AHLA

Journal of Health & Life Sciences Law

VOLUME 11, NUMBER 1 | OCTOBER 2017

OFFICIAL JOURNAL OF AMERICAN HEALTH LAWYERS ASSOCIATION

Comment

A Litigation Attorney's Formula for Changing the Factors that Influence a Patient's Decision to Sue

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What is the issue? Certain risk factors can adversely impact the physician-patient relationship and may launch patients towards litigation when the medical care and treatments provided result in unanticipated and harmful outcomes.

What is at stake? The economic consequences for both providers and patients can be quite significant when medical care and treatments result in unanticipated harm, not to mention the potentially long term physical and emotional toll suffered by the patient and his or her family members.

What do you need to know? Certain protective factors can bolster the physician-patient relationship and help shield the physician from the risk of claims. Establishing a communication pathway that cultivates an environment of safety, honesty, and confidentiality—including protections for both the patient and physician that encourage rather than hinder discussions about how and why the adverse outcome occurred—can go a long way toward defusing a patient's initial reaction to sue for damages.

Daniel J. D'Alesio Jr., *A Litigation Attorney's Formula for Changing the Factors that Influence a Patient's Decision to Sue*, J. Health & Life Sci. L., Oct. 2017, at 58.

D'Alesio: Formula for Changing Risk

CONTENTS

Introduction

Certain risk factors can adversely impact the physician-patient relationship and may launch a patient towards litigation. Conversely, certain protective factors can bolster the physician-patient relationship and help shield the physician from risk of claims. This Comment explores the risk factors that influence a patient's decision to undertake or forego litigation after experiencing a disappointing outcome related to care and outlines countervailing protective factors and the author's suggested approach by which physicians, hospitals, and the health care attorneys who advise them may reduce the probability of claims and mitigate the adverse economic consequences of claims.

Risk Factors That Increase the Possibility of Medical Malpractice Claims

In the mid-1980s, Moore and O'Connell referred to a survey by the All-Industry Research Advisory Council (AIRAC) that listed eleven possible reasons for the significant increase of medical malpractice lawsuits.[1] Some of the most frequent survey responses that Moore and O'Connell quote from the AIRAC survey include:

- People are more aware that they could sue.
- People want to make money on lawsuits.
- People expect doctors never to make mistakes.
- Doctors see too many patients.

These responses reflected historical changes in the medical and legal environment that parallel the following non-exhaustive list of risk factors which, in the author's opinion and experience, can influence a patient's decision to file suit:

1 Henson Moore & Jeffrey O'Connell, *Foreclosing Medical Malpractice Claims by Prompt Tender of Economic Loss*, 44 La. L. Rev. 1267 (1984), *available at* http://digitalcommons.law.lsu.edu/cgi/viewcontent.cgi?article=4833&context=lalrev (citing All-[Insurance] Industry Research Advisory Council (AIRAC), *Public Attitude Monitor 1983: A Public Attitude Survey on Drunk Driving, Medical Malpractice, Seatbelts, and Other Insurance and Safety-Related Topics* 24 (Oct. 1983)).

- Lawyer and medical community advertising
- Unrealistic patient expectations of perfect outcomes
- Minimal financial risk for patients to sue, with potential for large financial gain
- The depersonalization of medical practice[2]

Insurance program administrators and analysis from later surveys and studies corroborate the continuing existence of these risks individually and collectively.[3]

Advertising by lawyers and increased competition for clients

Until the 1970s, information available to the public regarding the medical and legal professions was quite limited. Lawyer advertising for professional services, for example, was almost generally prohibited as constituting unethical conduct.[4] Although advertising by lawyers was very limited during this time, motivated patients could locate attorneys through word of mouth, phone books, and signage. In the mid-seventies, the 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 provisions in the Arizona

2 *Id.*

3 *See, e.g.,* Bhanu Prakash, *Patient Satisfaction*, 3 J. Cutaneous & Aesthetic Surgery 151 (2010), *available at* www.ncbi.nlm.nih.gov/pmc/articles/PMC3047732; Beth Huntington & Nettie Kuhn, *Communication Gaffes: A Root Cause of Malpractice Claims,* 16 Baylor U. Med. Ctr. Proc. 157, 157 (2003), *available at* www.ncbi.nlm.nih.gov/pmc/articles/PMC1201002/pdf/bumc0016-0157.pdf; Richard L. Abbott, *Medical Malpractice Predictors and Risk Factors for Ophthalmologists Performing Lasik and PRK Surgery*, 101 Transactions Am. Ophthalmological Soc'y 239 (2003), *available at* www.ncbi.nlm.nih.gov/pmc/articles/PMC1358993/pdf/14971582.pdf; Gerald B. Hickson et al., *Factors that Prompted Families to File Medical Malpractice Claims Following Perinatal Injuries,* 267 J. Am. Med. Ass'n 1359 (1992); Caprice C. Greenburg et al., *Patterns of Communication Breakdowns Resulting in Injury to Surgical Patients*, 204 J. Am. C. Surgeons 533 (2007); *see also* CRICO Strategies, Malpractice Risks in Communication Failures: 2015 Annual Benchmarking Report (2015), *available upon request at* www.rmf.harvard.edu/Malpractice-Data/Annual-Benchmark-Reports/Risks-in-Communication-Failures.

