

Listening and Talking to Patients A Remedy for Malpractice Suits?

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This study evaluates the hypothesis that the way physicians communicate with patients and the degree patients perceive physician fault for bad medical outcomes are risk factors for the initiation of malpractice lawsuits. The study involved 160 adults who viewed a videotape of a physician treating a patient while using either positive or negative communication behaviors. Participants were told that the case had either a positive result, a bad result through no fault of the physician, a bad result for uncertain reasons, or a bad result that was the physician's fault. Participants then rated their litigious feelings.

Results showed that the use of negative communication behaviors by the physician increased litigious intentions. An increased perception of physician fault for the bad result also increased litigious intentions. Uncertainty as to the reason for the bad outcome, however, raised litigious feelings nearly as much as did perceived physician fault. The results of the study support the hypothesis that altering the way physicians communicate and improving patient education can affect the risk of malpractice lawsuits.

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How to prevent malpractice lawsuits continues to be an important concern for health care professionals. Although professional competence in medical practice is essential, studies have repeatedly shown that the quality of medical care is poorly correlated with the occurrence of malpractice lawsuits.¹⁻⁸ These data suggest that other factors are involved in triggering them. Many writers have speculated that two important risk factors for the initiation of malpractice lawsuits are the "quality of communication" between physicians and patients^{1,2,5,9-11} and the perception that the physician is at fault for a bad result.^{2,12,13} These factors may create a desire on the part of patients to strike back against their physicians, regardless of the practitioner's competence. The present study was designed to evaluate the validity of these speculations, which have not previously been tested experimentally.

Subjects and Methods

Participants in the study were 160 adults recruited from adult classes at two local community colleges and a local volunteer network. Participants were not required to have any particular level of experience with health care professionals and volunteered for the study in response to an invitation to participate in a research project that involved "viewing a videotape and completing a questionnaire." No other information about the topic of the study was provided until the beginning of each testing session, when participants were told that the study involved "physicians and medical treatment" and the presentation of a hypothetical medical case. Before participating, they were asked to complete an informed-consent form and were given permission to end their participation in the study at any time. Only one participant did not complete the testing sessions and was replaced with another.

We conducted the study in classrooms and meeting rooms with groups of participants. To minimize possible experimenter-bias effects in conducting the testing sessions, all instructions were provided in written form, and during the videotape viewing and questionnaire completion, the experimenter stood silently in the back of the room, out of sight of the participants. A video monitor used to show the videotapes was operated by remote control.

Participants were randomly assigned, by a coin toss, to one of two experimental groups, each of which viewed a different videotape of a hypothetical medical case in which a patient sees a physician for an office visit. One videotape showed the physician using "positive communication behaviors," including eye contact, a friendly tone of voice, presentation of information and requests for information, smiling, appropriate physical touch (shaking hands), self-disclosure, acknowledgment of verbalizations, reflections of affect, appropriate praise, and a relatively long period of contact (videotape length, 5 minutes 25 seconds). The second videotape showed the physician using "negative communication behaviors," including no eye contact, harsh and clipped tones of voice, criticism, a minimal presentation of information and minimal request for information, nonsmiling expressions, no friendly physical contact, no acknowledgment of verbalizations, no reflection of affect, no praise, and a relatively short period of contact (videotape length, 2 minutes 2 seconds).

In both videotapes, the patient described an identical complaint: "I have a mole on my neck that has started to itch and burn and has started to worry me," the physician made an identical diagnosis: "It's an angioma," and the physician performed an identical treatment: a subcutaneous injection and a prescription for antibiotics. The same medium-height,

approximately 35-year-old white male actor portrayed the physician in both videotapes, and the same medium-height, approximately 35-year-old white female actor portrayed the patient in both videotapes. Both videotapes were filmed in the same dermatologist's examining room, from the same camera angle, with the physician dressed in the same clothes and white coat and the patient dressed in the same clothes.

