Communication and Medical Malpractice

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Effective and positive communication between doctors and their patients has consistently been shown to be associated with a reduced risk of being sued.

The related aspect of overall patient satisfaction is critical in effective risk management.
Communication

Most patients or patients' families sue for one of three reasons:

1. To get information that is not otherwise being revealed
2. Because they are angry
3. To ensure that the same thing won't happen again

Communication

- 1000 patients who sued their doctor were asked if there was anything the doctor could have done to prevent the lawsuit.
- 37% responded that the following would have satisfied them:
  - Explanation or apology
  - Assurances that it would not happen again.*

*Midwest Medical Insurance Company Risklutions Toolkit Series, 2002
Communication

- Patient Complaints and Malpractice Risk

- Physician-patient communication. The relationship with malpractice claims among primary care physicians and surgeons

- Surgeons' tone of voice: A clue to malpractice history
Communication

- **Patient Complaints and Malpractice Risk**

- **Physician-patient communication. The relationship with malpractice claims among primary care physicians and surgeons**

- **Surgeons' tone of voice: A clue to malpractice history**
Communication

- **Patient Complaints and Malpractice Risk**
  - Unsolicited patient complaints captured and recorded by a medical group were positively associated with physicians’ risk management experiences.

*JAMA. 2002;287:2951-2957.*
Communication

- **Patient Complaints and Malpractice Risk**
  

- **Physician-patient communication. The relationship with malpractice claims among primary care physicians and surgeons**
  

- **Surgeons' tone of voice: A clue to malpractice history**
  
Communication

- 59 primary care doctors and 65 surgeons
- Audiotaped 10 office visits and coded the conversations in terms of aspects of communication
- Looked for communication differences between those with no prior claims and those with ≥ 2 claims

In the primary care group, there were significant differences in communication behaviors between physicians with no history of claims vs. those with a history of ≥ 2 claims.
Communication: How did the doctors with no-claims communicate?

- Used more statements of orientation (educated patients about what to expect and the flow of a visit)
- Tended to use more facilitation (soliciting patients' opinions, checking understanding, encouraging patients to talk)
- Laughed and used more humor
- Spent longer in routine visits (mean of 18.3 vs 15.0 minutes)
  - Also, the length of the visit had an independent effect in predicting claims status

Communication

- **Patient Complaints and Malpractice Risk**
  

- **Physician-patient communication. The relationship with malpractice claims among primary care physicians and surgeons**
  

- **Surgeons' tone of voice: A clue to malpractice history**
  
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- Surgeons' tone of voice: A clue to malpractice history*

Communication

Researchers audiotaped 114 clinic conversations during routine medical visits of 57 orthopedic and general surgeons.

- evaluated 10-second voice clips with content and 10-second voice clips with just voice tone
- The sound bites were taped during the first and last minute of each surgeon's interactions with two different patients

Communications

- Surgeons who were judged to be less concerned and more dominant in tone were more likely to have been sued than surgeons who were judged to be more concerned and less dominant.

Communication

- Medical malpractice: the effect of doctor-patient relations on medical patient perceptions and malpractice intentions

*Medical malpractice: the effect of doctor-patient relations on medical patient perceptions and malpractice intentions* West J Med 2000;173:244-250
Communication

- 104 obstetric patients who had borne healthy children in the previous 6-12 months were asked to review a clinical scenario.
- The scenario involved the pregnancy, labor, and delivery of a woman giving birth to her first child.
- The subjects (patients) reviewed one of four possible variations of the scenario.

*Medical malpractice: the effect of doctor-patient relations on medical patient perceptions and malpractice intentions* West J Med 2000;173:244-250
Communication

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“Positive” (good) behaviors inserted throughout the scenarios:

- Greeted patient warmly
- Apologized for delay
- Asked informal questions
- Made eye contact
- Provided explanations
- Rarely used medical terms
- Encouraged questions

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Outcome severity:

“Soon after the birth, it was determined that the baby had experienced ischemia (sharply reduced blood flow) and asphyxia (a lack of oxygen) as a result of these complications.”

Mild outcome = slight but very unlikely chance of developmental delay

Severe outcome = almost certain serious brain damage

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## Communication

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Communication

- Outcome Measures:
  - Patients’ perceptions of physician competence
  - Patients’ intentions to file a malpractice claim

*Medical malpractice: the effect of doctor-patient relations on medical patient perceptions and malpractice intentions* West J Med 2000;173:244-250
Results:

- Patients presented with positive physician communication behaviors reported significantly greater perceptions of physician competence compared to those exposed to more negative behaviors.
- Severity of the outcome did not influence these perceptions.

*Medical malpractice: the effect of doctor-patient relations on medical patient perceptions and malpractice intentions* West J Med 2000;173:244-250
Results:

- Patients presented with positive physician communication behaviors reported significantly lower malpractice claim intentions toward both the physician and the hospital.

- A more severe outcome increased the patients’ intentions to sue the hospital, not the physician.

*Medical malpractice: the effect of doctor-patient relations on medical patient perceptions and malpractice intentions* West J Med 2000;173:244-250
Communication Tips

To minimize risk:

- Apologize when you are late
- Make an effort to sit down when seeing patients in the hospital
- Use as much simple language as possible
- Encourage questions
- Make eye contact and reflect personal investment in your patients
- Provide explanations
- Recognize the important role that support staff have with respect to patient satisfaction
Communication Tips

To minimize risk:

- At the beginning of a patient encounter, ask:
  - “What do you want to make sure we address today?”

