

**The Journey From Patient To Plaintiff:  
*A Claims Attorney's Assessment Of Risk And  
Protective Factors That May Determine If  
Patients Continue To Travel With Their Phy-  
sicians On A Well-Paved Road Of Mutual  
Trust And Loyalty Or Choose Instead To  
Take The Rocky Road To Litigation***

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Risk factors that jeopardize trust and confidence between physicians and patients are those internal and external influences that impact negatively upon the physician-patient relationship, often launching patients on an adversarial course towards litigation. Conversely, protective factors represent those influences that bolster the relationship and help shield the physician from risk. This article explores, from an historical, legal, and personal perspective, some of the prevalent risk and protective factors affecting a patient's decision to undertake or to forego litigation when they experience disappointing outcomes related to their care.

### **Early Historical Perspective**

Understanding the historical aspects of the changing medical and legal practice environment is helpful in assessing the impact of the risk and protective factors that bear upon a patient's decision either to remain a loyal partner with their physician or to turn into the physician's worse nightmare.

When I was admitted to the practice of law in 1973, the medical and legal practice environment was quite different from that which exists today. Lawyer advertising, for example, was limited to

name, address, and phone number in the phone book and on a business card. Other forms of advertising were prohibited generally under state and federal bar rules. Word of mouth was the research tool of choice for people seeking legal services. The number of lawyers per capita in the United States was about 1 per 700 (Law Crossing, 2010), and there were few obvious signs of cut-throat competition in the quest to acquire clients. Medical practice was based upon trust and loyalty. Physicians formed bonds with patients that lasted years, seldom broken, except by retirement from practice, or by patients moving to locations where it became impractical to continue to be seen by their physician. Choice of physicians and patient loyalty were realities and not just aspirations. Three decades ago, managed care concepts were in early stages of formation and development, and many physicians saw their patients in the office and in the hospital. Good doctors were recognized as such because of C-D-C – not the Center for Disease Control - they developed good reputations because of their competence, diligence, and communication skills. Hospitals were viewed by the public as serving a charitable purpose and a community good. They developed their reputations primarily through word of mouth, and by their good works in the community. During this era, there was no proliferation of hospital advertising campaigns involving TV, radio, billboards, the internet, and modern marketing techniques. In the normal course of events, if the patient's trusted doctor had privileges in a particular hospital, the patient would most likely have confidence that the hospital would best meet the patient's needs.

### **The Changing Medical and Legal Environment and Emergence of Risk Factors**

In the mid-seventies, the medical and legal environment began to change significantly. In 1977, for example, the United States Supreme Court in

the case of *Bates v. State Bar of Arizona* ruled that the provisions in the Arizona Bar ethics rules prohibiting or severely restricting attorney advertising violated the First Amendment rights of free speech of attorneys. Medicare and Medicaid expanded the number and categories of eligible beneficiaries and broadened the scope of services in the three decades that followed (Key Milestones in CMS Programs, 2010). Private managed care was growing significantly during this timeframe (McGuire, 1994), and group practices increased (Madison & Konrad, 1988). These developments in the medical field, however, led to limitations on physician choice because of programmatic or insurance restrictions, and, to some extent, these developments limited the time patients spent with physicians in the course of care and treatment.

Advancing the timeline to current-day medical and legal practice, the interpersonal and public dynamics in these fields of practice bear faint resemblance to those of the past. Lawyer advertising now saturates the public domain in every media mode - TV, radio, newsprint, billboards, email, "newsletters," and the internet. Multi-media marketing of legal services by litigation firms project several consistent themes to the public: (a) more patients are injured or killed by doctors and hospitals than the public may realize; (b) if the patient's outcomes was not as expected, medical malpractice was committed; (c) insurance companies trying to settle with patients universally take advantage of them, so patients should never talk to the insurance company regarding settlement until they speak with an attorney; (d) patients pay nothing for the attorney's services unless and until the attorney wins the case; and (e) the lawyer or firm advertised is always the best firm to watch out for the patient's wellbeing. Lawyers are promoted as "Super Lawyers" in publications and attorneys regularly tout their niche specialty by using business themes and URL web site addresses that personify that niche. By 2007, the number of attorneys

in active practice in the United States had grown to over 1,140,000, almost tripling the lawyer per capita ratio in 1970 (Law Crossings, 2010). With the proliferation of attorneys in the marketplace, competition for clients is understandably aggressive, driving advertising campaigns that represent a significant budget expense for firms that advertise heavily. Increased advertising and competition also drive the need for trial attorneys to pursue an increasing number of cases to cover costs and to stay ahead of the competition.

