Creating and Maintaining Positive Physician-Patient Relationships

MICA®
RISK TEAM

Physician-patient relationships are the foundation of medical care, and effective relationships generally support quality care. Physicians and advanced health care professionals should appropriately manage these relationships to prevent medical professional liability claims and licensing board complaints.

The Risk Team at the Mutual Insurance Company of Arizona® (MICA) created this guide to help our member practices create and maintain positive physician-patient relationships. In this resource, you will learn about:

- Examples of legal duties that exist outside of the "traditional" physician-patient relationship
- How to handle unhappy patients with a successful complaint management process
- The importance of using a Code of Conduct or Patient Rights and Responsibilities document to set boundaries
- A sample Code of Conduct or Patient Responsibilities that you can adapt for your practice

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MICA's multidisciplinary Risk Team can help you reduce the risk of medical liability claims and licensing board complaints and support your management of a successful medical practice. Our Risk Consultants integrate their legal, nursing, practice administration, and quality management experience into responses and resources that address your pain points.

- See how your practice comes across to patients and potential jurors and investigators with an on-site or virtual medical practice risk assessment. A Risk Consultant will help you identify potential medical malpractice issues in your processes and documentation.
- Contact the Risk Team to talk about the medical malpractice questions and concerns that are specific to your individual practice.
- Use the Risk Team's guides, articles, risk strategies, and customized in-person presentations and webinars to achieve situational and organizational goals.

MICA members can connect with the Risk Team to schedule a risk assessment, ask for a resource, and talk about those pain points at 800-705-0538 or rm_info@mica-insurance.com.

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Legal Duties That Exist Outside the 'Traditional' Physician-Patient Relationship

Once a physician-patient relationship is established, a physician owes a legal duty of care to the patient. The duty requires the physician to conform to a particular standard of care when providing treatment to the patient. In a malpractice lawsuit, if a plaintiff cannot establish that a duty existed, the claim will be dismissed.

The "traditional" physician-patient relationship usually begins during the initial visit, when the physician and patient meet and expressly agree to establish a relationship. However, some state courts have found that a duty exists even when there was no express agreement to establish this type of "traditional" relationship. In one Arizona case, for example, the court determined that a physician performing an independent medical examination ("IME") owed a duty to the worker's compensation claimant he examined. Below, we discuss a few Arizona and Utah court rulings concerning the duty physicians owe/don't owe when they treat, examine, or are otherwise involved in an individual's medical care but no express physician-patient relationship is formed.[1]

Arizona

Duty: "Curbside" consult between treating physician and specialist

The *Diggs* case[2] was a wrongful death claim involving a missed diagnosis and an informal or "curbside" consult between a cardiologist and an emergency physician. The head of the hospital cardiology department was in the emergency department examining another patient when the emergency physician sought his opinion. The cardiologist never met the patient, but he was given a brief clinical history and summary of her physical exam and he reviewed her EKG. He then gave advice on the care and treatment of her severe chest pain. The emergency physician followed this advice, the diagnosis turned out to be wrong, and the patient died several hours after discharge from the emergency department.

The court found that the emergency physician was seeking assistance in making decisions about the patient's medical care that he was not qualified to make on his own without involving a specialist. Based on these facts, the court ruled that, as a matter of policy, the cardiologist owed a duty of care when he agreed to give advice, knowing the emergency physician would rely on it. The court distinguished this case from one where two physicians informally exchange medical information and one "merely serves as a resource such as a treatise or textbook." In that situation, the court said, "the treating physician exercises independent judgment in determining whether to accept or reject such advice" and no duty would attach. In this case, the

court believed the emergency physician was not free to reject the advice, because the cardiologist had specialized training and experience necessary to formulate a diagnosis and treatment plan.

Duty: Radiologist's read of a pre-employment chest x-ray

In the *Stanley* case,[3] the radiologist contracted with and was paid to read and report the results of a pre-employment chest x-ray to the employer. Although the radiologist's contract was with the employer (not the employee/"patient"), the court found that the physician "undertook a professional obligation with respect to Ms. Stanley's physical wellbeing" sufficient to impose a duty of care. The court ruled that the defendant had an obligation to act as a reasonably prudent radiologist when interpreting and reporting the results of the Plaintiff's x-ray.