4 Robert F. Boden, *Five Years After Bates: Lawyer Advertising in Legal and Ethical Perspective*, 65 Marq. L. Rev. 547 (1982), *available at* http://scholarship.law.marquette.edu/cgi/viewcontent.cgi?article=2020&context=mulr.

Bar ethics rules prohibiting or severely restricting attorney advertising violated the First Amendment right to free speech of attorneys.[5]

Lawyer advertising now saturates the public domain in every media—TV, radio, newsprint, billboards, email, newsletters, and the internet. Multi-media marketing of legal services by litigation firms promotes a variety of themes and messages to the public: more patients are injured or killed by doctors and hospitals than the public realizes; unexpected outcomes equate to medical malpractice; absent attorney involvement, insurance companies try to take advantage of patients when proposing settlements; patients pay nothing for the attorney's services unless and until the attorney wins the case; and the lawyer or firm advertised is the best firm to protect the patient's wellbeing.

As the number of attorneys has grown significantly, so has advertising of legal services. By 2016, the number of attorneys actively practicing in the United States had grown to over 1,350,000, almost quadrupling the number since 1970.[6] Given the proliferation of attorneys in the marketplace, competition for clients is understandably aggressive, driving advertising campaigns that represent a significant portion of a firm's budget, as well as the need to pursue a greater number of cases to cover costs. Not surprisingly, successful marketing efforts often require significant cash outlays. In 2015, the U.S. Chamber of Commerce Institute for Legal Reform projected television advertising for attorneys in 2015 would reach $892 million.[7] In that same year, attorneys spent 68% more on television than they had in 2008.[8] A handful of law firms today each spend over $10 million annually on TV advertisements.[9] The firm of Akin Mears, for example, spends in excess of $25 million per year, while the firms of Morgan & Morgan and Pulaski & Middleton are close

5 Bates v. State Bar of Ariz., 433 U.S. 350 (1977).

6 Am. Bar Ass'n, ABA National Lawyer Population Survey: Historical Trend in Total National Lawyer Population: 1878 – 2016, *available at* www.americanbar.org/content/dam/aba/administrative/market_research/total-national-lawyer-population-1878-2016.authcheckdam.pdf.

7 U.S. Chamber Inst. for Legal Reform, Trial Lawyer Marketing: Broadcast, Search and Social Strategies 4 (Oct. 2015), *available at* www.instituteforlegalreform.com/uploads/sites/1/KEETrialLawyerMarketing_2_Web.pdf [hereinafter Trial Lawyer Marketing].

8 *Id.* at 5.

9 *Id.* at 7.

behind, spending over $24 million per year.[10] According to Lisa A. Rickard, President of the U.S. Chamber Institute for Legal Reform, "The plaintiffs' bar orchestrates some of the most sophisticated and relentless marketing campaigns in our society."[11] These trends portend increasingly aggressive advertising campaigns to compete for and influence potential clients in their decisions to seek legal counsel for actual or perceived injuries related to their medical care and treatment.

Advertising by physicians/medical institutions and unreasonable expectations

The practice of medicine until the 1970s also had strict codes limiting the exchange of information about practitioners and hospitals. Until 1975, the American Medical Association prohibited physician comparison advertisements as "derogatory to the dignity of the profession" and attempts to advertise could result in sanctions for the physicians involved.[12] Hospital advertising guidelines by the American Hospital Association (AHA) were more liberal, but did not include comparison advertisement until 1984.[13]

Some advertising by the medical community can result in the unintended consequence of manipulating choice, as well as increase the risk of medical malpractice claims and litigation "by presenting limited and biased information that entice rather than to inform."[14] While advertising campaigns for physicians and hospitals can produce positive notoriety for their practices and entities, they may also encourage unreasonable patient expectations. Adver-

10 *Id.*

11 Press Release, U.S. Chamber Inst. for Legal Reform, Lawyer Spending on TV Ads Growing Six Times Faster than All Others, Report Finds (Oct. 27, 2015), *available at* www.businesswire.com/news/home/20151027006296/en/Lawyer-Spending-TV-Ads-Growing-Times-Faster.

12 N.D. Tomycz, *A Profession Selling Out: Lamenting the Paradigm Shift in Physician Advertising*, 32 J. Med. Ethics 26, 26 (2005), *available at* http://jme.bmj.com/content/medethics/32/1/26.full.pdf [hereinafter *A Profession Selling Out*]; *see also* AMA Code of Ethics (1847), *available at* www.ama-assn.org/sites/default/files/media-browser/public/ethics/1847code_0.pdf.

13 Lauren Strach, *Hospital Advertising in the Beginning: Marketplace Dynamics and the Lifting of the Ban* 22 Essays in Economic and Business History 229, 232 (2004), *available at* www.ebhsoc.org/journal/index.php/journal/article/viewFile /83/79.