After viewing the videotape, participants read one of four "Case Outcome Reports," distributed in a blind manner by the experimenter. The first report stated that the result had been good (detailed as the spot clearing up and healing normally, without subsequent ill effects). The second report

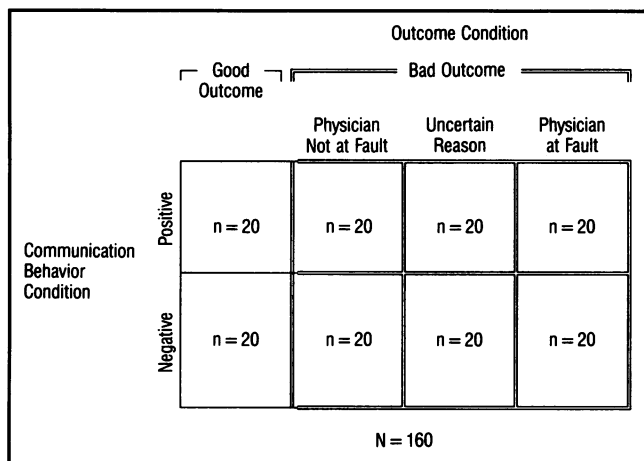


Figure 1.—The schema illustrates the overall experimental design: Communication behavior (positive or negative) is examined in relation to good and bad outcomes (no physician fault, uncertain, and fault).

stated that the physician was clearly not at fault, but there had been an unforeseeable and unpreventable bad result (detailed as worsening of the condition, substantial discomfort and pain, the necessity for further medical treatment, and substantial scarring and disfigurement). The third report stated that it was uncertain whether or not the physician was at fault but that there had been a bad result (detailed identically to that in the second report). The fourth report stated that the physician did not diagnose and treat correctly and was at fault for a bad outcome (also detailed identically to that in the second report).

After reading one of the four reports, all participants completed a four-page questionnaire specifically designed for this study to be as clear and simple as possible to minimize complexity and nuances and maximize potential reliability. The questionnaire required an average of about seven minutes to complete and consisted of ten questions. On a scale of 1 (least) to 10 (most), participants were asked to rate how professional, caring, friendly, trustworthy, and competent the physician was, how severe they found the outcome to be, how much they considered the physician to be negligent, liable, and to blame for the result, and how likely they would be to file a lawsuit against the physician. The questionnaire also solicited demographic data—age, sex, marital status, religious preference, ethnicity, and occupation. Participants were then debriefed, given the opportunity to ask questions, and excused.

Results

To minimize possible experimenter bias in data analysis, the experimenter not involved in conducting the testing ses-

sions coded the data and the other experimenter entered the data into the computer and did the statistical analyses. A few participants skipped answering an occasional question on the questionnaire, so sample sizes vary slightly from analysis to analysis, and there is a slight variation in the degrees of freedom in different analyses.

Analysis of the demographic data showed that participants had an average age of 39, an average education of 14 years, and 82% were women. A univariate analysis of variance done on each demographic variable revealed two differences between experimental groups: more participants assigned to the negative communication behavior than the positive communication behavior condition were married ($F[1, 142] = 11.37, P \leq .001$), and their average age was younger—means of 36.7 years versus 41.7 years, respectively ($F[1, 142] = 6.83, P \leq .01$). No other differences were found.

The experimental design crossed two levels of communication behavior (positive, negative) with the good result and three levels of physician fault for bad result (no fault, uncertain, fault), resulting in a 2x4 factorial design (Figure 1). Because a bad medical outcome is presumed to be required to reliably create litigious feelings, the good result was included in the study to establish whether the three outcome reports detailing a bad medical result successfully induced a sense of a bad result for the participants. This question was examined by using a *t* test to compare participants' ratings of severity of outcome between the good outcome and the bad ones. The test, using a two-tailed probability and a separate variance estimate, was significant: $t(42.55) = 15.11, P \leq .001$. This indicated that the experiment succeeded in inducing a sense of a bad result for participants in the bad-outcome conditions.

We also presumed that a consistent sense of the severity of the bad result across all bad-outcome conditions was desirable because this would indicate that the independent variables of communication behavior and perceived physician fault were not contaminated by differences in perceptions of the severity of outcome. Using a 2x3 analysis of variance on ratings of severity of results for the six bad-outcome cells, we found neither significant main effects nor significant interaction effects (Table 1), indicating that the perception of the

TABLE 1.—Analysis of Variance: Ratings of 'Severity of Outcome' in Bad-Outcome Condition: Communication Behavior (Positive, Negative) Versus Physician Fault (No Fault, Uncertainty, Physician Fault)

Source	Analysis of Variance		
	df	MS	F*
Communication behavior	1	.18	.19
Perceived physician fault	2	.56	.60
Interaction	2	1.54	1.64
Residual	112	.93	--

MS = mean square
*No significance found.

severity of outcome did not differ significantly between experimental groups. Because these analyses completed the intended use of the good result condition and the severity of outcome rating, we excluded both from subsequent hypothesis testing.

