Communication gaffes: a root cause of malpractice claims

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We are presently in the throes of another medical malpractice insurance crisis, not unlike the crisis that occurred in the late 1970s. The availability of medical malpractice insurance is diminishing; insurance premiums are skyrocketing; insurance carriers are going bankrupt or refusing to write insurance policies in Texas. In some areas, the cost of malpractice insurance is prohibitive, causing physicians to leave medicine. The most concerning fallout is that patient access to care is being compromised.

It is easy to blame insurance companies, plaintiff lawyers, and runaway juries for our woes. It is harder to examine our own practices and ask ourselves what we could do to change patients' feelings that they need to sue doctors, hospitals, and nurses. In this age of phenomenal technological innovations and highly successful treatments and cures, why is it that our customers, the patients, are dissatisfied with their health care to such a degree that they feel compelled to file a lawsuit?

Several papers have been published that address this question (1–3). The authors of these studies utilized different study techniques to tap into the mindset of the patient/plaintiff. In one study, deposition transcripts were reviewed (3). Another team used questionnaires to survey plaintiffs (2), and the third conducted their study by telephone survey. In all 3 studies, common themes emerged. The 4 predominant reasons prompting patients to file a lawsuit included 1) a desire to prevent a similar (bad) incident from happening again; 2) a need for an explanation as to how and why an injury happened; 3) a desire for financial compensation to make up for actual losses, pain, and suffering or to provide future care for the injured patient; and 4) a desire to hold doctors accountable for their actions.

Overwhelmingly, the dominant theme in these studies' findings was a breakdown in the patient-physician relationship, most often manifested as unsatisfactory patient-physician communication. Study participants described the perceived communication problems as follows: physicians would not listen, would not talk openly, attempted to mislead them, or did not warn them of long-term neurodevelopmental problems (in the case of newborn injury). Other communication problems cited included perceptions that doctors deserted patients or were otherwise unavailable, devalued patient or family views, delivered information poorly, or failed to understand the patient's perspective.

Clearly, these studies underscore the well-known principle that good communication is the cornerstone of the physician-patient relationship. As the authors have often observed, and as is well documented in the literature, patients are not likely to sue physicians with whom they have developed a trusting and mutually respectful relationship. Simply put, patients do not sue doctors they like and trust. This observation tends to hold true even when patients have experienced considerable injury as a result of a "medical mistake" or misjudgment.

Do physicians have influence over the circumstances that cause patients to file lawsuits? While physicians cannot control all the stated reasons for patients' seeking legal redress, they are able to influence the quality of their relationships with patients. And, as already noted, the foundation for a good patient-physician relationship is communication. This article discusses the "art" of communication as it occurs in everyday patient encounters, the important dialogue that occurs when giving informed consent, the challenge of encountering an angry patient, and the new trend of disclosing unexpected outcomes and medical errors.

THE "ART" OF PATIENT-PHYSICIAN COMMUNICATION

The American Association of Orthopaedic Surgeons (AAOS) strongly endorsed the communication aspect of the patient-physician relationship in its advisory statement "The Importance of Good Communication in the Physician-Patient Relationship" (4). In that statement, the AAOS described patient-focused communication as open, honest dialogue that builds trust and promotes healing. Taking it a step further, the AAOS commented that good communication has a favorable impact on patient behavior, patient care outcomes, and patient satisfaction; as a consequence, it often reduces the incidence of malpractice lawsuits.

According to the AAOS, physicians who practice patient-focused communication show empathy and respect, listen attentively, elicit patients' concerns and calm fears, answer questions honestly, inform and educate patients about treatment options, involve patients in medical care decisions, and demonstrate sensitivity to patients' cultural and ethnic diversity (4).

