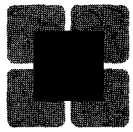
CME CREDIT



WILLIAM S. WILKE, MD, EDITOR

HIGHLIGHTS FROM MEDICAL GRAND ROUNDS

COMMUNICATION AND MALPRACTICE: WHY PATIENTS SUE THEIR PHYSICIANS

MANY PHYSICIANS feel anger and frustration when the topic of malpractice comes up. But physicians would all do well to examine *why* patients decide to sue their doctors. Further, examining what we actually do and say may help us not only to avoid the risk of litigation, but also to be more effective physicians.

A PROBLEM OF COMMUNICATION

From reading approximately 3700 pages of depositions from 45 malpractice cases, my research assistants and I found that many complaints concerned issues of communication and the relationship between the physician and the patient. For many plaintiffs, the actual alleged negligence or malpractice did not lead to a severe outcome. However, they were angry.

Some plaintiffs described waiting for a long time to see their physician, or not being able to see their physician at all. The most frequent relationship issue identified was the patient or family feeling abandoned. One recalled asking for pain medication and being refused because the physician was on vacation. Patients resented trying to tell their physicians that they had a problem, only to have their opinion or problem discounted, and feeling humiliated and ridiculed. (They felt especially angry if they were subsequently proved to be right.) They complained of not being informed of what was going on. These types of incidents foster the perception of physicians being uncaring and not feeling remorse for bad outcomes.

Surprisingly, the most frequent person to suggest malpractice was the consulting physician in the same field who saw the patient after the bad outcome. Saying to a patient that another physician made an error has tremendous impact on that physician and creates an ethical problem. I do not advocate that we cover up each other's mistakes, but we should refrain from making gratuitous comments about each other to patients unless sufficient information is available to reach an informed conclusion.

BUILDING BETTER COMMUNICATION SKILLS

In a survey reported in the *Wall Street Journal* only 42% of patients felt that doctors usually explain things well, 63% said doctors are too interested in making money, 38% said doctors act as if they are better than other people, and only 31% felt that doctors spend enough time with their patients.

Physicians who tape their visits often find that what they think they say has very little to do with what they do say. Many are surprised. For an impartial view, the physician's spouse (if a nonphysician) can listen and give feedback. As we learn to recognize our mistakes, we can try to improve our techniques and be more effective.

Considering the patient's opinion

Physicians often, without intending to or even being aware of it, insult and humiliate patients who offer an opinion as to what is wrong. We need to learn to respond in a respectful manner. One could say, "I can see that you are concerned, but I do not think this is happening because..." If a patient offers an opinion as to what is wrong, I treat the perceived problem as seriously as the problem I think they have.

■ Highlights from Medical Grand Rounds present take-home points from selected Cleveland Clinic Division of Medicine Grand Rounds lectures.

Learning to listen

The parental model of care that many of us learned is less popular than it used to be. More and more patients are seeking collaboration in their care, and we need to learn to work with them—not dictate to them. Active listening and paraphrasing what the patient says lets the patient know the listener understands, as do phrases such as "go on," "I see," "OK," "this is really interesting," "I'm really helped by this," and "this is a very interesting problem." Taking time to listen makes the patient feel heard and cared about; given a little more time, the patient might actually reveal what is wrong or what he or she is afraid of.

If a patient or a family member has an idea about treatment, such as a change in diet or activity, the physician can show respect by negotiating with them. Sharing responsibility with patients helps them feel heard and cared about. At the end of a visit, a question such as "What do you think about that plan?" might be illuminating. Some patients, for example, might be concerned about the cost of medication, in which case the physician could perhaps offer a less expensive medicine and discuss the pros and cons of the options (efficacy, side effects, cost). In this way, the patient has a choice, feels more involved in his or her care, and is less likely to be angry with the physician if there is a bad outcome.

Standing by the patient

Someone who is not medically trained, who believes that the presence of the practitioner increases the chance of survival, and who asks for help and is rejected will judge the medical staff very harshly. Residents and house officers can help when the attending physician is not available, but we should be careful to introduce them to the patient and place their role in a positive light so that the patient does not feel abandoned. In all of this, it is the patient's perception that counts.

Giving explanations

Patients are consistently angry when they do not receive an explanation, especially for a bad outcome. This presents an ethical problem: if the physician does not know why something happened, saying so might make the patient anxious. Some physicians are tempted to make up explanations. A better approach would be to say, "I do not know what caused this problem, but if it were serious I believe I would have found it. We have performed the appropriate tests. I am not sure what is going on, but I'd like to work with you over the next 6 months to follow your symptoms." This suggests that the problem is not in the patient's head and that the physician believes the patient.

Attending to psychosocial needs

Too often, patients are sent home without adequate psychosocial support. Fortunately, discharge planners, social workers, and others are available. The physician, however, must understand what the patient's needs might be and should contact the appropriate workers.

Praising each other

Medical personnel seldom give each other—or receive—encouragement, empathy, and praise, but they should. Our hospital has introduced "praise cards" to give us the opportunity to recognize people who have done a good job. (We also have "concern cards" for negative feedback.)

Over the centuries, we have undervalued the relationship between doctor and patient, focusing instead on science and technology. Technology does allow us to do amazing things, but it does not help us to help people feel cared about. We have far to go to return to taking care of people, but we can do it if we devote our attention to it.

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SUGGESTED READING

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