

Identifying and Addressing Communication Failures as a Means of Reducing Unnecessary Malpractice Claims

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Substantial research provides clear evidence of the relationship between communication failures and malpractice claims. Communication failures among health care practitioners are associated with most avoidable adverse outcomes.^{1,2,3} Poor communication skills also adversely impact patient-provider relationships, increasing the likelihood that families sue when faced with adverse outcomes whether or not errors have occurred.^{4,5,6}

In spite of the research, many within medicine cling to myths concerning why they get involved in claims, asserting, “Everyone in my specialty gets sued,” or “It’s just a cost of doing business.” Others contend they attract litigation-prone patients or attend to the most challenging cases. Unfortunately, such myths pose a stumbling block to one approach to reducing malpractice claims that everyone should support: identifying and addressing ways to promote improved patient-practitioner communication.

Our goal is to focus on just one factor promoting lawsuit generation—poor practitioner communication skills. We will review research concerning why families file suit, why some practitioners have a “dark cloud,” and the role that poor provider communication skills play in observed claims’ disproportionality. Finally, we will offer suggestions concerning what health care practitioners can do to identify and address risk.

Studies reviewed widely in the media by researchers at Harvard focused national attention on errors in medicine. Their studies involving chart review suggested that 1% to 2% of hospitalized patients in the US experience adverse outcomes due to medical errors.^{7,8} Study results should convince us that we share a duty to make medicine safer. How to make medicine safer is beyond the scope of this commentary, but we do want to focus on an often overlooked finding that suggests another problem needing attention. In completing thousands of reviews, the Harvard team identified cases where errors caused adverse outcomes and where families filed suit. However, for

every family who filed a “valid” claim, the Harvard team identified 5 families who sued with no evidence of negligence.⁹ Such findings are consistent with information from state-based claims reporting. Data from the state of Tennessee reveals that in 2006 over 80% of closed malpractice claims were dropped without an award or settlement.¹⁰

When such data are reviewed, many practitioners fall back on their old myths or seek to blame the plaintiff bar without asking two questions: Why are so many nonvalid claims filed, and is there anything we can do? Nonvalid claims create burdens for the families filing them because many relive painful experiences, for the practitioners who are named because they may experience emotions from anger to depression, and for members of society who ultimately pay the bill.

To understand why people sue, you begin by asking families who have filed claims. Although such studies are subject to recall bias, they provide evidence of how communication failures prompt some families to sue. When asked what prompted them to seek legal advice 25% of families interviewed mention the need for money.⁴ Most, however, cited noneconomic reasons

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including belief in cover-ups and the need for information.^{4,5} Results also highlight how often families believe that no one ever expressed concern about the family's loss or offered an apology in the face of what the family believed was an error.

Studies examining why some physicians attract more than their fair share of lawsuits offer additional insight into how poor communication skills promote claims. Sloan and colleagues reported that physicians can be sorted into 3 risk groups: those with no suits, those with an occasional claim, and a third group with high claims. Between 2% and 8% of physicians by specialty account for more than one-half of all malpractice-related costs.¹¹ In a follow-up study, Bovbjerg identified that claims experience is constant over time such that physicians at high malpractice risk today will be at high risk tomorrow.¹² Study results raise an obvious question: Why do certain physicians generate so many suits? Multiple hypotheses have been proposed, but studies reveal that individual claims experience is not predicted by patient characteristics, illness complexity, or even the physician's technical skills.^{13,14} Instead, risk is predicted by the practitioner's inability to communicate effectively and establish and maintain rapport with patients, especially in the face of an adverse event.^{4,6,13,14} In a study examining perceptions of care, patients seeing high-risk obstetricians were 3 times more likely to assert that their physicians would not answer questions or listen when compared with families seeing obstetricians with no malpractice claims.¹⁴ Over 30% of study subjects seeing high-risk physicians voiced dissatisfactions with care even after delivering healthy newborns.

In spite of evidence linking poor communication skills with claims experience, the question remains: Is there really anything that can be done to reduce risk? In response to this question, researchers with the Vanderbilt Center for Patient and Professional Advocacy developed 2 hypotheses. First, high-risk providers are unaware of their status. Second, if made aware, many will seek to change their practices or communication behaviors in ways to reduce risk.

