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THE PATIENT-PHYSICIAN RELATIONSHIP AND ITS IMPLICATIONS FOR MALPRACTICE LITIGATION

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A recent special issue of the *Journal of General Internal Medicine* has introduced a new model of medical practice termed "Relationship-centered care" (RCC).¹ RCC is based upon four guiding principles: "(1) that relationships in health care ought to include the personhood of the participants, (2) that affect and emotion are important components of these relationships, (3) that all health care relationships occur in the context of reciprocal influence, and (4) that the formation and maintenance of genuine relationships in health care is morally valuable."² In reference to these principles, it is the thesis of this article that the current malpractice environment is fueled by communication and relationship failures. Moreover, at least some portion of this failure may be repaired through a better understanding of the dynamics of communication in medical visits, physician training to enhance communication skills, and an appreciation for the role of reciprocated emotion in the doctor-patient relationship.

Disappointments in the doctor-patient relationship can contribute to a negative spiraling of confidence and regard with consequences for both the physician and the patient. For the physician, a single malpractice suit substantially increases the likelihood of future litigation. For instance, an analysis of the medical malpractice experience of physicians in Florida found that physicians having had any claim during a six-year baseline period (1975-1980) were associated with a two-fold increase in the likelihood of a subsequent claim in the next three years.³ Even a prior unpaid claim doubled the chances that a physician would have a subsequent claim.⁴ While the researchers did not address the question of why or how prior claims predicted future claims, they suggest that it may be some, as yet unmeasured, quality of the doctor-patient relationship.

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1. Mary Catherine Beach et al., *Relationship-Centered Care: A Constructive Reframing*, 21 J. GEN. INTERNAL MED. S3, S4 (2006).

2. *Id.*

3. Randall R. Bovbjerg & Kenneth R. Petronis, *The Relationship Between Physicians' Malpractice Claims History and Later Claims: Does the Past Predict the Future?*, 272 JAMA 1421, 1424 (1994).

4. *Id.*

This conclusion was supported by a failure to link repeated claims to clinically obvious differences in quality of care.⁵ A review of the medical records of obstetricians practicing in Florida between 1977 and 1983, who were still in practice in 1987 (a subset of the physicians included in the previously mentioned study⁶), failed to find any differences in the objective or subjective measures of clinical care quality based on varying malpractice claims history, including the number of prior claims or the cost of the claims.⁷ The authors concluded that if there are systematic differences in practice styles of physicians who are sued and those who are not, it is unlikely to be in the technical aspects of clinical care.⁸

I. PATIENTS' DISSATISFACTION WITH COMMUNICATION SKILLS

What then may account for the greater likelihood of repeated malpractice suits, if not the physicians' technical quality? Interviews with the mothers of infants with closed malpractice claims shed some light on the question.⁹ While there were many reasons noted for filing a claim, most women expressed dissatisfaction with some aspect of communication with their physician. The most frequent grievances included the belief that no one involved in providing care during the perinatal period told them that their infants might have permanent medical problems or die (70%), that the physician had misled them (48%), that the physician would not talk to them or answer questions (32%), and that the physician would not listen to their concerns (13%).¹⁰

Other investigations have similarly concluded that communication difficulties contribute to the likelihood of a patient's pursuing a claim. A review of plaintiff depositions taken from settled malpractice claims between 1985 and 1987 found that problematic relationships were evident in 71% of the depositions.¹¹ Deposition transcripts showed that complaints regarding communication were common, including the physician's failure to listen to and appreciate patient concerns or provide sufficient information about the adverse event. The authors suggest that communication failures were even more frequent than was evident

5. Stephen S. Entman et al., *The Relationship Between Malpractice Claims History and Subsequent Obstetric Care*, 272 JAMA 1588, 1590 (1994).

6. Bovbjerg & Petronis, *supra* note 3, at 1421-22.

7. Entman et al., *supra* note 5, at 1590.

8. *Id.* at 1591.

9. Gerald B. Hickson et al., *Factors That Prompted Families to File Medical Malpractice Claims Following Perinatal Injuries*, 267 JAMA 1359 (1992).

10. *Id.* at 1361.