Duty: IME of worker's compensation claimant

In the *Ritchie* case,[4] the physician contracted with a worker's comp insurance company to perform an IME on a claimant. Prior to the exam, the claimant signed the physician's form acknowledging that "…no Doctor/Patient relationship exists." The court, however, ruled the physician owed a duty to the claimant, regardless of the patient's signature on the form.

Utah

No duty: IME and radiology cases where physician contracts with third party

In a 2009 case, the Utah Court of Appeals ruled that a physician who contracted with the City to conduct a fitness for employment IME did not owe a duty to the examinee.[5] Twelve years later, in 2021, the Utah Supreme Court adopted the Court of Appeals' reasoning in a worker's compensation IME case.[6] The court ruled that a physician retained by a third party to conduct an exam and report results to the third party does not form a physician-patient relationship with the examinee. The Court relied on definitions of "patient" and "health care" in the Utah Health Care Malpractice Act.[7] Accordingly, the court said that for a physician-patient relationship to exist:

- The individual must be evaluated for or provided treatment;
- There must be an express or implied contract between the physician and the individual to provide health care; and
- The contract must arise from a "bargained for exchange" - where the individual seeks treatment and the physician agrees and provides treatment.[8]

Similarly, where a physician contracted with the City to read an x-ray and report results to the City, the examinee could not maintain a malpractice action for misread of the x-ray/missed diagnosis because there was no duty flowing from the physician to the examinee.[9]

Non-patient plaintiffs statute

In 2018, Utah enacted a statute that allows a "nonpatient plaintiff"[10] to sue a health care provider if:

- The nonpatient plaintiff suffered a foreseeable injury;
- The nonpatient plaintiff's injury was proximately caused by an act or omission of the health care provider; and
- The health care provider acted or failed to act with knowing and reckless indifference toward, and a disregard of, the nonpatient plaintiff's injury.[11]

Facts Matter

The rulings discussed above were based on the particular facts presented to the Court. While these cases provide valuable guidance for physicians, in everyday practice you should consult your business or health care attorney about whether the facts of your particular situation are likely to support a decision that a duty exists.

Managing Patient Complaints

Good reviews by patients, whether online, via a satisfaction survey, or when talking to someone new to their neighborhood, promote the growth and success of your medical practice. Patients' stories about a customer service issue they experienced at your practice, that you and your staff immediately and fairly addressed, may also drive new business your way.

Ignoring or superficially managing patient complaints carries risks. Unhappy former patients will tell others online and in person about their negative experience with your practice. Patients who feel their concerns went unheard by the practice may also file complaints with licensing boards or third-party payors or initiate malpractice lawsuits. The Executive Director of the Arizona Medical Board observed in a recent presentation that better communication with patients could reduce the number of complaints against physicians.[12] Communication was found to be a factor in nearly one-third of 20,000 malpractice cases analyzed in a closed claims study, with "unsympathetic response to a patient complaint" ranking as the second most common type of physician-patient communication breakdown.[13]

To avoid these risks and improve patient relationships and outcomes, practices need to take patient complaints to heart. Successful complaint management requires a well-oiled process to properly address patient concerns. Effective communication will be at the heart of this process, regardless of whether the patient's complaint and the practice's response are verbal or written. To ensure that patients receive timely and thoughtful responses to their complaints, practices should develop a written procedure for assessing, investigating, and responding to complaints. Providing staff with education on effective communication techniques and how to implement each stage of the process is essential.

In this article, MICA examines why patients complain and what they are seeking, offers tips on how to assess, investigate, and respond, and suggests strategies to reduce the number of complaints you receive. This article does not discuss patient complaints to licensing boards or patient verbal/written demands for money arising from patient care. **For these situations, MICA members should contact the MICA Claims Department 800-352-0402 as soon as possible to report an occurrence or claim.**

Why Patients Complain

Researchers who studied complaints in hospital and outpatient clinic settings say the majority relate to patient-staff communications or practice/facility management issues. Some examples include:

- Vanguard Communications (a marketing and practice improvement company) determined that 96% of online complaints about medical practices relate to customer service issues like communication, wait times, practice staff, and billing rather than medical treatment.[14]
- In an ambulatory cancer care clinic, most complaints involved management or relationship issues, including communication breakdowns, patient-staff dialogue, humanness and caring, billing, and service delays. Researchers noted most of the concerns "related to humanistic rather than technical aspects of care."[15]
- At the Cleveland Clinic, 25% of complaints were related to communication. Other reasons included scheduling processes, delays to receive results, wait times, and patients' perceptions that medical care or patient safety was compromised.[16]
- Researchers who conducted a review of nearly 90,000 complaints in various health care settings worldwide determined nearly two-thirds were related to either staff-patient relationships or facility/practice management.[17]

What They Want

A complaint represents an individual patient's perception and may reflect their dissatisfaction or frustration with unmet expectations. A patient who complains may be seeking:


an apology or explanation


your acknowledgment and acceptance of responsibility


answers or information about what happened and why


reassurance that you will act to make changes in a process or prevent a perceived mistake from happening again


service they feel has been denied or overlooked


follow-up on something you promised but did not deliver


simply to be heard

Taking the time to listen to and sympathize with the patient, understand their perspective, and (when appropriate) fix the situation can enhance patient trust which in turn may minimize the risk of a later lawsuit or board complaint.

The Complaint Management Process: Acknowledge, Assess, Investigate, Respond

To ensure that you give each complaint the attention it deserves, it can be helpful to break the complaint management process into stages. You may consider developing a complaint management checklist as part of a written procedure for responding to complaints.

Acknowledge and Assess

Don't sit on it

Swift action is critical, even if it's just an initial acknowledgment that you received the complaint and need time to investigate. Giving patient complaints immediate attention can build trust and keep minor issues from escalating. Consider specifying a response timeframe in your policy/procedure.

What type of complaint is it?

Some complaints can be handled verbally, on the spot, while other more serious or complicated complaints will require time for further investigation.

Is it a verbal complaint?

If so, the staff member taking the complaint should have good active listening skills. Make eye contact (if face-to-face), hear the patient out, don't interrupt, and don't get defensive. When the patient is finished, repeat the information back to acknowledge the patient's feelings and show that you want to correctly understand their concerns. Document the conversation thoroughly.

Will you need time to investigate and respond?

If so, let the patient know this. If it's a written complaint, consider a brief phone call to the patient acknowledging receipt. Explain you're looking into the matter and provide a response timeframe. This can go a long way towards diffusing anger. You may also take that opportunity to gather more information from the patient. Again, document these conversations.

Investigate

- Review documents and talk with those involved.
- Approach your investigation with an open mind. Don't automatically conclude the patient is being unreasonable.
- Look for opportunities to improve the delivery of care and practice operations. For example, is there is a process or policy that needs to be changed? Could staff or clinicians improve their communication with patients?
- Document your findings and decisions.

Written or Verbal Response, or Both?

Whether to provide a written or verbal response, or both, often depends on the situation. Some considerations include:

When clinicians and/or staff members have effective communication skills, face-to-face discussions can be an opportunity to use words, eye contact, and body language to express empathy and show that you understand the patient's perspective/feelings. Patients may also appreciate that you took the time to sit down and listen to their concerns.

Face-to-face discussions may allow you to get a better sense of what the patient is seeking and exactly how they are feeling about the situation, so you can tailor your response accordingly.

Some complaints are best resolved with a quick phone call and immediate action to correct an error or misunderstanding.

After an in-person meeting or a quick resolution by phone, a follow up letter is a good practice to confirm the discussion and any actions taken and demonstrate again that you understand the patient's feelings. Follow up letters show your genuine commitment to addressing the patient's concerns and can help ensure the practice and patient are on the same page following a verbal discussion.

Depending on the complexity of the situation, a written response may be needed to inform the patient of additional investigation or actions that occurred after the in-person discussion.

Sometimes you may only send a written response. This might occur if a meeting is not practical or optimal, you can't reach the patient to discuss or set up a meeting, or the patient requests something in writing.

Structuring the Written Response

Consider structuring your response to include these elements in this order:

Acknowledgment and Apology – Acknowledge the complaint, thank the patient for taking time to provide feedback, and apologize. You can apologize for the way the patient is feeling without accepting blame or admitting wrongdoing.