The importance of developing rapport with patients cannot be overemphasized. Effective communication skills are a critical tool that assists the physician in establishing that optimal patient rapport. Physicians need to keep in mind that today's

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health care consumers, particularly those in the baby boomer and younger age groups, have much more medical knowledge than senior citizens. Both young and old, however, often judge the quality of care received on the basis of the physician-patient interaction. Certainly, the physician's skill and reputation play an important role in a patient's confidence. However, many if not most patients assume that physicians have the requisite technical skill to treat their medical problems. From the patient's perspective, therefore, what separates the adequate or average physician from the truly great physician is how well the physician practices the "art" of medical care, conveying those highly valued human skills of compassion and caring concern that patients seem to need so much.

All too often, when physicians do not communicate caring concern, especially when the care is painful, difficult, or results in less-than-optimal outcomes, an inevitable cycle of miscommunication occurs among patient, family, and physician. Under these circumstances, patients who express their anger and frustration may cause the physician to react defensively in a way that may be perceived as hostile or arrogant. Most often it is this response that causes the patient to seek the advice of an attorney, because poor communication between a physician and patient can lead an already angry, dissatisfied patient to believe the care was poor even when it was entirely appropriate (5). In the arena of physician liability, the burden of "successful" patient-physician communication lies with physicians (5). That is not to say that patients do not share the burden, but society and the courts have deemed that physicians have the ultimate responsibility for initiating, clarifying, facilitating, documenting, and reinforcing discussions related to their patients' condition, treatment, and prognosis (5).

An often-cited study published in the February 19, 1997, issue of the *Journal of the American Medical Association* illustrates these points (6). The purpose of the study was to identify specific communication behaviors that were associated with an increased frequency of malpractice claims. The authors collected data by videotaping routine office visits of 59 primary care physicians and 65 general and orthopaedic surgeons and studying 10 tapes per physician. Interestingly, the researchers found no difference in communication behaviors between surgeons who experienced malpractice suits and those who did not. However, significant differences in communication behaviors were identified between primary care physicians who experienced no malpractice claims and those who were sued. The critical communication behaviors that differentiated the "no claims" from the "claims" primary care physicians were the following: 1) greater use of orientation statements that served to educate patients on what to expect, 2) greater use of laughter and humor, and 3) greater tendency to solicit patients' opinions, check their understanding, and encourage them to talk. What this all boils down to is that the physicians who had no claims established better rapport with their patients and evoked greater patient satisfaction.

Communication is something we all take for granted, which is why we don't consciously think about our communication habits and behaviors. For many, conscious awareness of one's communication habits requires considerable work and energy. And yet, it is the little things that can make such a difference. For example, the opening of the medical encounter sets the stage for a trusting and caring relationship when the patient is invited to share his feelings and concerns. A crucial point in the encounter is the physician's first greeting of the patient. Does the physician show personal concern by offering a handshake and a warm smile? This action instantly puts the patient at ease in what could otherwise be an unfamiliar, if not frightening, environment. An explanation of the agenda for the visit sets the patient's expectations and aligns them with the physician's. Maintaining eye contact rather than staring off into space, out the window, or at notes indicates that the physician cares about the patient. Additionally, maintaining eye contact cues the physician on the patient's reactions as conveyed by body positioning, eye movement, or other body language. The body language of the physician is also a powerful communicator of attentiveness to what the patient is saying. A sitting position demonstrates an interest and an unhurried attitude, while a standing position may give the impression of control, an authoritative attitude, and being rushed.

The bottom line is this: patients who enjoy a positive therapeutic rapport with their physicians do so because mutual expectations are in line and there is good communication flow from patient to physician and physician to patient. The key ingredient is that the patient is left with the strong sense that the physician cares about the care being given and the person to whom the care is rendered. A model developed by the Bayer Institute for Health Care Communication illustrates this dynamic well. The "4E" model uses the approach of engage, empathize, educate, and enlist for obtaining information and furthering the relationship (7). All these elements of communication are important to enhancing patient satisfaction and minimizing the desire to resolve problems through contentious lawsuits.