14 *A Profession Selling Out*, at 27.

tisements promising "the perfect physique" or physicians at a certain hospital having made a loved one's heart "as good as new" and claims of receiving one's emergency care "faster than Dominos delivers pizza" provide patients with unrealistic expectations of fast, state-of-the-art care with perfect outcomes in every case. Such unreasonable expectations, generated by advertising hyperbole, can result in patient dissatisfaction when expected outcomes do not occur, even if the services provided were within the prevailing professional standards of care. The author has also observed a trend in which plaintiff's lawyers request defendants' advertising materials in discovery to address the hyperbolic language used by defendant-physicians/hospital administrators in their advertisements during depositions and at trial. When a bad patient outcome is coupled with promises of outstanding outcomes featured in advertisements, a jury may be influenced to hold the physician to a higher standard of care implied in the advertisement instead of the actual legal standard, which is typically "reasonable" care. In addition, the disappointment experienced by the patient may lead to claims for breach of contract, breach of warranty, failure of satisfaction of a guarantee, and lack of informed consent.[15]

Limitations on physician choice and less time spent with patients

In today's medical practice, insurance plans, managed care programs, and related governmental regulations change on a regular basis, potentially impacting a patient's choice of physicians and services, which can affect the patient's perception of trust and confidence in the physician selected.[16] Physicians are also spending less time than they desire with patients in the course of care and

15 *See* Faktor v. Lifestyle Lift, No. 1:09-cv-511 (N.D. Ohio July 22, 2009); Lovely v. Percy, 826 N.E.2d 909 (Ohio Ct. App. 2005); Heffner v. Reynolds, 777 N.E.2d 312 (Ohio Ct. App. 2002); Ryan v. Staten Island Univ. Hosp., No. 04-CV-2666 (E.D.N.Y. Apr. 13, 2006); Karlin v. IVF Am., Inc., No. 65 (Ct. App. N.Y. May 4, 1999). *See also* Laura Brockway, *Advertiser Beware: The Do's and Don'ts of Physician Advertising*, Tex. Med. liability trust, Jan.-Feb. 2005; *Your Advertising for Lasik can Nullify Informed Consent*, AHC Media (Jan. 1, 2001), www.ahcmedia.com/articles/67800-your-advertising-for-lasik-can-nullify-informed-consent (providing examples outside of medical malpractice that a patient can sue physician for breach of contract, breach of warranty, and lack of informed consent).

16 Christopher B. Forrest et al., *Managed Care, Primary Care, and the Patient-Practitioner Relationship*, 17 J. Gen. Internal Med. 270, 276 (2002), *available at* http://onlinelibrary.wiley.com/doi/10.1046/j.1525-1497.2002.10309.x/epdf.

treatment.[17] The length of time spent in a patient visit can play a significant role in the physician-patient relationship. In fact, it is not uncommon to find a correlation between the length of time spent with the patient and the physician's risk of a medical malpractice claim—the shorter the time spent, the greater the risk.[18]

Patient expectations of minimized financial risk and major financial gain

The litigation process in the United States grants claimants, regardless of financial status, ready access to the courts to pursue medical malpractice claims. A major component of access is the contingency fee arrangement.[19] Without the burden of an initial monetary outlay, there is little or no financial deterrent to pursue a medical malpractice claim. Further enhancing a patient's expectation of minimized risk is the absence of a "loser pays" rule in the United States, which makes it difficult for physicians who successfully defend themselves in lawsuits to recover litigation fees and costs from the patient.[20] Except in very limited circumstances, attorneys' fees and costs will not be awarded to a successful health care provider or hospital litigant.[21] Even if a health care provider is successful in obtaining an order for fees and costs, financial recovery will not be practical if the patient is judgment proof, i.e., has few, if any, assets to satisfy a judgment of fees and costs.

17 David C. Dugdale et al., *Time and the Patient-Physician Relationship*, 14 J. Gen. Internal Med. S34, (Supp. 1 1999), *available at* www.ncbi.nlm.nih.gov/pmc/articles/PMC1496869/pdf/jgi_263.pdf.

18 Ezekiel J. Emanuel, *Preserving the Physician-Patient Relationship in the Era of Managed Care,* 273 J. Am. Med. A'ssn 323 (1995).

19 An agreement in a civil case between an attorney and client that the attorney will represent the client for a percentage of the amount recovered in a settlement or award.

20 John Leubsdorf, *Toward a History of the American Rule on Attorney Fee Recovery*, 47 L. & Contemp. Probs. 9 (1984), *available at* http://scholarship.law.duke.edu/cgi/viewcontent.cgi?article=3748&context=lcp.

21 *See e.g.*, Fla. Stat. § 768.79 and Fla. R. Civ. P. 1.442 (Florida's offer of judgment/proposal of settlement law that provides fees and costs to the prevailing party under certain circumstances upon a proposal for settlement prior to trial and rejection by the opposing party.).