- Thank you for sharing your concerns about… We're sorry to hear that your recent visit did not meet your expectations.
- Thank you for taking the time to provide me with feedback about… I'm sorry to hear that your interactions with my staff upset you.
- Thank you for letting me know about your experience in our clinic last week. I know your time is valuable and I sincerely apologize that you had to wait.

Summary of Events – Summarizing demonstrates your understanding of the patient's complaint. It makes patients feel heard. When writing, put yourself in the patient's shoes. How will your words make them feel? Use language that conveys your genuine concern and understanding of their feelings.

- I understand that you thought we would be able to schedule surgery next week. I'm sorry you were surprised and upset when you learned our surgery scheduler was out of the office and would not be available for several days.
- I know you were trying to help your child when you came to our office and asked for an antibiotic. I can understand how worried you were when you learned we couldn't do that because one of our providers would need to see and examine her before writing a prescription.

Share what you learned – from your review of the situation – when responding to each of the patient's issues. Explain what happened, correct misunderstandings, and acknowledge that the practice can do better.

- We understand you feel that staff were unprofessional in their interactions with you. We have discussed other ways they could have presented the information without upsetting you.
- Dr. Jones and I have spoken about your complaint. He understands that you were frustrated when he told you we could not proceed with surgery until we received the records from (another provider). He regrets that he did not do a better job of explaining the reasons why he needs to review the records before doing the surgery.

Statement of changes – you will make, or actions taken, if any.

- We have implemented a new system to keep this from happening again.
- We have changed our process, and in the future our staff will…
- We will call (someone outside your practice) and clear up the misunderstanding.

Additional closing apology

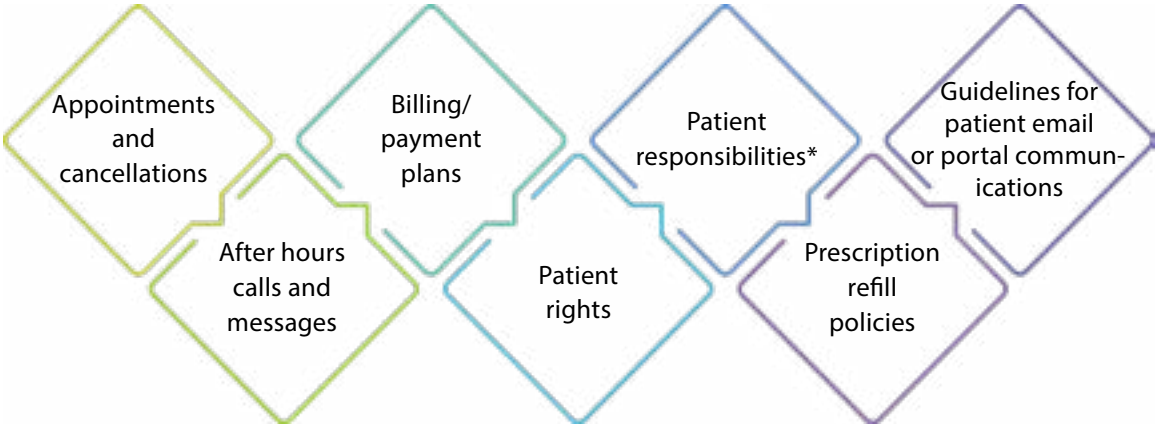
- Finally, I want to take this opportunity to thank you once again for bringing this situation to our attention and extend my sincere apologies for the distress you experienced.
- In closing, I want to say again how sorry I am that we didn't properly explain the process to you.

Information – regarding who to contact with further questions/concerns

- If you have any additional questions, please don't hesitate to call…
- Please don't hesitate to call … if you have other concerns.
- If there is anything else we can do for you, please call…

Reducing Complaints

Although it's probably impossible to eliminate complaints, decreasing the number or reasons for complaints can be an achievable goal. One strategy for reducing complaints and building patients' trust is managing patient expectations from the start. You can communicate expectations via new patient forms and/or policies and procedures that you post in the office, on the website/portal, or distribute. Potential topics include:



* Patient responsibilities (including behavior expectations) and notice of practice policy that violations may result in termination of the physician-patient relationship

Another way to reduce complaints is to follow the old adage: treat others how you want to be treated. This includes:

Finally, provide staff with education aimed at improving their customer service skills. Listen to how staff interact with patients and counsel employees whose communication needs improvement. Communication that is impatient, inattentive, condescending, rude, defensive, or apathetic increases the risk of complaints.