THE IMPORTANT TASK OF ALIGNING EXPECTATIONS

Today's patients, especially the younger generation, want to be involved in making decisions about their health care. Patients want to be told the treatment options available and why a particular option is recommended. Much has been written about the therapeutic effects of full informed consent. The very act of disclosure lessens patients' anxiety, increases their trust in the physician, often results in a smooth clinical course, improves patient understanding, and decreases the unpleasant "surprise factor" should anything go awry. This process allows time to dispel any unrealistic expectations before the treatment begins. The objective of informed consent should be to replace some of the patient's anxiety by providing a sense of participation in and control over his or her care. Obviously, this cannot occur if the informed consent process consists merely of handing the patient a piece of paper to sign. A golden opportunity to enhance patient-physician rapport is lost if the physician does not take time to go through all the elements of consent, which include explaining the procedure along with the specific risks, possible complications, and alternate treatments available.

Remember that the informed consent process is the physician's opportunity to allay patient anxiety, bridge the gap between patient ignorance and supposed physician omnipotence, and dispel uncertainty. This is one of those moments in the patient-physician relationship when the patient is most vulnerable. Thus, it is important to prepare patients without sabotaging their confidence. For example, compare these 2 statements:

- Here is a list of complications that could occur during your operation. Please read the list carefully and sign it. If you don't understand something, ask me.
- I wish I could guarantee that there will be no problems during your operation, but that wouldn't be realistic. Sometimes there are problems that cannot be foreseen, and you need to know about them. Please read about them, and let's talk about it.

The second statement is the better option. It lets the patient know that the physician is not omnipotent, that the patient and the physician are facing some degree of uncertainty together, and by implication both are going to cooperate in doing something to the patient's body that will make him or her better. But there are no guarantees as to how the patient's body will respond.

Some physicians try too hard to reassure patients. In some instances the reassurance may be overreaching, and unintentionally the physician creates unwarranted expectations. Compare the following statements:

- Don't worry about a thing. I've taken care of a hundred cases like yours. You will do fine.
- Barring any unforeseen problems, I see no reason why you shouldn't do very well. I'll certainly do everything I can to help you.

The second statement establishes more realistic patient expectations while at the same time remaining reassuring.

ENCOUNTERS WITH THE ANGRY PATIENT

Few encounters are more challenging than confronting the angry patient. The patient who is angry—with his doctor, about the care he is or is not receiving, or about an outcome of care—is a lawsuit waiting to happen. The physician, not the lawyer, is in the best position to defuse the patient's anger (8).

Remember, anger is the way people respond to unmet needs or expectations. Most of the time the anger (rightly or wrongly) is directed toward the physician because he or she is the most convenient and visible target. One of the worst mistakes a physician can make when dealing with angry patients or families is to avoid them. While this is an understandable reaction, it is also the surest way to hasten the patient's visit to the attorney's office. As difficult and unpleasant as it may be, the most effective way to defuse anger is to listen, empathize, and apologize that things did not turn out the way the patient expected or hoped.

When faced with someone who is upset or angry, it may be prudent to remain silent and allow that person to talk about the problem. Any person confronted by an angry, complaining patient is likely to feel personally affronted. In those moments, one's natural tendency is to become defensive or hostile. This is especially true when the complaint is unwarranted. While the easiest and most natural reaction is to strike back, the better practice is to avoid fighting words, listen without interruption, avoid becoming defensive, express empathy, ask questions, determine what the patient wants, explain what can and cannot be done, and discuss alternatives.

DISCLOSING MEDICAL ERRORS

One of the most difficult aspects of medical practice is dealing with adverse outcomes. A complication that occurs during medical care or treatment is distressing to the physician, the patient, and the patient's family. When the patient experiences an adverse outcome, it is always better to have a forthright conversation with the patient, explaining what happened and why. The best reason for disclosure is that it is the one sure way of assuring that the patient will continue to trust the physician. Nothing defuses patient anger better and faster than a sympathetic, open-minded physician who is willing to discuss not just the successful outcomes of care but the glitches and problems that arise as well. Studies have shown that what patients want from their physicians following an error is an apology and the assurance that what happened to them will not happen to someone else (2).