11. Howard B. Beckman et al., *The Doctor-Patient Relationship and Malpractice: Lessons from Plaintiff Depositions*, 154 ARCHIVES INTERNAL MED. 1365, 1366-67 (1994).

from their review since not all depositions included an inquiry into patient motivation for initiating the suit.¹²

Also exploring the patient perspective in regard to litigation, Charles Vincent and colleagues surveyed over 200 patients and relatives who were in the midst of an open malpractice case.¹³ Regardless of the primary reason for pursuing litigation, patients were critical of explanations given to them after the incident. Most indicated that explanations were largely inadequate; only a minority of patients was satisfied with the clarity of the explanation (31%), the accuracy of explanation (23%), or that the explanation was given in a sympathetic manner (37%).¹⁴

While the preceding studies assessed plaintiffs actively engaged in litigation, several other studies have investigated a common precursor to litigation—the formal lodging of a complaint. A large retrospective analysis of complaints made to the Victorian Health Complaint Information Program is particularly noteworthy.¹⁵ Almost one-third (29%) of over 19,000 patients complaints lodged during the study period (1997-2001) were related to some aspect of communication, including inattentiveness, discourtesy and rudeness, a general breakdown in communication, and inadequate information.¹⁶ Interestingly, the investigators found that the majority of complaints were easily resolved with an apology, additional information or explanation, or acknowledgement of the patient's point of view.¹⁷ A smaller but somewhat similar study of patient complaints in a U.S. Medical Center over a one year period (2000) also identified common communication themes.¹⁸ Disrespect (36%), disagreement regarding expectations of care (23%), inadequate information (20%), distrust (18%), and perceived unavailability (15%) were primary complaint themes.¹⁹

While the Florida study showed that there were no differences in the quality of technical care provided by sued and non-sued physicians,²⁰ other authors have hypothesized that the sued, compared with never-sued physicians, typically act in a

12. See *id.* at 1368 (noting the lack of opportunity in the study for patients to elaborate on interpersonal issues with doctors).

13. Charles Vincent et al., *Why Do People Sue Doctors? A Study of Patients and Relatives Taking Legal Action*, 343 LANCET 1609, 1609-10 (1994).

14. *Id.* at 1611 tbl.3.

15. See David McD. Taylor et al., *Analysis of Complaints Lodged by Patients Attending Victorian Hospitals, 1997-2001*, 181 MED. J. OF AUSTL. 31, 31-35 (2004) (describing complaints by patients and comparing rates of complaint in demographic subgroups of patients and hospital departments).

16. *Id.* at 31, 33 box.4.

17. *Id.* at 33, 34 box.5. The study reports that, of the 22,642 complaints resolved after discussion and/or explanation, 18,129 were resolved with these four methods. *Id.*

18. Marcia M. Wofford et al., *Patient Complaints About Physician Behaviors: A Qualitative Study*, 79 ACAD. MED. 134, 137 (2004).

19. *Id.* at 136.

20. Entman et al., *supra* note 5, at 1590.

way that elicits lower rates of patient satisfaction, particularly in relation to communication issues.²¹ Exploring this question, in-depth telephone interviews were conducted with the patients of sued and non-sued obstetricians. None of the women in the study had filed a malpractice claim, and the sample included those with both normal and adverse baby outcomes. Women who had seen the obstetricians with the most frequent number of prior claims were significantly more likely to report spending less than ten minutes on average with their physician during their visits, say that they felt rushed or ignored, and report inadequate explanations for tests.²² These patients were more critical of the care they received during labor and delivery and were more likely to report having seriously considered changing obstetricians during their pregnancy.