To test the hypothesis that the use of good communication

TABLE 2.—Analysis of Variance: Ratings of How Professional, Caring, Friendly, Trustworthy, Competent, to Blame, Negligent, and Liable Physician Is and How Likely Participant Would Be to Sue in Bad-Outcome Condition: Communication Behavior (Positive, Negative) Versus Physician Fault (No Fault, Uncertainty, Physician Fault)

Source	Professional			Caring		Friendly		Trustworthy		Competent	
	df	MS	F	MS	F	MS	F	MS	F	MS	F
Communication behavior.....	1	486.62	105.99*	1002.36	333.91*	1495.37	609.64*	465.08	137.87*	317.00	80.19*
Physician fault.....	2	13.30	2.89	8.44	2.81	1.14	.46	16.80	4.98	20.38	5.15
Interaction.....	2	10.28	2.41	9.35	3.11	1.50	.61	9.40	2.78	1.63	.41
Residual.....	113	4.59		3.02		2.45		3.37		3.95	

Source	To Blame		Negligent		Liable		Likelihood of Suing	
	MS	F	MS	F	MS	F	MS	F
Communication behavior.....	58.33	13.78*	134.10	29.24	76.39	13.10*	77.04	9.36†
Physician fault.....	64.56	15.25*	56.83	12.39	84.34	14.37*	44.04	5.35‡
Interaction.....	.97	.22	1.43	.31	7.97	1.35	15.45	1.87
Residual.....	4.23		4.58		5.87		8.22	

MS = mean square
 * $P \leq .001$. † $P \leq .01$. ‡ $P \leq .05$.

behaviors decreases the likelihood of a lawsuit and increases positive perceptions of a physician when a bad outcome occurs, we examined the communication behavior main effect of a 2×3 factorial multivariate analysis of variance (MANOVA) done on all bad-result conditions. The multivariate test, Wilks' lambda, was significant: $F(1, 113) = 72.74, P \leq .01$. A subsequent univariate analysis of variance, with the significance level partitioned across the nine analyses, was done on each dependent variable (Table 2). These tests show that participants were significantly more likely to sue physicians who used negative communication behaviors and also to rate them as less professional, caring, friendly, trustworthy, and competent and significantly more to blame, more negligent, and more liable.

Another hypothesis—that an increased perception of physician fault for a bad result increases litigious intentions and decreases positive perceptions of a physician—was tested by examining the perceived-physician-fault main effect in the 2×3 MANOVA used in evaluating the previous hypothesis. The result was significant: $F(2, 112) = 2.27, P \leq .01$. A subsequent univariate analysis of variance, with the significance level partitioned across the nine analyses, was done on each dependent variable (Table 2). These tests again confirmed our hypothesis.

Would increases in litigious feelings and a decrease in positive perceptions of a physician occur at each level of increase in probability of physician fault? This question was analyzed by using Hotelling's T^2 for two tests: comparing the no-physician-fault condition to the uncertain condition and comparing the uncertain condition to the physician-fault condition. The significance levels were partitioned across the two comparisons. The test for no fault versus uncertain was significant: $F(9, 67) = 2.44, P \leq .01$. Univariate t tests done on the dependent variables, using a two-tailed test and a significance level partitioned across the nine comparisons, showed that participants in the uncertain condition rated the physician as more to blame ($t[76] = 3.81, P \leq .001$), more negligent ($t[76] = 3.24, P \leq .002$), and more liable ($t[76] = 2.59, P \leq .01$). Ratings for how likely participants would be to sue the physician showed a trend ($t[76] = 2.59, P \leq .09$) but did not reach significance.

The multivariate Hotelling's T^2 test comparing the uncertain condition to the physician-fault condition was not significant: $F(9, 69) = .85, P \geq .05$.

Discussion

The results of this study support the hypothesis that the way physicians communicate is a risk factor for malpractice lawsuits. A physician relating to a patient in a "negative" manner triggered increased litigious feelings when there was a bad result, whereas a physician relating to a patient in a "positive" manner did not.