Since publication of the Institute of Medicine report *To Err is Human*, consumers have become more aware of errors and problems associated with health care. The news media's coverage of medical errors at that time created a public call for change. The Joint Commission on Accreditation of Healthcare Organizations responded by issuing patient safety standards that require health care providers to inform patients about "unanticipated outcomes." What could be more challenging to physicians than disclosing unanticipated outcomes, especially those that may have resulted from medical errors?

Despite this directive to the health care industry, physicians and nurses are fearful and reluctant to disclose. This is understandable if the provider believes that admitting mistakes is not safe and may cause patients to file lawsuits. The question is, are these assumptions valid? Not every error is the result of negligent behavior. Consider this example: it is not necessarily negligent to perforate the bowel during an endoscopic procedure. What might be considered to be below the standard of care would be the physician's failure to do any of the following:

- Explain this potential complication to the patient as part of the informed consent
- Describe to the patient symptoms to be aware of after the procedure that might indicate that a complication has occurred
- Tell the patient a perforation did occur
- Recognize the complication in a timely manner (9)

Maithel stated, "The principal argument in favor of disclosing medical errors to patients is based on the ethical duty that physicians have to patients. Physician-patient relationships are based on a bond of trust that develops when one person relies upon another's judgment for his or her well-being. Physicians are required to act in the best interests of the patient, putting aside one's own interests" (9).

Note that the professional medical groups also address the physician's responsibility to disclose errors to patients. The American College of Physicians, in its *Ethics Manual*, recommends that "physicians should disclose to patients information about procedural or judgment errors made in the course of care if such information is material to the patient's well-being. Errors do not necessarily constitute improper, negligent or unethical behavior, but failure to do so [disclose errors] may." The American Medical Association, through its Council on Ethical and Judicial Affairs, issued an opinion holding that physicians should disclose to patients mistakes that result in significant medical complications. The opinion states, "Concern regarding legal liability which might result following truthful disclosure should not affect the physician's honesty with a patient."

Fear of litigation is frequently cited as the reason not to disclose errors, but studies show that this fear is largely exaggerated (9). Malpractice litigation is not nearly as prevalent as physicians think. At least 4 major studies have found that only 1% to 2% of negligent adverse events led to actual claims (10–13). Most patients who experience iatrogenic injuries or are dissatisfied with their care ignore the problem or find other ways to resolve the problem, including changing physicians (14, 15). Physicians overestimate their risk of being sued by about 3 times the actual rate (16).

On the flip side, several studies have shown that failure to be honest with patients is a frequent cause of litigation. Witman et al found that patients were significantly more likely to sue if the physician did not disclose an error (17). In another study, researchers found that patients' decision to sue was influenced not only by the original injury but also by insensitive handling and poor communication afterward (2). Patients were more likely to sue when they believed there was a "cover-up" of information or when they wanted more information and the only way they could get it was to file a lawsuit. Note the common theme that seems to trigger litigation: uncertainty. Patients are uncertain about what happened and how. Patients are uncertain that they were given all the information that was available (18). Note the absence of fault finding. Patients do not seem to be suing because of a perception that their physician was at fault for their outcome. The authors have observed that patients are more willing to "forgive" the humanness of physicians when a mistake is made than physicians are willing to forgive themselves.

Keep in mind that failure to disclose mistakes can lead to allegations of fraud and negligent concealment (19–23). Such claims are not only uninsurable but also may lead to the awarding of punitive damages, which in many cases are also uninsurable.