Patients of physicians who have been sued in the past are less satisfied with their care and more likely to lodge a complaint against their doctor than patients of never-sued physicians.²³ Computerized records of all unsolicited patient complaints made against doctors in a large U.S. medical group between 1992 and 1998 were monitored and related to risk-management records.²⁴ The number of complaints was positively associated with risk outcomes, ranging from file openings to multiple lawsuits, even when statistically adjusting for clinical activity.²⁵

In another study, the satisfaction levels of discharged hospitalized patients predicted both the number of patient complaints and the malpractice experience of the treating physician.²⁶ In this study, the risk management experience of 343 physicians over a twenty-year period (1983-2003) was related to patients' satisfaction scores collected over a three-year period (2001 to 2003).²⁷ The five-item satisfaction survey pertaining to physician services was routinely administered to every discharged patient and largely reflected interpersonal aspects of care. Included in the measure was patient satisfaction with feeling well-informed, having adequate time with the physician, physician friendliness and courtesy, and physician's concern for patient worries and their questions. In addition, one item assessed satisfaction with physician skill. Notably, every question, with the exception of satisfaction with physician skill, was associated

21. Gerald B. Hickson et al., *Obstetricians' Prior Malpractice Experience and Patients' Satisfaction with Care*, 272 JAMA 1583, 1583 (1994) (reporting that physicians who are sued more frequently are also more likely to receive complaints about their interpersonal care).

22. *Id.* at 1585-86, 1586 tbl.2.

23. Gerald B. Hickson et al., *Patient Complaints and Malpractice Risk*, 287 JAMA 2951, 2955 (2002).

24. *Id.* at 2952.

25. *Id.* at 2955.

26. Henry Thomas Stelfox et al., *The Relation of Patient Satisfaction with Complaints Against Physicians and Malpractice Lawsuits*, 118 AM. J. MED. 1126, 1131 (2005).

27. *Id.* at 1127, 1129.

with patient complaints and risk-management episodes. Compared with physicians ranked in the top one-third of satisfaction ratings, those in the middle third had a 23% higher rate of complaints and a 26% higher rate of malpractice lawsuits.²⁸ Those physicians with satisfaction ratings in the lowest tertile had a 79% higher rate of patient complaints and 110% higher rate of lawsuits than the physicians in the highest satisfaction tertile.²⁹

II. THE NEGATIVE IMPACT OF MALPRACTICE LITIGATION ON PHYSICIANS

While there are particular risk-related physician behaviors and styles of communication that increase the likelihood that an adverse event will lead to malpractice litigation, it may also be true that the experience of being sued is so transforming an event for physicians that it results in the development and expression of risk-related behaviors. For instance, a survey of over 800 Pennsylvania physicians in high-litigation-risk specialties (i.e., general surgery, emergency medicine, neurosurgery, obstetrics/gynecology, orthopedic surgery, and radiology) found that nearly all (93%) reported changing their practices in some way due to fear of potential litigation.³⁰ Changes in behavior were evident in the use of both defensive and avoidance practices. The authors warn that while a defensive environment can sometimes lead to more thorough discussions and comprehensive patient care, it can also take a toll on the interpersonal aspects of care. Heightened levels of physician suspicion could lead to a characterization of almost any patient as a potential litigant, especially those who may be demanding, emotional, or unpredictable.³¹ A survey of physicians in Pennsylvania also concluded that liability pressures substantially diminish physician satisfaction and impinge upon the patient-physician relationship.³² Three-fourths of surveyed specialists in that study endorsed the view that every patient is a potential litigant; among physicians who had been sued or dropped by an insurer, this view was even more prevalent.³³

The impact of malpractice litigation on the psychological health of physicians also appears considerable. A random survey of members of the Chicago Medical Society found that there were significantly more reported symptoms of severe depressed mood, inner tension, anger, and frustration among sued, compared with

28. *Id.* at 1130.

29. *Id.*

30. David M. Studdert et al., *Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment*, 293 JAMA 2609, 2610, 2612 (2005).

31. *Id.* at 2616.

32. Michelle M. Mello et al., *Caring for Patients in a Malpractice Crisis: Physician Satisfaction and Quality of Care*, 23 HEALTH AFF. 42, 48 & exh.3 (2004).