To help make high-risk physicians aware of their status, the team sought a proxy for malpractice claims that is linked to risk events but occurs frequently enough to be counted and fed back to the at-risk clinicians. Many groups, clinics, and hospitals have patient advocates, called ombudsmen, who listen to families who are dissatisfied with care. Advocates record the stories and attempt to address what is perceived as wrong. Analysis of thousands of stories reveals that unsolicited complaints are not randomly distributed. Just like malpractice claims, 30% to 50% of practitioners never attract a complaint. An equal number get an occasional complaint. However, when coded for complaint type (34 separate categories) by practitioner, the complaint reports can be used to reliably identify a small subset of physicians (4% to 8% of any group) who account for over 40% of claims and 50% of all malpractice-related costs.^{15,16}

The Vanderbilt team then turned its attention to how complaint data could be used to promote awareness. At each study site, peer messengers are trained to deliver intervention materials to their at-risk colleagues, including (1) a report card

illustrating the individual's relative ranking, (2) a table illustrating the complaint type distribution, and (3) the actual complaint text so physicians can review and gain insight.^{17,18} Visits average just over 30 minutes and are mostly received professionally. Currently, the identification and intervention model is operational in 25 geographically-distributed sites (from free-standing group practices to major medical centers) with over 16 000 medical practitioners assessed yearly.

Intervention results are encouraging and reveal that many high-risk practitioners, when made aware, address recurring sources of patient dissatisfaction within their practices.¹⁸ Just under 60% of those receiving awareness interventions respond. Unfortunately, approximately 20% depart their practices, some seeking what is referred to as a "geographic solution," while an equal number require an authority-based intervention that mandates anything from a practice review to a comprehensive mental health evaluation.

The intervention study affirms that practitioners can act to reduce sources of patient dissatisfaction that promote risk within their practices. The study also provides important insight into common communication failures that promote risk. Review of over 200 000 unsolicited patient complaint reports leads us to a few suggestions that should benefit any provider who wants to improve patient-practitioner communication even if only for the purpose of reducing personal malpractice risk. These include making patients feel respected, using the informed consent process to build practitioner-patient relationships, and letting patients know the practitioner cares about feedback.

The first important strategy is for practitioners to send clear messages to their patients that they are respected as fellow humans. For a host of reasons, including anxiety, illness complexity, and the pressures of modern medical practice, patients sometimes can perceive a loss of connectedness with their health care providers. Such a loss impacts quality of medical history-taking, adherence with medical care plans, and risk of litigation. Practical means of sending a message of respect were identified in a study by Levinson.¹⁹ They include attention to body language (Do you look rushed?), efforts to solicit patients' opinions ("Which option seems most workable for you?"), and encouraging patients to talk ("What can we talk about today?" followed by a mandatory pause). Such strategies take time. However, in the Levinson study, providers modeling respect-generating strategies averaged just over 3 minutes more per encounter than their colleagues who did not but who were subjects to suits.

Another strategy for improving communication suggests the practitioner view the informed consent process as an opportunity for relationship building. Review of unsolicited complaint reports reveal that families often express uncertainty about the intended procedures including what they should expect, risks versus benefits, and specifically, when they will get follow-up information. One predictor of malpractice risk is a patient's assertion that the practitioner involved failed to show up after the procedure. We commend national efforts to promote teach back in association with informed consent.²⁰ Patients should have an opportunity to describe back to the practitioner the proposed procedure, the most common complications, and

when they should expect a follow-up discussion.

The final recommended step for improving communication is for practitioners to send the message that they want to hear from their patients, especially if the patients are dissatisfied. Both marketing and medical studies reveal that most families who experience significant dissatisfaction with care are hesitant to speak up to the provider involved or a representative of the

group.^{21,22} Consequently, hospitals and medical groups may fail to recognize recurrent sources of dissatisfaction that put them at risk. Most of us tend to be defensive in the face of a complaint, but complaints, if seen as an opportunity to learn, offer an important key to identifying and addressing unnecessary malpractice risk as well as a way of allowing patients to have a role in improving care for everyone. **NCMJ**

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