In today's medical practice, managed, compartmental care is the norm, and private and public



insurance programs and applicable regulations change continuously. Physician practice groups and hospitals use the same marketing media sources as attorneys when touting their competencies, their specialties, and their purported outstanding outcomes. Increased patient

load, limited reimbursements by insurance companies and governmental programs, and contractual and regulatory restrictions on ordering certain procedures or tests interfere with the opportunity for patients and physicians to form trusting and loyal relationships.

The changes in the medical and legal landscape during the last three decades have created risk factors that correlate to increased odds of physicians being dragged from the comfort of their medical practice to the battlefield of litigation. Over the past thirty years, medical malpractice claims have increased substantially. In their republication of The AMA Socioeconomic Monitoring System (AMASMS), 1982 Core Survey, Adams and Zuckerman (1984) noted that, prior to 1976 the rate of annual claims per 100 physicians was 3.1 for all phy-

sicians, while OB/GYN practitioners had a claims rate per 100 physicians of 4.9. From 1976 to 1981, however, these rates more than doubled for all physicians (6.7), while the rate of claims per 100 OB/GYN physicians more than tripled to 15.5. Although, in 1976, solo practitioners and group practice physicians had the same relative rate of claims, by 1981 group practice physicians were subjected to 19% more claims than those in solo practice. Over a decade later, in 1994, the AMASMS demonstrated that professional liability claims rates for all physicians increased to 9.5 per 100 physicians (AAP News, 2001). More recent claims data for the period of 2003 through 2008 reveal that the medical malpractice claim rate remains quite high, but with a detectable downward trend in the total number of claims paid nationally. Although this downward trend is encouraging, there was a concurrent and significant increase in the average claim payment during the same period (The Henry S. Kaiser Family Foundation State-healthfacts, 2010).

Risk and protective factors surfaced in the cultural response to the changes. Moore and O'Connell (1984) reviewed an interesting survey conducted by the All-Industry Research Advisory Council (AIRAC) that listed eleven possible reasons for the significant increase of medical malpractice lawsuits. Some of the most frequent responses given were: (a) people are more aware that they can sue; (b) people want to make money on lawsuits; (c) people expect doctors never to make mistakes; and (d) doctors see too many patients. These responses indicate that the historical changes in the medical and legal environment gave rise to the following current-day, non-exhaustive, list of risk factors which, in my opinion and experience, are likely to encourage patients to become litigious: (a) lawyer and medical community advertising; (b) unrealistic patient expectations of perfect outcomes (c) minimal financial risk for patients to sue, while financial gain can be large; and (d) depersonaliza-

tion of medical practice.

### Advertising and Unrealistic Expectations



Advertising by the legal community is successful, while advertising by the medical community has both its successes and its drawbacks. Lawyer adver-

tising targets potential clients in two primary ways: it provides a memory "hook" that potential clients will grab, if they believe that they are the victims of medical negligence, and the convincing advertising language gives a potential client a belief that if an injury occurred, then medical negligence caused the injury. In my experience, lawyer advertising works as intended, and meets the goals of trial lawyers. As noted in the AIRAC study, education about the medical malpractice litigation process is a significant factor in determining if a patient is willing to pursue a claim against a physician. Lawyer advertising, therefore, serves as an effective tool in delivering this education to patients.