Good Complaint Management Fosters Strong Patient Relationships

Solid patient relationships are building blocks for a successful medical practice and can reduce your risk of malpractice lawsuits and licensing board complaints. Fair, sincere, professional, and timely responses to patient complaints can help you preserve and strengthen those relationships.

Using a Patient Responsibilities/Code of Conduct Template

Patients and visitors to medical practices are increasingly displaying disruptive, hostile behavior directed at staff and clinicians. As a result, more and more MICA members are calling the Risk Team Hotline for guidance on how to manage those behaviors.

One strategy we suggest is to use a Code of Conduct or Patient Rights and Responsibilities document to set boundaries, manage patient expectations, and put patients on notice that certain behaviors will not be tolerated.

The Risk Team's template for developing or revising a Code of Conduct is at the end of this Guide. Medical practices should consider the following when editing the template to fit the practices' needs.

Instructions for Use

- **Make it your own** – We made the template broad to give you ideas. Include the items you want and delete those you don't. Change the wording to suit your style and reflect your practice rules. Add additional items.
- **Consider combining the code of conduct with a list of patient rights.**
- **When appropriate, use it as a basis for terminating the physician-patient relationship** – A Code of Conduct can be used to set patient expectations by specifying conduct that undermines the physician-patient relationship and may result in discharge from the practice. **Bear in mind, however, that termination is not always appropriate, even when a patient violates the Code of Conduct.** For example, a high acuity patient may need continued treatment making it necessary to delay the termination process until after the patient stabilizes. Read on for more considerations when using a Code of Conduct to support termination of relationships.

Guidance on Terminating Patient Relationships

Physicians may choose to end a physician-patient relationship when it is no longer effective. The patient's noncompliance with treatment recommendations, frequent appointment cancellations or no-shows, inappropriate conduct in the office, or noncompliance with financial agreements may undermine the treatment relationship.

Physicians, not staff, should make the decision whether to terminate a relationship with a patient. Staff can be involved in identifying reasons for termination, including non-compliance, inappropriate conduct, or abuse/misuse of medications. Physicians and practice staff should communicate about all potential decisions to terminate patient relationships and should document these discussions as part of a standardized practice policy, procedure, or process. Often, the physician has insight into the patient's situation and/or recognizes a clinical need to continue to treat the patient.

Before deciding to terminate the treatment relationship, the physician should carefully evaluate the patient's acuity, any special circumstances, and need for continuous care. The practice may need to assess its obligations in third party payor agreements related to care continuity and withdrawing from or terminating patient relationships. The obligations may arise from payor policies and procedures referenced in the contracts.

Considerations When Discharging Patients for Code of Conduct Violations

A Code of Conduct is one way to put patients on notice that certain conduct undermines the treatment relationship and may lead to the termination of their care. As noted above, depending on the patient's acuity or other important considerations, termination may not always be an appropriate response to a Code of Conduct violation. In those situations when termination is appropriate, medical practices should utilize these risk management strategies:

Make Sure Patients Receive the Code of Conduct

- Patients don't know what to expect if you don't give them a copy and post it in the clinic.

Consider a Warning

- Although the Code of Conduct warns patients of the risk that their care may be terminated, consider the severity of the incident, and issuing a warning after the first violation. Meet with the patient to discuss the situation and request a change in behavior. Tell the patient that a second violation may result in dismissal. Document thoroughly.

Document

- Before terminating **any** patient relationship, ensure the medical record contains clear documentation of the events that led up to and support the termination decision. If you have not recorded these events as they occurred, you should postpone the termination decision. Do not write a note on the day of termination summarizing events that occurred over several months. Many practices contact the Risk Team requesting guidance on termination due to a patient's history of inappropriate behavior, but staff and clinicians have not documented any of the events in the patient's record. If the patient subsequently complains to the medical board, it will be very difficult to prove that the patient relationship was terminated for inappropriate conduct that undermined treatment without supporting documentation made at the time of the events.