The depersonalization of medical practice

As restrictions on managed care and insurance coverage continue to grow, state and federal government programs are increasing in scope, which can limit opportunities for patients and the physicians who treat them to form bonds of trust, confidence, and loyalty.[22] Under the federal Emergency Medical Treatment and Labor Act (EMTALA), no patient may be denied emergency care at a hospital, regardless of his or her ability to pay.[23] Patients with low socioeconomic status use more acute hospital care and less primary care than patients with higher socioeconomic status.[24] Emergency departments, however, provide little opportunity for a patient to form bonds of trust and loyalty with physicians who rotate through the department in various shifts.

In the hospital setting, depersonalization of care, or the appearances thereof, can creep into the medical culture.[25] For example, physicians may unintentionally depersonalize their patients by referring to them as diseases or procedures when speaking with colleagues. Comments such as, "I have a lap chole (gall bladder surgery) scheduled for 1400 in operating room number 1," can foster a culture of depersonalization. Patients desire and expect to be treated as persons worthy of common courtesy, concern, and respect rather than be defined by a number or a medical condition. Even a physician's tone of voice can impact whether or not a patient feels he or she is being treated with respect. A 2002 study involving the tone of surgeons' voices revealed that expressions of dominance and lack of empathy may imply physician indifference, and that failure by surgeons to respond in a timely, reasonable, and respectful manner to patient inquiries thereby enhanced the risk for malpractice claims when outcomes did not meet patient expectations.[26]

22 Susan Dorr Goold & Mack Lipkin, Jr., *The Doctor–Patient Relationship: Challenges, Opportunities, and Strategies*, 14 J. Gen. Internal Med. S26 (Supp. 1 1999), *available at* www.ncbi.nlm.nih.gov/pmc/articles/PMC1496871/pdf/jgi_267.pdf.

23 42 U.S.C. § 1395dd.

24 Shreya Kangovi et al., *Understanding Why Patients of Low Socioeconomic Status Prefer Hospitals over Ambulatory Care*, 32 Health Aff. 1196 (2013), *available at* http://content.healthaffairs.org/content/32/7/1196.full.pdf+html.

25 Meghan O'Rourke, *Doctors Tell All—and It's Bad,* Atlantic (Nov. 2014), *available at* www.theatlantic.com/magazine/archive/2014/11/doctors-tell-all-and-its-bad/380785/.

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

Communication failures

A 2007 review of data on sentinel events obtained by the Joint Commission suggested that "poor communication contributed to nearly 70% of sentinel events reported in 2005."[27] In a more recent benchmarking report by CRICO Strategies that reviewed almost 24,000 claims and litigation cases filed between 2009 and 2013, poor patient-provider and provider-provider communication were factors that contributed to patient harm in 30% of the cases under review, with communication problems contributing to incurred losses of $1.7 billion.[28] The percentage of cases involving patient-provider communication errors (57%) and provider-provider communication errors (55%) were almost evenly divided, while 12% of the cases reviewed involved breakdowns in both types of communications.[29] The communication breakdowns were attributed to multiple causes, including, but not limited to: "[W]orkload pressure, cumbersome [electronic health records], lack of role clarity, distractions, and workplace culture (and hierarchies) …."[30] Although the benchmarking report noted that communication failures varied by different services, communication failures across all services resulted in misinformation that "can lead to mismanaged care, unmet expectations, and patient harm."[31]

The Protective Factor Equation: CDC + Compassion = Reduced Exposure to Claims and Suits

Based on years of health law practice and teaching practical legal knowledge courses for health care providers, the author has developed an equation to capture several broad categories of protective factors that can help reduce the risk of a patient's deciding to assert claims against his or her health care providers or medical institution, and which may also mitigate the costs of

27 Caprice C. Greenberg et al., *Patterns of Communication Breakdowns Resulting in Injury to Surgical Patients,* 204 J. Am. Coll. Surg. 533 (2007).

28 CRICO Strategies, Malpractice Risks in Communication Failures: 2015 Annual Benchmarking Report (2015), *available by request at* www.rmf.harvard.edu/Malpractice-Data/Annual-Benchmark-Reports/Risks-in-Communication-Failures.

29 *Id.*

30 *Id.* at 4.

31 *Id.*

litigation. This simple equation is CDC + Compassion = Reduced Claims and Lawsuit Exposure.

CDC stands for the attributes of competence, diligence, and communication. Under the umbrella of compassion, these attributes are protective factors that can help shield physicians from clams and litigation. While competence and diligence are extremely important in helping physicians successfully defend themselves, communication and compassion are just as important, if not more so, in helping to prevent or minimize the pursuit of claims and lawsuits in the first place. These protective factors are discussed separately below, but they all need to be utilized in combination to provide the best chance of reducing exposure to claims and lawsuits and to otherwise mitigate damages if claims and lawsuits are pursued.