While meeting the goal of being recognized in local, state, and national markets, some advertising by the medical community inadvertently spawns the unintended consequence of increasing the risk of medical malpractice claims and litigation. The advertising campaigns of physicians and hospitals, while gaining positive notoriety for their practices and entities, may also purvey unreasonable expectations. Advertisements (fictitious name but based upon actual ads) such as "The physicians at Megabucks Hospital made my grandpa's heart as good as new," and "Get your emergency care faster than Dominos delivers pizza," give patients expectations of superb, but unrealistic, outcomes in every case. Anything less is a major disappointment, leaving patients feeling betrayed. During trial, plaintiff's lawyers frequently present this type

of hyperbole to juries, thereby skewing the jurors' perception of the law to be applied in the case. Florida law does not equate less-than-optimal outcomes with medical malpractice. Medical malpractice occurs, as a matter of law, if a medical injury was caused by a breach of the *prevailing professional standard of care*. This standard of care is defined in law as "that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers" (FLA. STAT. § 766.102 (1)). The standard of care is that of a "reasonable" health care provider, and not that of a perfect provider or of the most skilled provider in the medical profession. Florida law further provides that "the existence of a medical injury shall not create any inference or presumption of negligence on the part of the health care provider" (FLA. STAT. § 766.102 (3)). With limited exceptions, such as retained foreign body cases, a patient's less-than-optimal outcome or medical complication is not proof of negligence. The law tacitly recognizes that medicine is an art as well as a science; it is always evolving and perfect outcomes are not guaranteed. As the great 20<sup>th</sup> Century philosopher, Yogi Berra once said, "When you come to a fork in the road, take it." Medicine presents many forks in the road for physicians to consider. There is more than one reasonable way to evaluate and treat a patient, with each reasonable choice having its own inherent risks and benefits. The choice of one reasonable method of treatment over another should not result in a valid claim of medical negligence, merely because a known risk of the treatment occurred and the outcome was not as expected. When lawyer advertising conveys to the public that physician negligence is more prevalent than reported and that injuries almost always occur through malpractice, and, concurrently, when medical advertising promises unrealistic outcomes, the legal standard of medical negligence is distorted in the mind of the public. This distorted view leads to the mistaken belief

that the standard of care exceeds that which is actually required under law, thus encouraging claims against health care providers when the optimal medical outcome is not realized.

### Patient Expectations of Minimized Financial Risk / Major Financial Gain

The litigation process in the United States grants claimants ready access to the courts to pursue medical malpractice claims. A major component of access, regardless of the financial status of a patient, is the contingency fee arrangement, whereby an attorney agrees to take a case for a fee based upon a cut of the settlement amount or of a judgment. If successful, the attorney may also recoup the costs incurred in pursuing the claim or litigation. Generally, plaintiffs pay no out-of-pocket expenses for the cost of litigation, although they will certainly bear the emotional stress of the litigation process - depositions, trial, and the protracted period of time inherent in civil litigation. Patients are comfortable with the proposition that they have nothing to lose in pursuing a medical malpractice claim, and they frequently anticipate that a large financial payout awaits them in the end. Although legal procedures exist for a physician to recoup certain costs of litigation from a plaintiff, if either the physician prevails in the case, or, in some circumstances, if the plaintiff refuses a proposal for settlement by the physician, it is often impractical for the physician to enforce these legal remedies against a plaintiff. Many plaintiffs are "judgment proof," having little or no attachable assets from which the physician may recoup the expense of litigation, and the case law regarding proposals of settlement make their enforcement very difficult. Accordingly, the financial consequences for a plaintiff who brings an un-



successful medical malpractice action against a physician have little deterrent value, making the risk factor of minimal financial risk/major financial gain a formidable one.

### **Depersonalization of Medical Practice**

As managed and compartmental care have grown over the years and state and federal government programs have increased in scope, patients and the physicians who treat them do not have the best opportunity to form bonds of trust, confidence, and loyalty. Many indigent patients and others without medical insurance utilize emergency departments of hospitals as substitutes for their primary care, knowing that under federal EMTALA provisions and similar state laws, they cannot be denied evaluation and stabilization of their condition in the emergency department (42 U.S.C. § 1395dd ; FLA. STAT. § 395.1041). Continuity of care is difficult when patients choose this treatment path, as follow-up care with specialists and other physicians is not obtained in an organized, systematic manner. Instead, such patients tend to recycle to the emergency department for their primary care, with little opportunity to form bonds of trust and loyalty with the emergency department physicians who happen to treat them on an occasional basis. In the hospital setting, depersonalization of care, or the appearances thereof, creeps into the medical culture. For example, I occasionally hear health care providers refer to patients by their diseases or procedures. Comments such as, "I have a gall bladder scheduled for 1400 in operating room number 1," instead of "Mrs. Jones, is scheduled for her gall bladder surgery in operating room number 1 at 1400," encourage a culture of depersonalization. Patients desire and expect to be treated as persons, with common courtesy, concern, and respect by the health care providers. They do not want to be looked upon as a number or a medical condition in the minds and hearts of those providing their care. A wise phi-

