giving In" (New York: Penguin Books, 1983). The other two steps are find alternatives and reaching sustainable commitment.
4. See, for example, Ernstand Fehr and Urs Fischbacher, "Why Social Preferences Matter: The Impact of Non-Selfish Motives on Competition, Cooperation and Incentives," Economic Journal, March 2002, pp.C1-C33.
5. Letter by Lam Chian Prong, "Lessening Fear of the Unknown," Straits Times, 2 November 2004, p. H7.