Other studies some 20 years ago similarly established that positive communication behaviors tend to strongly communicate caring and concern and to elicit positive and constructive responses.^{14,15} Based on our study, the first to apply such methods specifically to physicians' behavior, it seems likely that positive communications would result in less litigiousness because the physician is viewed as having cared about the patient and thus having acted in good faith. In the world of relating, good faith counts for a lot: one's reading of good and bad faith tends to define who is a malicious villain and who is a fallible human being.

On the other hand, negative behaviors tend to communicate lack of concern and even antagonism and may be seen by patients as a violation of the unwritten but inherent "caring" nature of the physician-patient relationship. Long before there is any medical outcome to be concerned about, the patient may believe that the physician has already done something "wrong" simply by relating in what is perceived to be an uncaring manner. This may set the stage for later retaliation if something does go wrong.

We undertook a post hoc data analysis related to this interpretation. A univariate, two-tailed t test was used to compare the ratings of physician negligence between the conditions of positive and negative communication behaviors within the good-result condition. Because the good-result condition described a good medical outcome, differences in perception of the physician had nothing to do with any bad outcome; they were based entirely on communication behavior. The test was significant— $t(37) = 2.77, P \leq .01$ —indicating that participants thought the physician using negative communication behaviors was more negligent than the physician using positive communication behaviors, even though there was no bad medical result. This is a post hoc data analysis, but it suggests that a subsequent bad medical outcome solidifies the perception of negligence and presents the opportunity and rationale for retaliation through a lawsuit.

How does communication behavior restrain litigious intentions? The data suggest that it may not simply be a function of inducing "nice" or "positive" feelings about the physician. First, litigious feelings are correlated with, but do not covary identically with, other perceptions of physicians (Table 3). Second, a review of cell means (Table 4) reveals that, whereas an interaction effect between communication behavior and perceived physician fault was not statistically significant in the overall MANOVA, the cell means for ratings of intentions to sue do not increase across the three fault conditions when positive communication behaviors were used, but the ratings of blame, negligence, and liability do. Although again this is a post hoc review of the data, it implies that positive communications restrain litigious feelings by a more complex process than presenting the physician in a

"positive" manner. The physician was still seen as being more to blame, negligent, and liable for the bad result, even though there was no accompanying increase in the desire to retaliate.

It may seem self-evident that patients are less likely to sue a physician they perceive as caring, but, if so, it is difficult to explain why practitioners seem to perceive "bedside manner" as superfluous, bothersome, or simply irrelevant to the practice of competent and technologically sophisticated medicine. In fact, while conducting the current study, we were struck by consistent anecdotal data suggesting that even if practitioners do not feel that way, many people seem to think they do.

We were initially concerned that our portrayal of the negative communication behavior condition was excessive, given that the physician in the videotape showing negative communication behavior exhibits *all* negative communication behaviors and *no* positive communication behaviors. But during the study we heard dozens of off-hand comments about the videotaped scenes, none of which suggested that the negative communication behavior condition seemed unusual, harsh, or unrealistic. To the contrary, the reaction often seemed to be, "Well, that's just the way they are." Although this view may not be accurate or fair, it reflects a widely held opinion that physicians are uncaring and unkind.

The results of this study also support the hypothesis that perceived physician fault for bad outcomes raises litigation risk, although the increase occurred only when the fault was clear, not uncertain. This contrasts with the ratings for blame, negligence, and liability that increased between the no-fault and uncertain conditions, but not between the uncer-

TABLE 3.—Correlation of Ratings of 'How Likely to Sue' With Other Perceptions of Physician

Perception of Physician	How Likely to Sue Pearson r
How professional	-.32*
How caring	-.23†
How friendly	-.21†
How trustworthy	-.35*
How competent	-.52*
How much to blame73*
How negligent69*
How liable72*

*P≤.01. †P≤.05.