33. *Id.* at 48-49, 48 & exh.3.

non-sued, physicians.³⁴ The investigators interpreted the symptom cluster to constitute an adjustment disorder with malpractice litigation as the specific psychosocial stressor.³⁵ Other investigators similarly conclude that the psychological aftermath of a malpractice suit can be devastating and long-lasting. Researchers in Wisconsin, surveying physicians, found that as many as 20% of sued physicians reported anger and tension even years after a malpractice claim had been filed.³⁶ Findings were especially strong for physicians who had judged their relationship with their patient to have been good prior to the claim.³⁷

III. THE TRANSMISSION OF NEGATIVE EMOTION

It is reasonable to suspect that for many physicians, the negative experience of litigation generalizes to negative feelings toward patients. Moreover, these feelings are likely to be conveyed to their patients—directly or indirectly—through their attitudes, manner, communication behaviors, and voice tone. Whether some aspect of a sued physician's communication behavior would be distinguishable from that of non-sued physicians was explored in an audiotape study of surgeons and primary care physicians with varying malpractice experience.³⁸ The study included over 1,200 patient visits with sixty-five surgeons and fifty-nine primary care doctors.³⁹ The doctors were matched on their specialty and number of years in practice, but half of the physicians had never had a malpractice claim and the other half had two or more lifetime claims.⁴⁰ (Malpractice claims in this study were defined as any patient request for funds, any malpractice suit filed by a patient, or any contact by an attorney who represented a patient in an action against the physician, regardless of outcome.) Ten random patients drawn from each physician's appointment log were recruited for the study and audiotape recorded during their medical visit. Interaction analysis of the physician visits found that there were a number of differences in the way the sued and non-sued physicians talked with their patients.

34. Sara C. Charles et al., *Sued and Nonsued Physicians' Self-Reported Reactions to Malpractice Litigation*, 142 AM. J. PSYCHIATRY 437, 437-38 (1985).

35. *Id.* at 439.

36. Robyn S. Shapiro et al., *A Survey of Sued and Nonsued Physicians and Suing Patients*, 149 ARCHIVES INTERNAL MED. 2190, 2190, 2193 (1989).

37. *Id.*

38. Wendy Levinson et al., *Physician-Patient Communication: The Relationship with Malpractice Claims Among Primary Care Physicians and Surgeons*, 277 JAMA 553 (1997).

39. *Id.* at 533-55.

40. Malpractice claims in this study were defined as any patient request for funds, any malpractice suit filed by a patient, or any contact by an attorney who represented a patient in an action against the physician, regardless of outcome. *Id.* at 554.

Using communication variables derived from the audiotape analysis, 80% of primary care physicians were accurately classified in terms of their malpractice status based solely on their communication patterns—a 30% improvement over mere chance.⁴¹ The sued doctors had shorter visits by almost three minutes, used less partnership-type exchanges (i.e., asking for the patient's opinion, understanding of what was said and expectations for the visit, showing interest in patient disclosures, and paraphrasing and interpreting what the patient said), engaged in less humor and laughter, and were less likely to orient the patients as to what to expect in regard to the flow of the visit than physicians who had never been sued.⁴²

The communication analysis did not predict surgeons' malpractice experience as well as it did for primary care physicians, although several variables showed a similar trend. Sued surgeons had shorter visits, by almost one-and-a-half minutes, and used less partnership-type exchanges. Interestingly, patients (but not physicians) appeared to laugh more frequently in the surgical visits of sued doctors compared to never-sued physicians. While laughter is usually associated with a relaxed and friendly atmosphere, it can also reflect something quite different—an indication of nervousness, embarrassment, or anxiety.⁴³ It is possible that the relatively high levels of patient laughter, in the absence of corresponding physician laughter, in the visits with sued physicians may reflect tension or discontent.

To further investigate the emotional tone of the surgical visits, a thin-slice analysis of the surgeons' interactions was conducted.⁴⁴ Thin-slice analysis relies on very short segments of speech or video clips, as short as a few seconds. In this case, the speech segments were stripped of literal content by an electronic filter and judged by multiple raters on a variety of affective dimensions (including concern/anxiety and dominance). Two patients were chosen for each of the study's sixty-five surgeons (the most satisfied and the most dissatisfied) and a ten-second speech segment was taken from the first and last minute of the visits. Surgeons judged to have more dominant voice tone were almost three times as likely to be in the sued group than others, while the surgeons whose voice tone was rated as conveying concern and anxiety were half as likely to be in the sued group.⁴⁵ Other studies using thin-slice analysis found that an anxious physician voice tone coupled with positive words (sympathetic and calming) was associated with more

41. *Id.* at 557.

42. *Id.* at 558.