Competence and diligence

In common parlance, competence is the cognitive and technical protective factor in the equation. It is the acquisition of sufficient knowledge and the development of satisfactory technical skills by practicing what is learned. In medicine, a competent physician has acquired knowledge, including expertise, to develop the proper skill sets to practice medicine within the prevailing professional standard of care in delivering health care and treatment. Diligence is the action of putting one's competence into practice. The most brilliant, technically-skilled surgeon may possess the competence to provide excellent inter-operative care and treatment for patients, but if he or she is not diligent in the patient's pre-operative assessment or post-operative management, such lack of diligence can negatively overshadow the surgeon's competence, exposing the surgeon to liability if the surgical results are not optimum. Further, competence and diligence are compromised when not exercised by the entire medical team. It is not uncommon to find that the weakest link in the chain of health care professionals may have been the one to pull an entire medical team into a lawsuit. A consulting physician's sub-par performance, for example, not only reflects negatively on the referring physicians and others treating the patient's medical condition, but can also expose the referring physician to liability if he or she knew or should have known of the consulting physician's

incompetence.[32] Having reasonable checks and balances in place to help ensure that care and treatment are delivered in a competent and diligent manner, along with training and proper oversight to implement them, can go a long way toward shielding providers against claims of incompetent care.

It is axiomatic that practicing with competence and diligence also requires that physicians, staff, and their administrators be thoroughly versed in policies relating to their administration of health care to patients. Although courts have held that, without the addition of expert testimony, evidence of the failure to follow policies is insufficient to prove a breach of the standard of care,[33] courts in other states have held that a policy violation may by itself establish such a breach, or may be relevant to establish breaches of administrative or managerial duties a health care institution owes to a patient. [34] In the author's experience, in almost all deposition or trial testimony, health care providers and representatives of health care institutions will be questioned by plaintiffs' attorneys regarding the witness's knowledge and understanding of relevant polices and whether or not they had been followed. Answers demonstrating lack of knowledge or understanding and failure to implement relevant policies are often used as leverage in settlement negotiations or at trial to show that patient safety may have been adversely affected by a lack of competence and diligence. This risk can be reduced by taking several proactive steps:

- Conducting a regular review of patient care and administrative policies for relevancy, accuracy, and effectiveness.
- Conducting a legal review of policies to ensure language does not convey requirements of care that would be unreasonable to attain or are otherwise in excess of the recognized prevailing professional standard of care.

32 *See e.g.*, Estate of Tranor v. Bloomsburg Hosp., 60 F. Supp. 2d 412 (M.D. Pa. 1999).

33 *See* Neil Edwards & Meg Twomey, *Health Care Policies and Procedures As a Basis For Liability*, Medical Malpractice Law & Strategy (July 2015), *available at* www.lawjournalnewsletters.com/sites/lawjournalnewsletters/2015/07/01/health-care-policies-and-procedures-as-a-basis-for-liability/; *see also* Heastie v. Roberts, 877 N.E. 2d 1064 (Ill. 2007); Blankenship v. Collier, 302 S.W. 3d 665 (Ky. 2010).

34 *See* McCorkle v. Gravois, 152 So. 3d 944 (La. Ct. App. 2014); *see also, Heastie,* at 1077-1078.

- Training new staff on policies affecting the scope of their duties, including additional training when policies change.
- Ensuring that witnesses are properly prepared in advance of deposition or trial to respond appropriately to questions posed about the policies at issue.

Communication

Effective physician-patient communication can reduce the risk of claims and lawsuits. In 2003, Huntington and Kuhn commented on several published studies that, despite having used different study techniques, concluded that one of the four most common themes among litigious patients was a need for an explanation as to how their injuries occurred.[35] In 2000, the American Academy of Orthopedic Surgeons/American Association of Orthopedic Surgeons issued an advisory statement that patient-centered communication and open, honest dialogue that fosters trust and promotes healing has a favorable impact on "patient behavior, patient care outcomes, and patient satisfaction; [and] as a consequence, it often reduces incidence of malpractice lawsuits."[36] Health care communications take place during evaluation and treatment, when disclosing adverse events and unanticipated outcomes, and when making early offers of compensation.

Communication during evaluation and treatment

During the evaluation and treatment phase of medical care, effectively communicating the potential risks, benefits, alternatives, and expectations to the patient is a major protective factor. Advising the patient of the known and recognized risks of a procedure is essential to dispelling any misconceptions or unrealistic expectations that the patient might have. One study involving primary care physicians showed discernable communicative behaviors that

35 Beth Huntington & Nettie Kuhn, *Communication Gaffes: A Root Cause of Malpractice Claims*, 16 Baylor U. Med. Ctr. Proc. 157, 157 (2003), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1201002/.

36 *Id.* (citing Am. Acad. of Orthopaedic Surgeons/Am. Ass'n of Orthopedic Surgeons, The Importance of Good Communication in the Patient-Physician Relationship (2000)).

identified those who were less likely to be sued.[37] These physicians demonstrated greater use of orientation statements to educate their patients on the risks, benefits, alternatives, and expectations of care and treatment; they had a better sense of humor and use of laughter; and were more likely to seek out the patient's understanding and opinions about the plan of care by encouraging them to engage in conversation.[38]

In the author's experience, physicians who discuss the risks, benefits, and alternatives for care in an objective and compassionate manner, using tailored consent forms and accurately charting their discussions with their patients, minimize the risk of the patient and/or the patient's family reacting with anger when complications occur. Such discussions are also likely to promote better dialogue when trying to address the patient's concerns, answer questions, or resolve any complaints.