losophy professor I had in college once asked the class, "what is the opposite of love?" Almost all of us who were awake said, "hate." He admonished us that we were incorrect; and counseled that, in his learned opinion, the opposite of love is "indifference." I have remembered this sagacious comment, and I have found this maxim to be true in the practice of law and in what I have seen in the practice of medicine. Patients are most upset when they feel they are being taken for granted or ignored. Failure to respond in a timely, reasonable, and respectful manner to their inquiries or requests enhances the risk of patients becoming litigious, especially when outcomes do not meet patient expectations.

### **The Protective Factors – CDC**

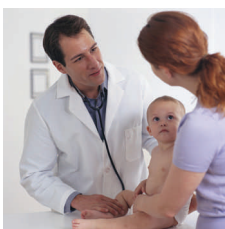
Competence, diligence, and effective communication are the three primary protective factors shielding physicians from the risk of claims and litigation. Of these risk factors, competence and diligence are the most important factors that help physicians successfully defend themselves in lawsuits, but communication is often the most important protective factor that militates against patients pursuing litigation in the first place.

### **Competence and Diligence**

Competence and diligence are effective protective factors, only if the entire medical team or medical collaborators treating the patient comport themselves with competence and diligence. The weakest link in the chain of healthcare professionals often drags the entire chain into a lawsuit. With managed care and its limitations on choice of primary physicians and consultants, the treating physician may not have the flexibility to request consults from those specialists whom the treating physician believes have sufficient competence to ensure excellent continuity of care. If the consultant

to whom the patient is referred lacks competence, the consultant's sub-par performance reflects negatively upon the referring physicians and others treating the patient's medical condition. The protective factor of competence, however, is weakened when members of a health care team fail to act with due diligence. In the hospital setting, for example, if a physician orders lab tests as part of a competent patient evaluation, but the hospital clerk or hospital nurse fails to transmit the order in a diligent and timely manner, risk of litigation will inure to the physician as well as to the hospital, if the delay adversely affects the patient's outcome. When patients consider their treatment to have been delivered in an indifferent manner, because of a lack of diligence, they project their frustration and anger on the entire medical team, whom they will blame collectively for the bad outcome. Establishing policies and processes that ensure that the health care professionals collaborating in a patient's care carry out their responsibilities with due diligence shields against patient frustration and anger.

### Communication During Evaluation and Treatment



During the evaluation and treatment phase of medical care, effective communication with patients about risks, benefits, alternatives, and expectations is a major protective factor. Advising the patient of the known and recognized risks of a procedure is essential, not only to practice within the standard of care, but also to dispel misconceptions and unrealistic expectations on the part of the patient. In my experience, physicians who discuss these potential complications in an objective and compassionate manner, using tailored consent forms, and charting their patient discussions accurately, minimize the risk of the patient or the patient's family

becoming angry at the physician when complications occur. These good practices are also extremely helpful in defending the physician's care if a lawsuit is filed.

### Communication After Treatment Is Rendered

Effective, compassionate, and timely communication with the patient after care and treatment are rendered is equally as important to the maintaining of good physician-patient relations. In situations where untoward outcomes occur, patients feel more confident that they received proper care when they are given objective, comprehensive information concerning the reason for the complication, their prognosis, and the future plan of care. In most circumstances, effective communication is a team effort, with physicians and nurses explaining matters relating to the prognosis and future medical care, and administrative and clerical staff ensuring that processes are in place to help the patient schedule referrals, testing, and other future care and treatment. Incomplete communication results in incomplete understanding on the part of the patient who may unwittingly fail to take steps to obtain the care and treatment that would increase the odds of a good, ultimate outcome. Patients complain about "being abandoned" and being "let down" by their treating physicians, when communication glitches cause breakdowns in the continuity of care. They are likely to conclude that the medical team was indifferent to their needs, and are apt to become litigious, if they further conclude that the unsatisfactory outcome was caused by the lack of continuity of care. Plaintiff's attorneys regularly exploit breakdowns in communication, especially when the record evidence shows that communications made to the patient about future care were incomplete or vague. Whenever the effectiveness of these communications are questioned at trial, even if the patient was responsible for all or part of the non-compliance with fol-