43. See Fabio Sala et al., *Satisfaction and the Use of Humor by Physicians and Patients*, 17 PSYCHOL. & HEALTH 269, 278-79 (2002) (finding that some humor in doctor-patient visits may be indicative of patients' frustration, disappointment, or tension).

44. Nalini Ambady et al., *Surgeons' Tone of Voice: A Clue to Malpractice History*, 132 SURGERY 5, 6 (2002).

45. *Id.* at 7, 8 tbl.

patient satisfaction and better appointment-keeping over a six-month period.⁴⁶ In this context, voice tone may act to frame the way in which the verbal message is interpreted. A second study similarly positively linked anxious vocal qualities with patient satisfaction.⁴⁷

It should not come as a surprise that emotion is highly reciprocal; patient and physician satisfaction are related to one another and many of the physician behaviors that predict patient satisfaction suggest the way people act when they like someone. Indeed, research shows that when doctors like their patients, and patients believe their doctors like them, they are more satisfied with their care, even a year later, and less likely to have thought about changing doctors.⁴⁸ The opposite is true as well—critical judgments and perceptions of rejection or disregard also inspire similarly negative emotions. For example, in the Wisconsin study mentioned earlier,⁴⁹ researchers found a disconnect in patient and physician perceptions of liking and respect; patients of the physicians who had been sued thought that the doctor liked and respected them less than the doctor indicated was the case. Clearly, there was miscommunication and in this case the miscommunication was probably nonverbal in nature. It is possible that the sued physicians conveyed more negativity toward their patients than they intended, perhaps inadvertently leaking suspicion, irritation, or disapproval in their tone of voice or facial expressions.

IV. IMPLICATIONS FOR CLINICAL PRACTICE AND TRAINING

It is evident that the specter of malpractice litigation looms large for many physicians, and the consequences of the crisis for the patient-physician relationship, physician stress, professional dissatisfaction, and the future organization of medical care delivery are considerable.⁵⁰ These consequences raise challenges in regard to litigation risk in interpersonal, intrapersonal, and organizational realms. The interpersonal challenges are reflected in the large body of literature demonstrating physician skill deficits in a variety of communication domains. In this regard, study after study has reported physician failure to listen,

46. See Judith A. Hall et al., *Communication of Affect Between Patient and Physicians*, 22 J. HEALTH & SOC. BEHAV. 18, 27 (1981) (reporting that reassuring and positive words, although coupled with an angry or anxious tone, resulted in positive patient feelings).

47. See Debra L. Roter et al., *Relations Between Physicians' Behaviors and Analogue Patients' Satisfaction, Recall, and Impressions*, 25 MED. CARE 437 (1987) (reporting that patient task satisfaction was higher with less-bored physicians).

48. Judith A. Hall et al., *Liking in the Physician-Patient Relationship*, 48 PATIENT EDUC. & COUNSELING 69, 72-74 (2002).

49. Shapiro et al., *supra* note 36, at 2192.

50. Michelle M. Mello et al., *Caring for Patients in a Malpractice Crisis: Physician Satisfaction and Quality of Care*, 23 HEALTH AFF. 42, 42-53 (2004).

inform, answer questions, provide clear explanations, and address the concerns of their patients. Fortunately, there is substantial evidence that communication skills can be taught and that physicians' interviewing performance can be improved, particularly when the participants are given the opportunity to practice skills.⁵¹ It is notable that some successful continuing medical education programs have produced positive changes in physician skill in as little as eight hours.⁵²

In the intrapersonal domain, physicians need help coping with the devastating psychosocial stress of malpractice litigation. The psychological aftermath for a physician who has experienced a malpractice suit can be terrible. Physicians report diminished career satisfaction, the use of defensive medical practices, avoidance of potentially problematic patients, and a host of serious psychological symptoms. Even physicians who have never been sued carry a burden of potential litigation and report many of the same responses as those who have been sued. Under these circumstances it is likely that fears and negative sentiments are conveyed, either purposely or inadvertently, to patients nonverbally through negative voice tone, a brusque or irritated manner, or facial or body cues that convey distrust and suspicion. It is clear from the studies reviewed that patients receive more negative messages from sued physicians than those who have not been sued; they do not feel liked or respected by these physicians and they seem to reciprocate by feeling dissatisfied and mistrustful.

