Medical Malpractice: A Communications Centered Solution

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Introduction and Problem Analysis

According to the New England Journal of Medicine, “one in fourteen doctors faces a malpractice suit every year,” (Most Doctors Sued, 2011). That is an incredibly high number, considering there are only 916,264 licensed physicians in the United States, according to a 2014 census by Aaron Young, PhD (2015). If you run the numbers, that’s 6,534 doctors that have committed some form of malpractice and been prosecuted for it. That’s 6,534 people and their families that have been victims of malpractice and are having to deal with the red tape of the lawsuit that follows. That’s 6,534 too many because the vast majority of medical malpractice suits are due to miscommunication, whether within the medical team or between the physician and the patient. Many medical malpractice lawsuits are the result of communication problems, and correcting these problems can mitigate these suits. This proposal will discuss what the issue is, why it exists, a possible solution and the efficacy of the plan.

By law, medical malpractice is an incident between a medical professional and patient that results in serious injury or death to the patient. For a case to be legally considered malpractice, it must violate the standard of care, be caused by negligence, and result in significant damages (What Is Medical Malpractice, 2017). Much of the time, the patient never learns about aspects of their care that could be considered malpractice because it doesn’t cause any issues. According to the National Practitioner Data Bank Public Use File from 2016, 34% of malpractices are due to a diagnosis, 24% are from surgery, 18% are from treatment, and 24% are due to everything else. Additionally, thirty-one percent of all malpractices result in death. Malpractices from diagnosis are generally because a piece of patient history has been left out or is unknown to the health care physician, those from surgery are due to an unnecessary procedure or an error in anesthesia, or something during the healing process. Similarly, malpractice from

treatment is usually due to the wrong treatment being prescribed, not being prescribed in the wrong dose or for the right amount of time, or a patient being discharged too early. Malpractice being a result of miscommunication and poor patient-physician relations can be proved because it has been found that there are behavioral differences between primary care physicians that have been accused of malpractice and those that have not that center around communication habits . The ones that have not been involved in malpractice suits use humor, sit down while speaking, have an open stance (not holding a clipboard or other items), smile, and check the patient's understanding along the way and ask for their opinion and give them treatment options rather than telling them how they will be treated. This gives the patient the idea that the physician truly cares about them as a person, beyond just being a patient, which makes the patient more likely to just talk to the physician than go straight to their lawyer to sue should an issue occur. While personal errors on the side of the health care provider are very common causes of malpractice, there are several other factors that perpetuate malpractice suits.

Barriers to a Solution

There are barriers that inhibit or prevent doctors from being able to communicate effectively and lower the number of malpractice cases. These barriers include the Health Insurance Portability and Accountability Act of 1996 (HIPAA), differences in health literacy between patients and physicians, and inadequate communication between medical professionals.

HIPAA was passed in 1996 by the Clinton Administration and according to the United States Department of Health and Human Services, the main goal of the law is to "assure that individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care" (2017). However, there is an adverse effect on physicians and their ability to communicate. Dr. Nancy Rogic, an

anesthesiologist for Boys Town National Research Hospital, says, “HIPAA has made it difficult to talk about patients with other physicians” (personal communication, June 22, 2017). Basically, it has severely impacted physicians’ ability to utilize horizontal communication which is “messages between members of an organization with equal power” (Adler, Elmhorst and Lucas, 2013, p. 18). Physicians can’t coordinate tasks or share information readily (Adler, et al., 2013) which will lead to malpractice suits.

Health literacy differences between patients and physicians is a source of miscommunication that leads to malpractice. Health literacy is a term to describe the ability to understand medical jargon and jargon is defined as “specialized vocabulary” related to a profession (Adler, et al., 2013, p. 108). Sometimes, jargon is useful such as between medical professionals but in patient–physician interactions, it is inappropriate to use jargon as the patient might not understand. According to Lefevre, Walters and Budetti, a “failure to communicate is a significant source of malpractice suits” and in fact, “only one in six malpractice claims involved negligence” (2000, p. 258). Clearly, breakdowns in communication carry huge weight when it comes to malpractice, a claim further backed up by a study that found 81% of medical malpractice cases involved insufficient explanations by the physician and “the doctor’s explanation and the patient’s understanding of this explanation have been shown to influence patient satisfaction” (Hamasaki, Takehara and Hagihara, 2008, p. 1). Miscommunications from poor understanding of explanations lead to malpractice suits.

Poor communication between medical professionals leads to malpractice claims. Bad handwriting can lead to serious injury. In 1995, both a doctor and a pharmacist had to pay $225,000 after the doctor’s poor handwriting on a prescription led to the patient receiving the wrong medication from the pharmacist (Hirshhorn, 2000). Another instance of poor

communication was when two doctors gave conflicting orders that lead to irreparable damage to the patient's back (A failure to communicate, 1997, p. 32). The doctors utilized asynchronous communication, or indirect channels of communication (Adler, et al., 2013, p. 11), and it failed them as it led to a horrible miscommunication. The method of giving orders is not ideal as the doctors needed to speak directly to avoid such a miscommunication. The methods of communication between physicians leads to poor communication which leads to more malpractice claims for health care professionals.