Adequate documentation of these good practices will help in defending the care provided by the physician if a lawsuit is filed because the documentation will corroborate the nature and extent of the consent process and related conversations. Documentation practices recommended by this author for providers and medical institutions include:

- Have witnesses to conversations regarding risks, benefits, and alternatives.
- Train new physicians, nurses, and other hospital staff on the process of informed consent and the use of standardized forms.
- Conduct periodic review by departments of standardized and tailored-to-procedure informed consent documents for sufficiency of the informed consent advice.
- Avoid overuse of pre-checked entries on forms, which can create confusion where they do not apply.

37 *Id.* at 158 (citing Wendy Levinson et al., *Physician-Patient Communication: The Relationship with Malpractice Claims Among Primary Care Physicians and Surgeons*, 277 J. Am. Med. Ass'n 553 (1997)).

38 *Id.*

- Have a section on forms for free text, which may include documentation of additional information that may be useful in the event of a claim, such as any special concerns presented by the patient and/or addressed by the physician.
- Conduct periodic training for those involved in the informed consent process (e.g., health care providers and administrative personnel) regarding their legal responsibilities.
- Implement and document effective and timely response by the institution to concerns expressed by providers about the form, including assessment of the concerns and actions taken to improve the documentation.
- Ensure that medical records reflecting the informed consent process are consistent with the form used.
- Require and document review by the physician's or institution's health care attorneys for legal sufficiency of the documents.

Communication of adverse events or unanticipated outcomes

Surveys and studies have long shown that when adverse events or other unanticipated outcomes occur, a physician's objective, non-speculative, non-accusatory, and compassionate communication to the patient concerning the outcome may reduce the likelihood of ensuing litigation or reduce the cost of litigation if a claim is made.[39] Even when an undesirable event may have been

39 *See* Comm. on Patient Safety & Quality Improvement, Am. Coll. of Obstetricians & Gynecologists, Committee Opinion: Disclosure & Discussion of Adverse Events (Dec. 2016) *available at* www.acog.org/-/media/Committee-Opinions/Committee-on-Patient-Safety-and-Quality-Improvement/co681.pdf?dmc=1&ts=20170618T1817219850 (citing Charles Vincent et al., *Why do People Sue Doctors? A Study of Patients and Relatives Taking Legal Action*, 343 Lancet 1609 (1994); Howard B. Beckman et al., *The Doctor-Patient Relationship and Malpractice: Lessons from Plaintiff Depositions*, 154 Archives Internal Med. 1365 (1994). *See also* Lenny Lopez et al., *Disclosure of Hospital Adverse Events and its Association with Patients' Ratings of the Quality of Care*, 169 Archives Internal Med. 1888 (2009); Bernard Black et al., *The Effects of "Early Offers" in Medical Malpractice Cases: Evidence from Texas*, 6 J. Empirical Legal Stud. 723 (2009), *available at* https://papers.ssrn.com/sol3/papers.cfm?abstract_id=1112135 [hereinafter *The Effects of "Early Offers" in Medical Malpractice Cases*].

preventable, patients are more likely to consider truthful disclosure of objective facts as being integral to good quality care.[40] A 1996 article concluded that patients desired acknowledgment of medical errors, regardless of the seriousness of the errors, and that they were more likely to consider litigation when physicians did not disclose errors.[41]

Disclosure of adverse events and unanticipated outcomes is not only good practice, but is also the law in a number of states.[42] In addition to disclosure laws, several dozen states have apology laws that apply to medical situations, and some have both disclosure and apology laws, such as Florida.[43] Florida law obligates both hospitals and health care practitioners to notify patients of adverse incidents that result in harm to the patient. Specifically, "[a]n appropriately trained person" designated by each hospital must inform a patient or lawful representative (if the patient is incompetent) "in person about adverse incidents that result in serious harm to the patient." [44] A similar statutory provision requires licensed heath care practitioners to make the notification.[45] An "adverse incident," as defined in other areas of Florida law, is "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 …."[46] The occurrence of an adverse incident does not necessarily mean that the incident was caused by a breach in the standard of care. Known complications from medical interventions and undesired outcomes can and do occur absent medical negligence. The Florida disclosure statutes implicitly recognize this reality and specifically state that the disclosure of an adverse event to a patient, in and of itself, "shall not constitute

40 *The Effects of "Early Offers" in Medical Malpractice Cases.*
41 Amy B. Witman et al., *How do Patients Want Physicians to Handle Mistakes? A Survey of Internal Medicine Patients in an Academic Setting*, 156 Archives Internal Med. 2565, 2569 (1996).
42 Anna C. Mastroianni et al., *The Flaws in State 'Apology' and 'Disclosure' Laws Dilute Their Intended Impact on Malpractice Suits,* 29 Health Aff. 1611 (2010), *available at* http://content.healthaffairs.org/content/29/9/1611.full.pdf [hereinafter *The Flaws in State 'Apology' and 'Disclosure' Laws Dilute Their Intended Impact on Malpractice Suits*].
43 *Id.*
44 Fla. Stat. § 395.1051.
45 *Id.* § 456.0575.
46 *Id.* § 395.0197(5).