- When you are finished seeing a patient, ask:
  - “Do you have any other questions for me today?”
Communication Among the Healthcare Team

- Effective communication for good quality patient care goes beyond the communication occurring between the doctor and the patient.
Communication Among the Healthcare Team

- Common areas of risk:
  - Patient “sign outs”
  - Transitions of care
  - Poor perception of a provider’s openness and willingness to address concerns
Written Communication

- The medical record is the primary means of communication for the patient’s healthcare.
Written Communication

“The patient’s chart can either be a gold mine or a land mine when defending against a malpractice claim.”

*Malpractice Handbook, Midwest Medical Insurance Company, 1998*
Written Communication

- A 41-year-old woman with a strong family history of heart disease...
- The patient’s family filed a malpractice claim alleging negligent failure to conduct appropriate tests and negligent failure to diagnose an MI resulting in the patient’s death.

*Malpractice Claim Review, Midwest Medical Insurance Company, 2/2003*
During the investigation of the lawsuit, the clinic and cardiologist maintained that the patient had been scheduled for an angiogram the following day *at her request*. However, when asked to produce evidence of the scheduled test, there was nothing on the schedule and no documentation in the patient’s chart reflecting her request.
This claim was settled against the cardiologist for $275,000.
Documentation

To minimize risk:

- Timely
- Complete
  - Document patient non-compliance
- Accurate
  - Review dictations
- Do not go back and alter the record
- Legible-not a significant issue due to EHRs
- Objective
  - You never need to use an exclamation point
- Appropriate
  - Avoid criticizing other colleagues
Communication Among the Healthcare Team

Actual example:

“While I strongly disagreed with Dr. ________’s proposed surgery, he convinced the patient to proceed. Her many post-op complications and finally death have proved my advice correct.”

*MMIC’s Perspectives on Prevention, August 2002
Prevalence of Copied Information by Attendings and Residents in Critical Care Progress Notes*

J. Daryl Thornton, MD, MPH\(^1\)\(^2\); Jesse D. Schold, PhD, MStat, Med\(^3\); Lokesh Venkateshaiah, MD\(^2\); Bradley Lander, BA\(^4\)

**Objectives:** To determine the prevalence and mechanism of copying among ICU physicians using an electronic medical record.

**Design:** Retrospective cohort study.

**Setting:** Medical ICU of an urban, academic medical center.

**Patients:** Two thousand sixty-eight progress notes of 135 patients generated by 62 residents and 11 attending physicians between August 1, 2009, and December 31, 2009.

**Interventions:** None.

**Measurements and Main Results:** Eighty-two percent of all residents and 74% of all attending notes contained greater than or equal to 20% copied information \((p = 0.001)\). Although residents authored more copied notes than attendings, residents copied less information between notes than attendings \((55\% \text{ vs. } 61\%, p < 0.001)\). Following greater than or equal to 1 day off, residents copied less often from their own prior notes compared to attendings \((66\% \text{ vs. } 94\%, p < 0.001)\). Of the copied information following a day off, there was no difference in the amount of information copied into notes of residents \((59\%)\) or attendings \((61\%, p = 0.17)\). In a regression model of attending notes, no patient factors were associated with copying. However, the levels of copying among attendings varied from 41\% to 82\% \((p < 0.001)\).

**Conclusions:** Copying among attendings and residents was common in this ICU-based cohort, with residents copying more frequently and attendings copying more information per note. The only factor that was independently associated with attending copying was the attending. Further studies should focus on further elucidating the factors influencing copying in the ICU and the effects of copying on patient outcomes. ([Crit Care Med] 2013; 41:382–388)

**Key Words:** cohort study; electronic health records; ICUs; medical informatics
Copy and Pasting

- 2,068 progress notes of 135 patients generated by 62 residents and 11 attending physicians
- 82% of all residents and 74% of all attending notes contained ≥20% copied information ($p=.001$).
1) Septic shock - due to pneumonia (hospital acquired - poss MRSA, pseudomona). On Vanc/Mero. D10 of 10. Stopped Cipro and Voriconazole. Increasing levo gtt now - but after blankets taken off and peripheral vasodilation resolved, pressor requirements decreasing. Goal MAP 55 mm Hg. Will change TLC to another site today. Consider cardiogenic shock as well, given VBG with CVO2 of 72%.

2) Acute on chronic respiratory failure - due to sepsis. 7/37/45/97 2 days ago on stable vent settings. On full MV support. No SBT due to pressors. May need trach as this recurrent illness has been going on for about 2 months.

3) Chronic lung disease - possible ILD? Will likely have chronic O2 requirement. Had HSV + on BAL. Start acyclovir, per ID recommendations.

4) Acute oliguric renal failure - has a history of RPGN? Appreciate renal consult. No indication for HD at this time.

5) Possible sources for sepsis - does not appear to have significant recurrent pneumonia. Await sputum cultures. Obtain blood and urine cultures. Removed femoral arterial line (replace to radial yesterday). If bx positive for pressure requirements continue to increase, consider changing triple lumen line site.

6) Nutrition - tolerating TF's well.

Code Status: Full Code. Palliative care consult
How much does this matter?

According to a study of EHR-related closed claims from 2007 to 2013, incorrect information is the most common user-related contributing factor in malpractice cases involving EHRs.

http://www.thedoctors.com/KnowledgeCenter/PatientSafety/articles/CON_ID_006803
The Doctors Company examination of EMR-related closed claims from 2007 to 2013.
How much does this matter?

In one case, a judge commented about copy and pasting:

“I cannot trust any of the physician notes in which this occurred and the only conclusion I can reach is that there was no examination of the patient...it means to me that no true thought was given to the content that was going into the note.”

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What are the implications?

- Inaccurate or outdated information
- Redundant information which in turn makes it difficult to identify the current information
- Inability to identify the author or intent of the documentation
- Inability to identify when the documentation was first created
- Propagation of false information
- Internally inconsistent progress notes
- Unnecessarily lengthy progress notes
In Summary...