Concepts and Application Plan

A physician's attitude and communication skills are the main reason people file a malpractice suit (Kurtz, Silverman, Draper, Dalen and Platt, 2014). Most complaints about physicians are due to improper communication and not medical negligence. A physician's incapability to communicate effectively and start and continue a relationship with their patient will result in a higher risk of being sued (Hickson and Jenkins, 2007). A poor physician-patient relationship can create distrust and dissatisfaction from the patient and ultimately result in a malpractice suit being filed.

Most patient dissatisfaction is due to a poor physician-patient relationship. Communication and interpersonal skills can play a crucial role in how this relationship is perceived. When a physician communicates with a patient, their goal is to gather information so that they may provide high quality medical care and improve their patient's health. A good physician-patient relationship has the potential to help regulate patients' emotions, help with the understanding of medical information, and allow for better identification of patients' needs and expectations (Ha and Longnecker, 2010). These factors lead to a positive bedside manner, created by the physician, leaving their patients satisfied with their treatment.

In our increasingly globalized world, patients can come from anywhere on the planet. Due to patients' different backgrounds, they may have different perceptions of physicians. For example, in the African American community, traditional African medicine may be viewed more positively than professional physicians. If the physicians don't understand the African American culture, they may not be able to effectively communicate with them. Physicians who are culturally literate or understand how a certain culture behaves (Adler, et al., 2013, p. 52) are more likely to build a successful relationship with their culturally different patients. Avoiding the pitfall of ethnocentrism is important for doctors. Ethnocentrism is the "inclination to see all events from the perspective of your own culture and to evaluate your own culture as superior" (Adler et al., 2013, p. 54). This would be disastrous to a patient-physician relationship and becoming more open and well versed in other cultures would greatly help with malpractice. Instead, physicians and medical providers need to learn more about different cultures so they can become culturally literate.

Communication Accommodation Theory, or CAT, can help patients and physicians avoid miscommunication. CAT is when both parties, speaker and listener, modify their interaction pattern, including dialect, tone and voice (Gallois and Giles, 1998). When the parties are similar, a convergent interaction occurs; for example, if the physician and patient are part of a similar culture, they will be able to understand each other's background, communicating smoothly. However, if the physician and patient are from different cultural backgrounds, a divergent interaction occurs, with communication being rough. Therefore, convergent interactions can be an aid to effective communication while divergent interactions can hinder it.

Another way to improve physician-patient relationships is by focusing on patient-centered medicine. Patient-centered medicine focuses medical attention on the individual

patient's needs and concerns (Bardes, 2012). This allows patients to make an informed decision with the physician and can lead to a trusting and respectful relationship between physician and patient (Jones, 2014). This form of collaborative communication requires physicians to schedule time to be able to discuss treatment options to the patients. Communicative and interpersonal skills are fundamental components to this approach of this type of care. Patient-centered care ensures that important information is shared by both parties and that treatments are discussed and tailored to each unique case.

Most physicians are not born with great communication and interpersonal skills. These skills are essential in creating a good physician-patient relationship. This can be solved with communicative skills training. There has been a recent phenomenon of adding communicative skills training in medical schools to try to teach better physician-patient communication (Training to Advance Physicians' Communication Skills, 2015). This is done by incorporating more interactive learning as opposed to the traditional lecture-style teaching.

In the past, medical schools ignored these important skills, resulting in many physicians' lack of empathy towards patients. This means that many of the older physicians do not know how to communicate effectively with their patients. To solve this, health care facilities should host mandatory communication programs provided by outside organizations. These programs can be offered as seminars and workshops where many strategies may be covered in a short period of time.

Many physicians do not realize that they suffer from poor communicative and interpersonal skills. One solution to improving physicians' communicative skills is asking for feedback from their patients so that they may learn on what should be improved. This can either be accomplished by surveys or verbal responses.

The organizational culture of the health care world makes it difficult for physicians to spend a lot of time with their patients. To save time and help identify what skills a physician is lacking, clinics and hospitals can use patient advocates to help listen to patients' dissatisfaction. These advocates can record these stories and use them to identify what skills need to be improved on. The reports can then be used by the physician to discover what skills they need to practice. It is important that these skills are constantly improved on so that the physician can provide the best care possible.

Efficacy Analysis and Conclusion

Having seen not only what a serious problem malpractice suits are in modern medicine but how communication plays into this problem, what the barriers to a simple solution are, what possible concepts can be applied to the problem and how a these concepts can be applied, we have a plan and here is why it will work.

We have observed one of the most important aspects of the issue, the physician–patient relationship. As this plays into a patient's perception of a physician and their likelihood to sue, a focus on bettering these relationships will improve patient perception. And, having improved patient perception, we will lessen the likelihood of a malpractice suit (Kurtz, et al. 2014).

We've discussed yet another important concept, patient–centered medicine. This concept helps to ensure that both a physician and a patient are on the same page, helping the physician make more educated suggestions and the patient make more informed decisions. An informed decision helps a patient to take ownership of their own care, further reducing the likelihood of a suit.

