

Physician Communication Skills Decrease Malpractice Claims

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All studies that have attempted to determine the characteristics of patients who bring medical malpractice suits against their physicians find similar results: a clear and direct relationship between malpractice claims and communication failures between physician and patient.^{1,2} Assuming an “even playing field” (i.e., equal quality of medical care), patients who sue are more likely to be unhappy with the interpersonal relationship with their physician than the actual outcome of the care they received.³

One of the most common reasons patients initiate legal proceedings is to get information when they perceive that it is purposely being withheld or that their physician is being less than forthcoming. Following an adverse event that may or may not involve negligence, patients report greater satisfaction and are less apt to sue when they perceive the physician as communicative, caring, honest, personal, and apologetic, when appropriate.^{4,5} Non-physician factors that increase the likelihood that a patient will sue include television advertising by law firms, recommendations by other health care workers to seek legal advice, and unique situations of financial constraint.^{3,6} In fact, patients’ calls to law firms are often initiated after receiving notice that their unpaid bills were referred to a collection agency.

One study that attempted to determine why some physicians get sued more than others revealed three types of physicians with regard to their propensity to get sued: low-risk (no suits), medium risk (an occasional claim) and high risk (multiple claims).⁷ The high risk group represented between 2% and 8% of physicians in a specific specialty that accounted for more than 50% of malpractice claims. What explains these results? Multiple studies reveal that physicians at high risk for a lawsuit do not have inferior skills or more complicated patients, but are less effective at providing meaningful communication and maintaining rapport with patients and their families, especially when a complication occurs.^{8,9}

Hospitals, too, have developed programs that enhance communication between physician and

patient when a complication occurs,¹⁰ and have created programs to improve communication skills in high risk physicians.^{11,12}

Let's momentarily leave the "science" and meet a remarkable woman named Dale Ann Micalizzi. In 2001, her son Justin, a healthy 11-year-old, died suddenly during surgery for osteomyelitis of his ankle. Since then, Dale has dedicated her life to improving patient safety and opening the lines of communication between patient and physician. She has good reason, as she explains in this excerpt from her website¹:

"We returned home from the hospital silently and in shock. The phone rang as we made our way into what was once our safe, happy refuge. It was someone from the coroner's office making an unthinkable request following the death of Justin, at 11 years old our youngest child, just hours earlier. The man's voice echoed as I sat with tears streaming down my face: "The partial autopsy isn't sufficient; something isn't right, and you need to retain an attorney". What could have gone so terribly wrong? The immediate silence from the physicians, nurses and the hospital's chief executive officer was deafening. I recognized the classic pattern of denial and defense. I never wanted lawyers involved. I never wanted to question a physician's judgment or a hospital's care. There was no other option available to us; mediators, ombudsmen, patient safety officers and patient advocates were not yet invented. After three years of exhausting and frustrating attempts at an explanation, I sat in a law firm opposite attorneys representing Justin's orthopedic surgeon and anesthesiologist. They leafed through a 6-inch-thick binder with my son's records and the results of the hospital's investigation. Information I had begged to see for such a long time and have still never seen. Ultimately, because of lack of evidence, the case was dropped by our own attorneys, but we did eventually receive an apology of sorts from the hospital. But, an apology means little if there is no disclosure and no effort to fix the problems that caused Justin's death."

Since that time, Dale has transformed herself into a tireless patient advocate. As the founder of Justin's HOPE at the Task Force for Child Survival and Development, she has traveled the country delivering speeches to medical groups on patient safety and how to optimize communication between patients and physicians. I asked Dale why patients seek legal action against their doctors. She said, "Almost no one

¹ <http://www.taskforce.org/justinhope.asp> (accessed September 6, 2009)

wants to sue their doctors, especially following the death of a child. We love docs for caring for our children. But the stonewalling and the lack of responsibility and accountability that can occur after a complication infuriates patients and families. They want answers and a discussion even if nothing was intentionally or accidentally done wrong. Patients and families feel that the medical community owes them this. When they don't receive it, their own community pushes them into doing something, and litigation is the last straw. When a patient or family has been injured, and they sense this lack of disclosure, the priority shifts to preventing it from happening to someone else. The guilt that occurs by not acting to prevent injury or death to someone else is difficult to live with. We know what that pain feels like.” From her extensive work in this area, Dale has developed several recommendations for physicians when a complication occurs (Tables 1 and 2).

In summary, the most effective way for physicians to avoid lawsuits is to be open and honest with their patients, especially when a complication occurs. Physicians should be readily available for communication with their patients who have suffered complications. In the event of a complication that may or may not be caused by physician negligence, the physician should closely collaborate with the hospital's division of risk management to proactively approach the patient and/or the family and decide upon a corrective course of action. In general, patients who have suffered complications do not want financial compensation, but rather desire an analysis of the root causes and implementation of corrective and preventative measures.¹³

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Table 1. Things NOT to Say to Patients or Families After a Complication

(Adapted from <http://www.taskforce.org/JustinHope/YJustinsHOPETASKFORCE.ppt>)

YOU signed the consents for surgery and anesthesia.
Are you receiving counseling? You need to get over it.
These things happen and you may never know what went wrong.
I have no idea what happened - go ask a specialist.
I guess I can squeeze you in for a meeting, but I'm very busy.
I don't have to share the M&M and QA investigations with you.
I didn't tell the resident to begin surgery alone.
Medicine is an imperfect science - I did nothing wrong.

Table 2. What Patients and Families WANT and NEED Following an Adverse Event

(Adapted from <http://www.taskforce.org/JustinHope/YJustinsHOPETASKFORCE.ppt>)

Immediate unbiased investigation with complete disclosure.
To be listened to and taken seriously. Don't protect us. Don't lie to us. Don't diminish our need to know.
Practices and systems changed to prevent a similar event.
Standards of care mandated with regulatory systems in place and someone put in charge.
Respect, empathy, apology.
Medical bills dismissed.
Justice.