TABLE 4.—Means for Cells in Bad-Outcome Condition: Communication Behavior (Positive, Negative) Versus Physician Fault (No Fault, Uncertain, Fault)

Lawsuit Likely According to Perception of Behavior	Positive Communication Behavior			Negative Communication Behavior		
	No Fault	Uncertain	Fault	No Fault	Uncertain	Fault
Likely to sue						
Mean	5.16	5.90	5.90	5.21	7.90	8.50
SD	3.32	3.25	3.16	2.14	2.57	2.54
Professional						
Mean	7.25	5.35	5.50	2.10	2.20	1.65
SD	2.44	2.66	2.58	1.55	1.85	1.42
Caring						
Mean	7.78	5.90	7.05	1.05	1.10	1.15
SD	2.27	2.44	2.56	.22	.31	.49
Friendly						
Mean	8.63	7.95	8.45	1.15	1.25	1.35
SD	2.08	1.90	2.13	.36	.55	1.35
Trustworthy						
Mean	6.84	4.80	4.90	1.75	1.45	1.45
SD	2.31	2.40	2.71	.91	.69	.76
Competent						
Mean	6.10	4.85	4.30	2.40	1.65	1.40
SD	2.35	2.89	2.58	1.84	1.23	1.09
To blame						
Mean	5.00	6.74	7.10	6.05	8.25	8.75
SD	2.40	2.42	2.10	2.11	1.91	1.16
Negligent						
Mean	4.79	6.47	6.70	6.60	8.50	9.25
SD	2.59	2.50	2.36	2.11	1.85	1.12
Liable						
Mean	4.73	5.95	6.80	5.40	8.10	8.90
SD	2.72	2.89	2.65	2.89	1.83	1.45

tain and physician-fault conditions. Why negative perceptions but not litigiousness should increase with uncertainty as to fault is unclear. It may mean that inducing litigious feelings is simply more difficult than inducing negative perceptions and so may require a greater overall degree of difference in perceived physician fault. It may also be that because of the lack of resolution uncertainty creates, it is at least as upsetting for most people as knowing who is at fault. This kind of reaction can be seen in cases of "mysterious" misfortunes wherein people devote many years of their lives to trying to find out who or what is responsible for a particular tragedy or crime, even when nothing can be done about it.

Another possible interpretation of this finding is that people have unrealistic expectations concerning physicians and the state of medical science and are unwilling to believe that a bad result can occur without someone having done something wrong. Thus, they may blame someone even when there is really no one to blame. In either case, it seems to be another piece of bad news for physicians—that when there is uncertainty as to the reason for a bad outcome, they do not get the benefit of a doubt.

The results of our study support the idea that physicians may be able to affect their risk of lawsuits by changing the way they behave with patients. The use of good communication behaviors, for example, may not be technically more "competent" medicine, but it may prevent lawsuits, even when something has clearly gone wrong and even when it is clearly the physician's fault.

The study also suggests that patient education may reduce the frequency of litigation. When patients are informed enough to be certain that a bad result is not the physician's fault, negative perceptions and perhaps litigiousness remain low. At the same time, even though a well-informed patient may also be able to tell when the physician is at fault in a bad outcome, this knowledge seems to raise negative perceptions and possibly litigious feelings only a small amount beyond what occurs when the patient is uncertain about the reason for a bad outcome. As a result, there may be much to be gained and little to lose from having well-informed patients.

This study is relatively small and, as far as we know, the first to examine these variables in a controlled experimental setting. The whole issue is complex, difficult, and deserves much attention and research. The positive results of the present study suggest that attempts to lower litigation risk by using extra medical procedures and tests, consultation, and extensive documentation, often known as "defensive medicine," may miss the point. Although such efforts may be preventive in that their "double-checking" may help to avoid some bad medical results, they will not prevent them all. And

when a bad result does occur, even lack of physician fault and the presence of extra procedures seem unlikely to diminish litigious feelings and the resulting chance of a lawsuit. Defensive medicine is not so much a tool to prevent lawsuits as it is to win them if they do occur. It can help provide the necessary courtroom evidence that a physician provided an appropriate standard of care. But if the intention is to prevent a lawsuit in the first place, forging a physician-patient bond that can effectively resist the pressures of our litigation-crazed and socially antagonistic society seems indispensable. An important way of accomplishing this may be through improving physician communication skills and patient education.

Perhaps Gregory best sums up our feelings when she says,

An attitude of care and concern, a relationship that bespeaks thoughtful professionalism, and a humanistic approach many times solves more problems, melts more hostilities, and *eliminates more suits* than almost any other single recommendation [emphasis added].^{5(p185)}

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