Physician-Patient Meeting

- Whenever possible, the physician should meet with the patient in person or by phone to discuss the reason for the termination before sending the final dismissal letter via certified mail. Document the discussion in the medical record. Reference the date of the conversation in the letter. See MICA's Guide, Terminating the Physician-Patient Relationship, for more details on this process and sample letters.

30 Days Minimum

- The dismissal letter should specify the effective date of the termination. Give the patient **at least** 30 days to find a new physician. Remain available during this time for emergency care and medication refills. Where feasible, a good risk management practice is to be as hands-on as possible in facilitating the transfer of care to avoid gaps in treatment.

Medical Board Complaint Case Study: Inappropriate Patient Dismissal

A 2023 Arizona Medical Board decision, summarized below, contains a lesson on the risks of dismissing patients (even difficult or aggressive patients) without giving them 30-days to find a new provider.

The Board investigated the patient's allegations of inadequate care, failure to diagnose, and failure to refer the patient to another provider. After a formal hearing where the physician was represented by counsel, the Board voted to issue the physician a Letter of Reprimand for failing to maintain adequate records and conduct that may harm or endanger the patient's health.

In support of this decision, the Board made the following factual findings:

1 November

The patient presented with severe diarrhea, abdominal pain, and rectal bleeding. The physician ordered diagnostic testing.

2 Two months later

The patient presented with the same complaints. The physician made a diagnosis and prescribed medication.

3 Three Weeks later

The patient presented with complaints of frequent bowel movements and reported one of the medications was not covered by insurance. The physician prescribed medications and instructions to follow up in three months.

4 On April 7th

The patient called the office to report the medications were not working. He said he was still having frequent bloody bowel movements.

5 On April 13th

The patient called again, complaining that no one returned his call.

6 On April 14th

The patient came into the office. The physician noted the patient would be referred to ABC Clinic for a second opinion.

7 On April 18th

The patient called the office stating ABC Clinic never received a referral. **The physician's staff said the patient yelled and used "bad words." During the formal interview, the physician testified he and his staff felt threatened by the patient's aggressive behavior.**

8 Conclusion

The practice discharged the patient for inappropriate behavior.

The Arizona Medical Board concluded that a physician deviated from the standard of care by inappropriately discharging a patient without a 30-day notice. One Board member observed that although the physician said this was a difficult patient, this was not documented anywhere in the medical records. The Board also found deviations from the standard of care in the workup of the patient and the physician's documentation.

Sample Policy: Code of Conduct or Patient Responsibilities

IMPORTANT INFORMATION ABOUT PATIENT/FAMILY/VISITOR RESPONSIBILITIES

Aggressive Behavior is Prohibited

XYZ Practice wants to maintain a safe, respectful, and caring clinic where we can provide good care for all patients. To help us meet these goals, we expect patients, family members, and visitors to treat others respectfully while they are here. Inappropriate behavior or language that is rude, disruptive, hostile, intimidating, harassing, or discriminatory towards anyone in the clinic will not be tolerated and may result in your dismissal from the practice (dismissal means we will no longer provide you with care and you will need to find another provider). Examples of inappropriate behavior include:

- Yelling
- Disrespectful, insulting, intimidating, aggressive, or abusive language or swearing/cussing
- Threatening or intimidating gestures
- Words or actions that get in the way of patient care or running our business
- Words or actions that upset, scare, or threaten others in the waiting room
- Demanding providers or staff do something that our policies and procedures do not allow
- Demanding providers do something they believe is not good medicine or goes against their medical training and education
- Insulting or offensive remarks about an individuals' race, color, ethnicity, national origin, religion, gender, age, disability, accent/language, or sexual orientation
- Refusal to cooperate with practice policies
- Hostile or violent behavior
- Sexual remarks, gestures, or physical contact
- Physical assault/attempted assault

- Behavior that may or does damage practice property
- Failure to respect an individual's personal space
- Talking to staff/providers in a way that is too personal and not related to patient care - such as trying to contact staff/providers on their personal time outside the clinic setting, asking staff/providers for a date or to get together in a social setting
- Written statements sent by mail, portal, email, etc. to clinicians or staff that are harassing, threatening, offensive, or disrespectful