low-up care, juries tend to blame the more learned medical team for the patient's failure to receive needed services, rather than blame the less knowledgeable patient for failing to obtain care.

### **Communication of Adverse Events Or Disappointing Outcomes**

In my experience, when adverse events or other disappointing outcomes occur, caring, compassionate, and objective physician-patient communications not only help to avoid litigation, but also tend to reduce the cost of litigation if a claim is made. Research is consistent with my experience. Lopez et al. (2009) concluded that, even when preventable, adverse events occur, patients are much more likely to consider truthful disclosure as being integral to good quality care. This study tracks with findings of Witman, Park, and Hardin (1966) who concluded that patients desire acknowledgment of medical errors, regardless of the seriousness of the errors, and that they were more likely to consider litigation when physicians do not disclose errors. A number of institutions, such as the Veteran's Affairs Hospital in Lexington, Kentucky (VA-Lex), and the University of Michigan Health System (UMHS) instituted disclosure programs that require health care providers to communicate with patients whose care and treatment resulted in an unexpected, adverse outcomes. In 2006, then Senators Hillary Rodham Clinton and Barak Obama co-authored an article in the *New England Journal of Medicine* that noted that disclosure produces positive results for physicians and medical facilities. Since VA-Lex instituted its disclosure policy, average settlements were substantially lower than other VA hospitals without disclosure policies, and that the VA-Lex claims processing times were reduced from two to four years, to two to four months. The UMHS realized dramatic reductions in time, cost, and the number of claims and lawsuits over the first five years (2001 – 2005) of the institutional disclosure program; the average time to resolution of

claims and lawsuits was cut in half, the number of claims was reduced by more than half, and annual litigation costs dropped by two-thirds (Clinton & Obama, 2006). In Florida, disclosure of adverse events that result in serious injury is not only the right thing to do, it is the law. As part of tort reform, the State of Florida recognized that timely disclosure to the patient of adverse outcomes and medical errors mutually benefit patients and the medical community. Florida law obligates both hospitals and health care practitioners to notify patients of outcomes of care that result in harm to the patient. Specifically, "an appropriately trained person" designated by each hospital must inform patients or lawful representative (if the patient is incompetent) "in person" about "adverse incidents that result in serious harm to the patient" (FLA. STAT. §395.1051). A similar statutory provision requires licensed health care practitioners to make the notification (FLA. STAT. § 456.0575). Although these statutory provisions do not specifically define the term "adverse incident," guidance is found in Florida internal risk management statutory provisions which, for the purpose of a hospital reporting requirement, defines the term, "adverse incident" as "an event over which health care personnel could exercise control and which is associated in whole or in part with medical intervention, rather than the condition for which such intervention occurred" (FLA. STAT. § 395.0197 (5)). The occurrence of an adverse incident does not necessarily mean that the incident was due to a breach of the standard of care. Known complications from medical interventions and bad outcomes can and do occur when no medical negligence is involved. The Florida disclosure statutes implicitly recognize this reality and specifically provide that the disclosure made to the patient "shall not constitute an acknowledgment of admission of liability, nor can such notification be introduced as evidence" (FLA. STAT. § 395.1051; FLA. STAT. § 456.0575). Objective, non-speculative, non-accusatory, and compassionate communication by a mature physician to the