Just as there are successful examples of training curriculum in communication skills, there are also programs designed to help physicians better understand their reactions, motivations and responses to patients through personal awareness training experiences, Balint groups, self-reflection and mindfulness exercises, clinical supervision, and individual therapy.⁵³

Finally, there are organizational challenges that must be addressed. The health care delivery system can be far more responsive to physician needs in regard to the delivery of quality care. Several studies reviewed earlier have noted the relationship between visit length and litigation—sued physicians spend less time with their patients and patients more often report that the time spent with these doctors is inadequate. The perception that there is organizational pressure to see more patients in less time is a source of considerable stress and dissatisfaction for

51. STEVEN A. COLE & JULIAN BIRD, *THE MEDICAL INTERVIEW: THE THREE FUNCTION APPROACH 4* (William Schmitt ed., 2000); Dave Davis et al., *Impact of Formal Continuing Medical Education: Do Conferences, Workshops, Rounds, and Other Traditional Continuing Education Activities Change Physician Behavior or Health Care Outcomes?*, 282 JAMA 867, 867-74 (1999).

52. Debra L. Roter et al., *Improving Physicians' Interviewing Skills and Reducing Patients' Emotional Distress: A Randomized Clinical Trial*, 155 ARCHIVES OF INTERNAL MED. 1877, 1877-84 (1995); Debra L. Roter, *Use of an Innovative Feedback Technique to Enhance Communication Skills Training*, 38 MED. EDUC. 145 (2004).

53. COLE & BIRD, *supra* note 51, at 251; Ronald M. Epstein, *Mindful Practice*, 282 JAMA 833, 833-839 (1999).

physicians.⁵⁴ Coupled with the lack of financial incentives to reimburse physicians for non-procedural tasks, there are strong disincentives for physicians to take the time they need to meet fully their patients' informational and emotional needs. Indeed, a significant source of physician discontent is a perception of an eroding sense of autonomy that physicians believe impede their ability to delivery high-quality services.⁵⁵ More flexible scheduling of patients and the pay for performance approaches that might allow billing for patient education and counseling services could help alleviate these significant pressures and better facilitate the delivery of quality care.

It is evident that advances in technical care are diminished in the public eye by disappointments in the veracity of the medical dialogue and the quality of the doctor-patient relationship. While it is thought that failures of technical quality do not account for the majority of malpractice complaints, it is noteworthy that communication itself is considered to be a quality of care marker, as in the past several years, three Institute of Medicine reports have noted the link between communication skill and health care quality.⁵⁶ Indeed, communication is so valued that the Surgeon General's Healthy People 2010 Objectives for the Nation included an improvement in the delivery of sensitive and responsive medical communication among the national health priorities.⁵⁷

CONCLUSION

The current review does not bring forward any new ideas; the link between malpractice litigation and the power of communication to support or undermine the doctor-patient relationship is widely recognized by patients and physicians alike. As noted in a *New York Times* essay on medical malpractice:

[P]atients who like their doctors don't sue, no matter what their lawyer says. Our efforts in medical schools to turn out skilled yet empathetic physicians who communicate clearly and who can put themselves in their patients' shoes is critical to stemming the malpractice crisis. Patients sue when their feelings are ignored or when they are angered by lack of genuine concern for their welfare. . . . Though it provides no

54. Mello, *supra* note 32, at 49, 50 ex.4.

55. *Id.*

56. INST. OF MED., CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY (2001); INST. OF MED., UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE (Brian D. Smedley et al., eds. 2003); INST. OF MED., TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM (L.T. Kohn et al. eds., 2000).

57. U.S. DEP'T OF HEALTH AND HUM. SERVS., MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL (1999).

guarantee, a sound physician-patient relationship is a powerful antidote to frivolous lawsuits.”⁵⁸

Relationships matter to both patients and physicians and the relationship itself may be the most powerful antidote to the malpractice crisis that medicine can provide.

58. Abraham Verghese, *Hard Cures: Doctors themselves could take several steps to reduce malpractice suits*, N.Y. TIMES, March 16, 2004, § 6, at 11.