The Clinician-Patient Relationship: Patient Responsibilities

The clinician-patient relationship is a partnership based on mutual trust and respect. Effective medical care requires a team effort by patients, clinicians, and practice staff. As a patient, you have the responsibility to:

- Give us correct and complete information about what brings you in today, medications, medical history, surgeries, treatments, procedures, and other health issues.
- Take part in your care and ask questions about your diagnosis, treatment recommendations/instructions, or medications.
- Do your best to follow the treatment plan you and your provider agree on.
- Recognize that a healthy lifestyle can prevent or reduce illness and take responsibility for adopting healthy habits.
- Pay your bill in full. If you're on a payment plan, make your payments on time.
- Keep your appointment or notify us ahead of time if you need to cancel or change your appointment.
- Put your cell phone, tablet, or laptop away while interacting with practice providers and staff.
- Be open and honest about your health insurance, if you have it. Only use your health insurance card for yourself and don't let others use it.

Complaints About Our Service

If you have questions or complaints about your care, bills you receive from us, or our customer service, we want to know. Please ask to speak with the Manager.

MICA members may contact the Risk Team at 800-705-0538 or rm_info@mica-insurance.com for an editable version of this sample policy.

Endnotes

1 This article does not discuss cases involving clinician duty to third parties the clinician has never treated, examined, consulted on, or met.

2 *Diggs v. Arizona Cardiologists, Ltd.*, 198 Ariz. 198, 8 P.3d 386 (App. 2000).

3 *Stanley v. McCarver*, 208 Ariz. 219, 92 P.3d 849 (2004).

4 *Ritchie v. Krasner*, 221 Ariz. 288, 211 P.3d 1272 (App. 2009).

5 *Joseph v. McCann*, 147 P.3d 547, 2006 UT App 459, (App. 2009).

6 *Kirk v. Anderson*, 496 P.3d 66 (Utah 2021).

7 *Id.*; "Patient" means "a person who is under the care of a health care provider, under a contract, express or implied." "Health care" means "any act or treatment performed or furnished, or which should have been performed or furnished, by any health care provider for, to, or on behalf of a patient during the patient's medical care, treatment, or confinement. UT Code 78B-3-403(24) & (11).

8 *Kirk v. Anderson*, 496 P.3d 66 (Utah 2021).

9 *Wilcox v. Salt Lake City Corp.*, 26 Utah 2d 78, 484 P.2d 1200 (1971).

10 A nonpatient plaintiff is one who does not meet the definition of "patient" under the Act. See note 7, above for definition.

11 UT Code 78B-3-426.

12 Arizona Society of Healthcare Attorneys. 2022 Health Law Conference. Executive Professional Board Panel: Audit Trends and Enforcement from the Executive Directors of Arizona's Professional Boards.

13 Crico Strategies, Malpractice Risks in Communication Failures, 2015 Benchmarking Report.

14 Vanguard Communications (2016). Online complaints? Blame customer service, not doctors' care. https://vanguardcommunications.net/patient-complaints/.

15 Mack, J.W., Jacobson, J., Frank, D., Cronin, A.M., Horvath, K., Allen, V., Wind, J., Schrag, D. (2017). Evaluation of patient and family outpatient complaints as a strategy to prioritize efforts to improve cancer care delivery. Jt Comm J Qual Patient Saf. 43(10):498-507. doi: 10.1016/j.jcjq.2017.04.008. https://pubmed.ncbi.nlm.nih.gov/28942774/.

16 Bayer, S., Kuzmickas, P., Boissy, A., Rose, S. & Mercer, M.B. (2021), Categorizing and rating patient complaints: an innovative approach to improve patient experience. J Patient Exp. 2021 Mar 3; 8:2374373521998624. doi: 10.1177/2374373521998624. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8205334/.

17 Reader, T.W., Gillespie, A. & Roberts, J. (2014), Patient complaints in healthcare systems: a systematic review and coding taxonomy. BMJ Qual.Saf. 2014 Aug; 23(8): 678-689. doi: 10.1136/bmjqs-2013-002437. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4112446/.