Many physicians are unsure about how to disclose a medical error and when to do it. The short answer is as soon as possible. Timing is crucial, and once it is clear that a medical error leading to a complication has occurred, the physician should disclose all relevant information to the patient as soon as possible after verifying the facts. Delaying the discussion only makes it more difficult for a patient to accept and may cause the patient to believe that the physician is trying to hide information. Keep in mind that a defensive or accusatory response will only inflame the situation. A better approach is to focus on the current health needs and stick to the known facts. It is important to refuse to speculate on causes or outcomes and to resist the impulse to blame the patient or anyone else involved. Even if a physician thinks someone else made a mistake or caused the problem, he or she should wait for the results of the event analysis. The first take on an event can turn out to be incorrect. Physicians should be especially prudent about blaming themselves. Many physicians have rushed to confess their shortcomings only to find out later that the outcome was unrelated to the care given.

First and foremost, express empathy for the patient's pain and suffering. Second, do not hesitate to provide the patient with all known facts. Remember, patients have a need and a right to know about their medical conditions. They can and will request copies of their medical records. And alone, or with the help of an attorney, patients will be able to reconstruct the facts of the case sooner or later. Physicians have little to lose and much to gain by disclosing facts. Most importantly, a frank discussion without speculation or blame will begin the process of restoring a patient's faith and trust, which will enable the physician to give the best possible care going forward.

To summarize, when an adverse or less-than-optimum outcome occurs, it is recommended that the physician implement the following plan of action:

- Recognize the patient's frustration and possible fear
- Recognize your own feelings of disappointment and anxiety
- Don't panic—keep lines of communication open
- Express regret that the adverse result occurred but avoid finding fault or blaming others
- Explain what happened and the proposed plan of action in terms the patient can understand
- Keep the patient and family informed and involved in subsequent treatment plans and discussions; document the discussion in the medical record

In any situation, good physician-patient communication is the mainstay of a therapeutic, mutually respectful, and trusting relationship. The advice of treating each patient as you would want a close family member treated will give a physician all the guidance needed.

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Invited commentary

The article by Ms. Huntington and Ms. Kuhn on malpractice reduction by better communication is clearly on target and based upon long-standing recognition that an empathetic, communicative relationship with patients reduces the risk of a lawsuit even after adverse clinical events or outcomes.

As the authors indicate, openness, honesty, empathy, and good anger management are fundamental components of a healthy doctor-patient relationship. Most experienced physicians have had patients who were willing to "forgive" an error or omission when it was openly disclosed. Defensiveness on the part of the physician only polarizes the situation. Untruthfulness, such as changing a record entry, is a recipe for disaster.

Some physicians are more adept at these interpersonal relationships than others. Many physicians know of others they regard as less skilled who are "never sued," presumably because of their exceptional interpersonal skills. Conversely, I have observed many patients referred to extremely competent, knowledgeable physicians, only to return complaining of how they were treated or communicated with. Sometimes highly analytical doctors, deep in thought about the problem they are dealing with, are perceived as unconcerned about the patient they have in front of them. So the question might be whether or not such quiet, analytical physicians can achieve the empathy and communication levels needed. The answer is yes, but only by consciously applying some of the principles suggested by Huntington and Kuhn.

It is beyond the scope of this article, but physicians have considerably more risk reduction tools than the interpersonal skills well illustrated in the article. The culture of medicine is now more complex than in the days when every physician was expected to be the sole repository of skill and knowledge for a patient. Now physicians have the opportunity to harness the skills of others on the health care team to produce superior outcomes, fewer errors, and fail-safe mechanisms. We all need a support team to avoid mistakes and maximize effectiveness.

The new complexity of technology, information, genomics, and highly specialized, fragmented care is also depersonalizing for patients. The Institute of Medicine's book *Crossing the Quality Chasm* illustrates that patient-centered care will be a critical component of successfully restoring our health care system. In most surveys, patients consider items that deal with the way they are treated as important quality indicators; they simply assume that they will get correct treatment. Physicians, instead, regard "giving the right drug" or "a successful surgical technique" as the critical factors in quality. Patients want choice in their treatments, access to care, and respect of their own value system. They will insist on understanding their options, integrating outside information, and participating in their own risk decisions. Communication skills will be critical in meeting these needs.

Thanks to the authors for their work. Any of us can apply their advice if we will.

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