The final part of our plan, communicative skills training, will help to make sure that physicians better understand the impact they have on patients, increasing mindfulness of their

communication patterns. When this happens, the physicians will become more effective, have better relationships with their patients, pay more attention to their needs, and focus more on *communicating* with their patients, ensuring that both parties understand the plan of care and help reduce the likelihood of lawsuits.

If our plan is implemented in a timely manner, hopefully, in a few years, we won't have this problem of one of every fourteen doctors being sued for malpractice (Most Doctors Sued, 2011). The goal of our plan is not just to prevent malpractice but to help overcome the barriers presented utilizing communication concepts and tools so physicians are better equipped to communicate with everyone involved in the care of the patient. Improved communication will lead to less malpractice cases which is favorable for everyone involved.

References.

A failure to communicate. (1997). *Nursing*, 27(2), 32.

Adler, Elmhorst, & Lucas (2013). *Communicating at work: Strategies for success in business and the professions.* [Customized e-textbook for the University of Nebraska-Lincoln]. Lincoln, NE: McGraw Hill.

American Board of Professional Liability Attorneys. (2017). *What is medical malpractice?*. Retrieved June 29, 2017, from http://www.abpla.org/what-is-malpractice

Bardes, C.L., M.D. (2012, March 1). Defining “Patient-Centered Medicine”. Retrieved from http://www.nejm.org/doi/full/10.1056/NEJMp1200070#t=article

Department of Health and Human Services. (2017). Summary of the HIPAA privacy rule. Retrieved June 26, 2017, from https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html

Diederich Healthcare. (2017). *2017 medical malpractice payout analysis* Retrieved June 29, 2017, from http://www.diederichhealthcare.com/the-standard/2017-medical-malpractice-payout-analysis/

Gallois, C., & Giles, H. (1998). Accommodating mutual influence in intergroup encounters. In M. T. Palmer & G. A. Barnett (Eds.), *Mutual influence in interpersonal communication: Theory and research in cognition, affect, and behavior* (pp. 135–162). New York, NY: Ablex.

Ha, J. F., & Longnecker, N. (2010). Doctor-Patient Communication: A Review. *The Ochsner Journal*, *10*(1), 38–43.

Hamasaki, T., Takehara, T., & Hagihara, A. (2008). Physicians' communication skills with patients and legal liability in decided medical malpractice litigation cases in Japan. *BMC*

Family Practice, 9, 1-10.

Hickson, G. B., MD, & Jenkins, A. D. (2007, Sept. & Oct.). Identifying and Addressing Communication Failures as a Means of Reducing Unnecessary Malpractice Claims.

Hirshhorn, C. (2000). Poor penmanship costs MD $225 000. *CMAJ: Canadian Medical Association Journal*, 162(1), 91.

Huntington, B., & Kuhn, N. (2003). Communication gaffes: a root cause of malpractice claims. *Proceedings (Baylor University. Medical Center)*, *16*(2), 157–161.

Jones, K. B., MD. (2014, December 12). Patient-Centered Care Versus Patient-Centered Care [Web log post]. Retrieved from http://www.physicianspractice.com/blog/patient-centered-care-versus-patient-directed-care

Kirn, T. F. (August 11, 2011). Most doctors sued sometime in career. *Insurancejornal.com.* Retrieved June 29, 2017, from http://www.insurancejournal.com/news/national/2011/08/19/211634.htm

Kurtz, S. M., Silverman, J., Draper, J., Dalen, J. V., & Platt, F. W. (2014). *Teaching and learning communication skills in medicine* (2nd ed.).

Lefevre, F. V., Waters, T. M., & Budetti, P. P. (2000). A survey of physician training programs in risk management and communication skills for malpractice prevention. *Journal Of Law, Medicine & Ethics, 28(3)*, 258.

Medical Council of Canada (2017). *Communication skills module: A brief history of physician-patient communication.* Retrieved from http://physiciansapply.ca/commskills/introduction-to-medical-communication-skills/a-brief-history-of-physician-patient-communication/.

Palmer-Wackerly, A. (2015) Health Communication. [Lecture].

Rogic, MD, N. A. (2017, June 22). Anesthesiologist, Boys Town National Research Hospital.

Spence, D. L., Feigenbaum, E. M., Fitzgerald, F., & Roth, J. (1968). Medical student attitudes toward the geriatric patient. *Journal of the American Geriatrics Society. 16,* 976-983. doi. 10.1111/j.1532-5415.1968.tb02727.x.

Training to Advance Physicians' Communication Skills. (2015, December 23). from https://www.ahrq.gov/cahps/quality-improvement/improvement-guide/6-strategies-for-improving/communication/strategy6gtraining.html

Young, PhD, A., Chaudhry, DO, MS, H. J., Pei, PhD, X., Halbesleben, PhD, K., Polk, DO, D. H., & Dugan, MBA, M., (2015). A census of actively licensed physicians in the United States, 2014. *Journal of Medical Regulation, 101(2),* 8-23.