an acknowledgment of admission of liability, nor can it be introduced as evidence."[47] Florida also has an apology law, similar to that in other states, declaring that "statements, writings, or benevolent gestures expressing sympathy or a general sense of benevolence relating to the pain, suffering, or death of a person involved in an accident and made to that person or to the family of that person shall be inadmissible as evidence in a civil action."[48] A statement of fault, however, whether it is part of the apology statement or in addition to such statement, is admissible as evidence.[49]

Communication and early offers of compensation

Research indicates that even when patients assert claims or suits, there is less cost and earlier resolution of claims and litigation when effective communication of adverse events occur. The Veteran's Affairs Hospital in Lexington, Kentucky (VA-Lex) and the University of Michigan Health System (UMHS), for example, instituted disclosure programs that require health care providers to communicate with patients whose care and treatment resulted in unexpected, undesired outcomes.[50] Since VA-Lex instituted its disclosure policy, average settlements substantially decreased compared to other VA hospitals without disclosure policies; claims processing times also were substantially reduced.[51] UMHS realized dramatic reductions in time, cost, and the number of claims and lawsuits over the first five years (2001–2005) of its institutional disclosure program; the average time to resolve 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.[52]

47 *Id*. § 395.1051; *see also id*. § 456.0575.
48 Fla. Stat. § 90.4026 (2).
49 *Id*. For other examples and variations, *see The Flaws in State 'Apology' and 'Disclosure' Laws Dilute Their Intended Impact on Malpractice Suits*.
50 Hillary Rodham Clinton & Barack Obama, *Making Patient Safety the Centerpiece of Medical Liability Reform*, 354 New Eng. J. Med. 2205, 2208 (2006), *available at* www.nejm.org/doi/pdf/10.1056/NEJMp068100 [hereinafter *Making Patient Safety the Centerpiece*]; *See also* Richard C. Boothman, et al., *A Better Approach to Medical Malpractice Claims? The University of Michigan Experience*, J. Health & Life Sci. L., Jan. 2009 at 125.
51 *Making Patient Safety the Centerpiece.*
52 *Id*.

In addition to disclosing medical events that have resulted in harming 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 filed.[53] Billing patients for situations in which medical mistakes were disclosed can add insult to injury, leaving patients to wonder why they should pay for the provider's mistakes. Coordinating the disclosure of errors with writing off bills for services related to the errors may frequently satisfy the patient and lessen his or her desire to file suit. Attorneys advising physicians and hospitals should be cognizant, however, that billing write-offs may trigger Medicare reporting requirements for Medicare beneficiary patients,[54] and systematic write-off of only the patient's portion of the bill can run afoul of federal law if the providers' charges are submitted to Medicare or Medicaid for payment.[55]

If verifiable damages resulted from the event, early offers of compensation may help resolve the matter earlier and more cost effectively than litigation. In addition to direct patient-physician, post-incident communication, using early mediation as an alternative dispute resolution effort to resolve medical malpractice claims can help facilitate and support meaningful communication between physicians and patients in a setting where relevant laws and rules of court can ensure confidentiality.[56] The Florida Patient Safety and Pre-suit Mediation Program (FLPSMP), established in 2008 by the University of Florida J. Hillis Miller Health Center Self-Insurance Program, is one such program that has produced a template for replication beyond the state of Florida.[57] An eight-year study of the FLPSMP revealed that meritorious patient

53 *The Effects of "Early Offers" in Medical Malpractice Cases.*

54 *Mandatory Insurer Reporting (NGHP): Mandatory Insurer Reporting for Non-Group Health Plans (NGHP)*, Ctrs. for Medicare & Medicaid Servs., www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Non-Group-Health-Plans/Overview.html (last visited July 12, 2017).

55 31 U.S.C. § 3729.

56 Randall C. Jenkins et al., *Mandatory Pre-Suit Mediation for Medical Malpractice: Eight-Year Results and Future Innovations*, Conflict Resolution Quarterly (Apr. 2017), *available at* http://flbog.sip.ufl.edu/wp-content/uploads/2017/06/Jenkins_et_al-2017-Conflict_Resolution_Quarterly.pdf. Note that not all states have mediation confidentiality privileges. Florida is among a number of states with such a privilege.

57 *Id.*

claims were resolved more quickly than the average resolution time of less than six months required to litigate, and that legal expenses in defending claims were reduced by 87%.[58] As important as these time and cost savings are, the FLPSMP process gives patients a real sense of being heard and understood. The process also provides an opportunity in a confidential setting to fully discuss why the incident occurred and what steps the physician will take to prevent the problem from reoccurring. The process further presents a platform to help preserve the physician-patient relationship.[59]

These early intervention and mediation programs used by VA-Lex, the University of Michigan, and the University of Florida can serve as blueprints for medical practice groups, hospitals, and academic medical centers nationwide, with appropriate modifications that take into account the laws of the particular jurisdiction in which each program exists.

