



Hearing vs. Listening: A Case Study



For years, it's been understood by risk managers, malpractice insurers and defense attorneys, that the driving force behind malpractice litigation cannot, and should not, be dismissed simply as an artifact of greedy lawyers and ungrateful patients. That's not

to say they don't exist. They do, but not nearly in the numbers that support this contention. Although, patients generally have no idea of whether malpractice, in the legal sense of the term, has actually occurred, they *do* believe, however, that the course or outcome of their treatment fell far short of their expectations, whether they were reasonable or not. In addition, the value of credible ongoing two-way communication between patient and provider cannot be overemphasized. Does the importance of communication really matter or is it another "soft" issue dreamed up by alarmist risk managers?

Case in point, a 26-year old mother brought in her 18-month old to their family practitioner for assessment of a mild temperature, congestion and irritability. After waiting for about three hours, the child was finally seen. The doctor told the patient's mother that the child likely had the same flu virus that afflicted most of the other patients in the waiting room. The mother later testified, "I tried to explain to him that I thought it was something worse...The baby's crying sounded odd and she walked funny, like her back hurt. *But the doctor wouldn't listen.* He just shook his head and told me to put [the child] to bed and give her Tylenol and lots of fluids. He also gave her a prescription for some oral antibiotics and said that, even if it wasn't the flu, the medicine would surely take care of it." The child couldn't keep anything down and vomited all of the medications. Later that night, her temperature rose to 104 and her mother observed her to be arching her head

backward. The mother called the doctor's emergency number at around 10:00 p.m. He returned the call and, after listening to the account of the child's apparently worsening condition, advised the mother to give the child an electrolyte solution and bring her back to the office the first thing in the morning. According to the patient's mother. "I tried to tell [the doctor] why I thought this was something worse than just the flu. But he cut me off and told me to stop worrying myself so much." By 11:30, the child's temperature had climbed to 106 and she was rushed by her parents to the emergency department. She soon lapsed into a coma and within four hours expired from pneumococcal meningitis.

During the ensuing trial, the physician testified that he hadn't inquired about the child's temperature during the phone call nor did he ask about any changes in symptoms. He did mention, however, that he was used to the child's mother "second-guessing" him all the time and, even before she had left the office, he knew she would call back. Which she did. Whatever opportunity existed to prevent the child's deterioration ended with that phone call. A mini Risk Management "root cause analysis" shows a number of contributing factors, including;

- 1) A rushed, overworked physician who was apparently less attentive than he should have been to the changes in the child's condition.
- 2) A patient's mother who was regarded by the doctor as "high-maintenance", a chronic worrier and always in need of reassurance.
- 3) A breakdown in communication between the doctor and the child's mother. As a result of the doctor's impression of her, the mother's credibility suffered, setting the stage for her observations about the child's worsening

Physician's Risk Advisory

Published quarterly for Sutter Health Affiliates by Sutter Health Risk Services

2200 River Plaza Drive, Sacramento, CA 95833

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symptoms to be discounted or dismissed out-of-hand by the physician who permitted his perception of the mother to color the information she was conveying.

- 4) The doctor's objective clinical reasoning reversed course. Instead of looking for symptoms that might rule out the flu, he used his presumptive diagnosis to rule it in; the doctor heard only what was consistent

with the diagnosis he expected.

- 5) The doctor had simply stopped caring.

Although relatively few examples of poor communication end this tragically, the fact remains that this type of scenario is played out daily. The only difference between a catastrophic outcome and a benign one is pure luck. Can you tell the difference beforehand which it will be?

Cognitive Bias and Error in Diagnosis.

Given the often overwhelming amount of information physicians must process daily, coupled with the understanding that absolutely everyone is subject to cognitive biases and other errors in information processing, it should be understood that such processes are often significant contributors to nondiagnosis and misdiagnosis. Understanding that these "process" errors exist and how they influence what and how we handle information can help doctors better avoid or address them.

Anchoring: The tendency to disproportionately weight (anchor in on) a subset of information to make a decision. Once a patient receives a preliminary diagnosis, it can often be hard for doctors to think of other potential diagnoses as they anchor on this hypothesis.

Availability: The tendency to reach for the plausible explanation nearest at hand and ignore competing theories.

Confirmation bias: The tendency to seek out or interpret data in a way that confirms a hypothesis. If a doctor has a diagnosis in mind, he or she may be more likely to test for and recognize signs and symptoms that support this diagnosis and dismiss those that contradict it.

Premature closure: The tendency to consider a case to be solved once a satisfactory solution has been achieved without sufficiently considering alternative solutions. A doctor may stop considering other diagnoses once a diagnosis has

been reached.

Inter and intra observer error: Variation in the interpretation of evidence across multiple views by an individual (intra) or between different individuals (inter). For example, the same radiologist looking at the same image may see different things on different occasions, while different radiologists looking at the same image will see different things.

How pervasive are these problems? In his book, "How Doctors Think," Jerome Groopman, M.D., a professor of medicine at Harvard and frequent contributor to the New Yorker, notes that uncertainty hovers over the practice of medicine and found that 80% of physician related medical errors were cognitive. Dr. Groopman relates that in medical school, doctors are taught to recognize symptoms and then propose hypotheses as to their cause, ruling them out one by one until the correct answer, and of course treatment, emerges. In the real world, this model often goes out the window, and something called pattern recognition takes over. The doctor instantly and semiconsciously assimilates the relevant data, compares it with past cases and comes to a decision. "The mind acts like a magnet, pulling in the cues from all directions," Dr. Groopman writes. In the case referenced above, the tragic consequences of permitting cognitive bias to creep into practice are self-evident.

"As a physician, I would rather be humane than encyclopedic. I can always look up the information, but where can I find humanity?"

~William Crosby, M.D. (1980)