patient concerning any less-than-optimal outcome minimizes the probability of a claim being asserted against the physician. The University of Florida health care system has a policy implementing compliance with Florida disclosure laws. A key policy component requires that an attending physician with proper training in the disclosure requirements will make the required disclosure to the patient, as distinguished from a resident physician (resident), nurse, technician, or other health care provider. The policy correctly places the responsibility for disclosure on the health care provider who has the most knowledge of the care, and who is best suited to evaluate comprehensively the various processes related to the care. Patients benefit from the enhanced indicia of accuracy of the disclosure, when the attending physician assesses the facts and conveys the information to the patient. If an adverse event occurs, gratuitous comments by lesser-qualified health care providers are counterproductive to all concerned, as they may be based upon speculation, lack of knowledge of the event, and an incomplete understanding of the medicine and the processes related to the care. Disclosure of incomplete or inaccurate information is unhelpful to the patient and the colors the patient's perception of the credibility of information that later proves to be accurate. I recall an incident where a patient had a respiratory arrest in the emergency department. The arrest was handled appropriately and the patient did not suffer any harm. Prior to the arrest, a penicillin-based antibiotic was ordered by a first-year resident, but the drug was never administered. When the patient was revived, the resident realized that he missed the penicillin allergy flag in the patient's chart. The remorseful resident apologized to the patient for the perceived error. He further advised the patient erroneously that, in his opinion, the penicillin contributed to her respiratory arrest. Had he checked the medication record or had he spoken with the nurse responsible for executing the medication order, the resident would have learned that penicillin was not

administered to the patient. In fact, the antibiotic had not yet been pulled from the pharmacy distribution system. When the attending physician was alerted to the matter, he assessed all the facts and then advised that patient correctly that the penicillin was never administered and that the arrest was related to her underlying co-morbidities. The patient, however, received this accurate communication with great skepticism. She believed erroneously that the disclosure by the attending physician was merely an attempt to cover up a medical error. Shortly after her discharge, the patient engaged the services of a medical malpractice attorney. Had the resident waited for the attending physician's assessment, misinformation would not have been conveyed to the patient by the resident, and the attending physician's credibility would not have been questioned by the patient.

### **Communication and Early Offers When Medical Negligence Causes Harm**

In addition to disclosure of medical errors that cause harm to the patient, taking early steps to minimize the economic damages caused by the error may not only help to reduce the risk of lawsuits, but also may mitigate litigation costs and the amount of settlements or jury awards, if a suit is brought (Black, Hyman & Silver, 2009). Billing write-offs, fee waivers, and early, reasonable offers of compensation may avoid adding insult to the patient's injury. Consider the following scenario: A single mother of two young children falls and injures her ankle. She presents to an emergency department where she is diagnosed as having an ankle sprain. She is discharged with instructions to take pain medication as needed and to apply ice and/or heat. She is not told to remain off her feet, however. She follows the discharge instructions, but after a week, she continues to have severe pain in her ankle and her lower extremity remains weak. The patient is frustrated and returns to the emergency department for further evaluation.



During this visit, the physicians conclude that the initial x-ray was misread and the patient's ankle was actually fractured at the time of her first visit. Additionally, the assessment indicates that surgery will now be necessary, because the fracture was not healing properly and was misaligned due to weight bearing activity by the patient. The emergency department attending physician dutifully advises the patient of the error and expresses her regrets that the patient suffered such pain over the past two weeks. She further advises the patient that she would need orthopedic surgery to correct the improperly healing and misaligned fracture. The attending physician, an honest professional, also admits that had the ankle been properly stabilized, the orthopedic surgery would most likely not have been necessary. A week later, the patient receives a bill for several thousand dollars for services rendered during both emergency department visits, and she is worried about the loss of wages she will incur, because of the upcoming surgery and recovery time. In cases fitting this and similar scenarios, patients naturally and rhetorically ask, "why should I be charged for your mistakes?" Disclosure of errors, coupled with writing off the bills for the services related to the error frequently satisfy the patient without further claims being made. If verifiable damages resulted from the medical error, early offers of compensation for these damages may also help to resolve the matter without litigation, especially in cases where economic damages are low or moderate.

### Conclusion

By establishing effective medical and risk management practices that enhance the protective factors of competence, diligence, and effective communication, physicians create a positive practice environment conducive to good physician-patient relationships. These protective factors are effective in minimizing the impact of the risk factors discussed in this article, and they help reduce the risk

of the physician and patient embarking on an unpleasant journey from the examining room to the courthouse.

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