Genesis and mechanics of malpractice suits - Minimizing the risks

Utpal De
Department of Surgery, Burdwan Medical College, Burdwan - 713101, India.

ABSTRACT
The article illustrates malpractice history among primary care physicians and surgeons. It explores why patients sue their healthcare providers. It recommends specific measures, based on satisfying a myriad of patient needs through better communication behaviours, consenting practices, and early recognition and resolution of patient issues by providers.

KEY WORDS
Malpractice claims, medical

INTRODUCTION
Being a defendant in a malpractice claim is rather more challenging to a surgeon compared to his day-to-day professional activity. It drains the surgeon emotionally, personally and professionally. It is more so when the individual initiating the claim is the very person whom he was trying to help to overcome morbidity. This article explores and recommends measures that should reduce the incidence of indefensible malpractice suits.

THE GLOBAL MALPRACTICE ENVIRONMENT

The global incidence of settlements in malpractice suits is 15% to 20%. The adverse malpractice environment has taken its toll on insurers, some of whom have gone into bankruptcy and others to drop their medical malpractice business. The practice of medicine has found itself in a war with patients, the court judiciary and political lobbies influenced by lawyers who have built powerful law firms by profiting from the system.

THE ACCUSED

Most physicians find it difficult to cope with the stress inflicted by medical malpractice claims. Allegations of negligent and substandard care against any physician are bitter pills to swallow but are more painful when accompanied by punitive damages. Personal capability to handle such a problem varies and a number of factors influence such variations. These factors include the physician’s previous exposure to litigation claims, degree of familiarity with legal system and the litigation process, previous experience of testifying in the courtroom, size of the claim measured by seriousness of injury, presence and absence of a claim for punitive damages and insurance liabilities. The physician finds himself in profound isolation and extreme fear when named in a suit, especially when the suit papers are accompanied by instructions from the risk management group and legal counsel not to discuss the case with anyone, and a detailed account of personal assets which may require attachment in the event of a judgment in favour of the plaintiff.

INITIATING MALPRACTICE CLAIMS

A review of the literature reveals that 1% of the hospitalised patients suffer from significant injury as a result of negligence and of these only 2% initiate a
malpractice claim. Ten to twelve per cent patients file malpractice claims that are legally not compensable.\(^1\)\(^-\)\(^8\) When catastrophic injuries follow surgery or treatment, the emotional impact coupled with the economic burden creates an environment, which results in a claim.\(^4\) On the other hand not all adverse events result in malpractice claims. The skill of the surgeon or indicators of the physician’s ability do not influence initiation of malpractice suits.\(^4\) Moreover, there is no relationship between the degree of disability and the payment of claims nor have these litigations brought about a better quality of medical care delivery.\(^5\) The malpractice claims seem to be more influenced by the physician-patient relationship the professional skills of the physician.\(^5\)

**REDUCING MALPRACTICE CLAIMS**

True, “defensive medicine” is the best way to minimize the risks.\(^6\) This does not mean ordering unnecessary tests or refusal of essential treatment. Rather, it is the habit of exercising extra care and foresight to avoid medical hazards and to apply prompt remedial measures when they occur. The likelihood of claims can be reduced if the concerned physician or surgeon adopts a few key habits and practices them with the patients and their families. These include building trust through open communication, making effective use of informed consent, keeping accurate medical records and educating office staff. It means being aware of the patient’s personality and needs. It means taking time to talk to the patient about proposed procedures and their risks. This kind of “defensive medicine” offers the best hope for reducing the frequency and cost of claims that result in the present critical malpractice problems.

**COMMUNICATION**\(^4\)-\(^7\)

The most common cause of malpractice suits is failed communication with the patients and their families. Advancement of medical technology has elevated the patient’s expectations regarding treatment outcome. Moreover, easy public access to medical information through the Internet has made patients partners with their physicians in their own care. In general, patients have high respect and regard for their physician and at the same time expect intelligent answers regarding the diagnosis, treatment plan, risks and outcome. Effective patient communication and trust between physician and patient are of paramount importance. The communication gap can be classified into four major categories: (1) perceived unavailability, (2) devaluing the views of the patient and his family, (3) poor delivery of medical information, and (4) failure to understand the patient’s perspective. It is seen that malpractice suits are filed mostly against specialist doctors rather than general practitioners. This perhaps is due to excellent relationship which general practitioners develop with family members over a period of time. Seventy-one per cent of the suits arise from dissatisfied patient-physician communication. Of these 13% believed that their physician would not listen, 32% felt that their physician did not talk openly, 48% felt misled by their physician and 70% indicated receiving poor long-term knowledge about the outcome of the disease.