Compassion: Giving soul to the heart of the protective factors

Competence, diligence, and communication form the heart of the protective factors that reduce lawsuits and damages therefrom, enhance patient safety, and improve the quality of the delivery of medical care to patients. It is the trait and skill of compassion, however, that infuses the soul into these protective factors. Compassion provides the additional incentive to maintain competence for the good of one's patients, and to remain diligent and vigilant, even when faced with daunting workloads and administrative and bureaucratic distractions.[60] Practicing with compassion extols benefits to all involved, reducing error-causing injury to patients, resulting in better outcomes, and reducing medical malpractice claims.[61]

Compassion and empathy are recognized as extremely important skills for physicians, but they may be difficult to develop and exhibit given physicians' busy schedules and limited time with patients in today's medical practice.

58 *Id.*
59 *Id.*
60 *See* Stephen G. Post, *Compassionate Care Enhancement: Benefits and Outcomes,* 1 Int'l J. Person Centered Med., 808 (2011), *available at* www.stonybrook.edu/bioethics/CCE.pdf.
61 *Id.* at 810.

These skills and mindsets are encouraged in medical education and training in classwork, seminars, and online training programs,[62] but compassion is often best taught by example. One such sterling example is Dr. Richard C. Christensen,[63] a former professor in the Department of Psychiatry at the University of Florida College of Medicine. "Dr. C," as he was affectionately known by his colleagues, resident physicians, and medical students, was a trailblazer in the teaching of effective physician-patient communication. Dr. Christensen was renowned as an expert teacher and was awarded the medical school's Hippocratic Award, the highest teaching honor bestowed upon the College of Medicine's faculty. Countless students, residents, and colleagues benefitted greatly by his "clinical pearls,"[64] time-honored concise teaching advice based on clinical observation and experience. Although his specialty was psychiatry, Dr. Christensen's pearls assisted all physicians, regardless of specialty, in learning how best to communicate with compassion, especially when physicians were confronted with patients who were angry or hostile or struggling with great internal conflict about their medical condition. Dr. Christensen rendered sage advice with a simple mnemonic, "PEACE," as an approach that still helps physicians better communicate and engage with patients in a constructive manner to foster better care and better patient compliance.[65] PEACE recommends that physicians demonstrate Presence, Empathy, Acceptance, Collaboration, and Empowerment. Dr. Christensen opined that physicians can effectively communicate in an empathic and compassionate manner when they:

62 Lisa Pevtzow, *Teaching Compassion: Humanities Courses Help Aspiring Doctors Provide Better Care,* Chicago Tribune, March 20, 2013, http://articles.chicagotribune.com/2013-03-20/health/ct-x-medical-school-arts-20130320_1_doctors-students-humanities.

63 Richard C. Christensen M.D. was tragically killed in a hit-and-run incident in 2015 while performing humanitarian services with Habitat for Humanity in Zambia, Africa.

64 *See* Melinda Fawcett, '*Christensen Pearls' Distributed to Psychiatry Clerkship and Interns*, UF Dep't of Psychiatry: Coll. of Med. (Aug. 7, 2016), *available at* http://psychiatry.ufl.edu/2016/08/17/christensen-pearls-distributed-to-psychiatry-clerkship-and-interns/ (The book was compiled by the University of Florida Department of Psychiatry Editorial Board for use as a teaching tool "to provide medical students and psychiatric interns with information to pass on Dr. Christensen's legacy of teaching.").

65 Richard C. Christensen, *Making 'PEACE' with Hostile, Unwilling Patients,* 3 Current Psychiatry 78, (2004).

- demonstrate by their Presence that the patient has the physician's undivided attention;
- convey Empathy by trying to understand that the patient may feel powerless, patronized, or coerced;
- show Acceptance of the patient's feelings of distress by acknowledging the patient's struggle and anger regarding his or her care and treatment;
- maintain Collaboration with the patient to form a therapeutic alliance; and
- Empower the patient to make choices in a manner that does not make the patient feel like he or she is being forced into the plan of care.

Conclusion

Today's legal and medical landscape consists of a number of risk factors that have either emerged or otherwise become more pronounced since the 1970s. By establishing effective medical and risk management practices that enhance the protective factors of competence, diligence, and effective, compassionate communication, physicians create a positive practice environment conducive to good physician-patient relationships. These protective factors can play an important role in minimizing the impact of the risk factors and helping to reduce the risk of having unanticipated medical outcomes turn into claims and lawsuits. J

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An earlier version of limited portions of this article was published by this author previously as, *From Patient to Plaintiff* (short form title) in *Risk, Rx.* April–June 2010, an internal publication of the J. Hillis Miller Health Center Self-Insurance Program for the benefit of the state of Florida's Professional Liability Self-Insurance Programs. Those components are re-printed with permission of the J. Hillis Miller Health Center Self-Insurance Program.