The principles of good communication include:

1) Content. Medical information should be conveyed through easy, descriptive and simple language that the patient can understand, using sketches and diagrams, explaining therapeutic regimen and specific treatment plan. At no point of time should the patient feel ill-informed and under-informed.

2) Process. The patient’s understanding should be ensured with due respect for cultural and socioeconomic differences.

3) Emotional affect. Concern, understanding, empathy, patient’s occupation, social circumstances, hobbies and interest should be adequately demonstrated (?).

4) Follow-up. Returning telephone calls, good postoperative resident care and coverage, keeping the patient and the family informed about the progress of the patient and in the event of casualty dealing with the family in a sympathetic manner.

**INFORMED CONSENT**\(^8\)

Effective informed consent can reduce the risk of litigation. Informed consent is not the consent form. The form is merely a piece of evidence that consent has occurred; the critical factor is the content of discussion. For the form to be effective, it must categorically summarize the disclosure in such a manner that it would be difficult for the patient to refute the version. Informed consent is merely an extension of good communication practice, albeit one that is mandated by law. Another critical element in informed consent is the disclosure of reasonable alternatives available other than the procedure in question. Non-disclosure of reasonable alternatives may result in litigation suits. Time spent in informed consent discussion is valuable, otherwise the few minutes needed for this discussion pale in comparison with the...
time needed to defend a lawsuit.

**DOCUMENTATION**\(^\text{6-8}\)**

The habit of good documentation can minimize a surgeon’s risk of becoming a defendant in a medical malpractice suit. Although medical records provide subsequent caregivers important information about the patient’s condition and treatment, in the context of litigation, these records are used to demonstrate what care was or was not rendered. Maintaining logbook records of each and every detail including telephonic conversation, equipment failure, and untoward outcome can be helpful. If one recognizes an error in documentation, the appropriate method of correction should be a single line through the inaccurate information and initial and date the amendment. Medical records should not be tampered with, as in the event of a suit, this act could lead to the loss of an otherwise defensible case.

**EDUCATING AND INFORMING OFFICE STAFF**\(^\text{3,5,8}\)**

Practising surgeons should recognize that his or her office staff should be well versed with malpractice issues. In-service training of office staff is pivotal to reducing the risk of being sued. Office personnel should be educated on issues of confidentiality, answering phone calls and appropriate conversations about medical information. Good patient relations, willingness to listen to a patient’s displeasures may improve the delivery of patient care and may well prevent some claims.

**ADDITIONAL FACTORS**\(^\text{8}\)**

Be vigilant about litigious patients. Extra effort must go into documentation and informed consent. These patients should be tackled patiently without becoming paranoid and the physician should refrain from making derogatory remarks about any other physician’s advice or treatment.

**CONCLUSION**

The source of malpractice claims, contrary to widely held views, is not simply improper or inadequate medical care.\(^\text{3,4,6,7}\) In the majority of cases, malpractice litigation ensues because of negative non-clinical factors and the incidence of an unexpected result in medical treatment. High on the list of non-clinical causes are faults in the physician-patient relationship.\(^\text{3,4}\) Many malpractice suits are brought neither because of malpractice nor because of complaints about the quality of medical care but as an expression of anger about some aspect of patient-doctor relationships and communications. The theory presented is that under the stress of anxiety and physical illness, some patients regress to childhood needs; physicians are not generally trained to fulfil such needs.\(^\text{5}\) Thus, these patients, angry because of this, express their anger in malpractice suits. The communication skills must be formally taught to the medical students in their curricula and to the physicians through the CME.\(^\text{3,5-7}\) Physicians who understand and can respond appropriately to the emotional needs of their patients are less likely to be sued. This may also translate into a more fulfilled practice of medicine by those physicians who are most aware of the importance of a positive relationship.

**REFERENCES**