

A Friendly Approach to Reducing Medical Malpractice Litigation

Aaron A. Bucco

A Friendly Approach to Reducing Medical Malpractice Litigation

PLATO ON TRUST AND EFFICIENCY

The importance of efficient communication and appropriate bedside manner in the physician-patient relationship are not novel concepts derived to counteract increased medical malpractice litigation.¹ Patient confidence and trust in a treating physician were recognized as integral components of effective healthcare nearly 2,500 years ago when Plato distinguished between "slave medicine" and "medicine for free men".² To Plato, medicine should not be reduced to a scientifically empiric endeavor.³ He acknowledged that a treating physician has a responsibility to learn from the patient and establish trust.⁴ In a time where efficiency dangles the monetary carrot before an over-worked core of medical practitioners, perhaps the teachings of Plato offer a powerful incentive for physicians to slow down.

SCOPE OF ANALYSIS

This manuscript offers a brief analysis of the correlation between doctor-patient relationships and medical malpractice lawsuits. The focus of the analysis, however, does not include circumstances where a potential claim of medical malpractice is based on the

¹ President George W. Bush continuously attacks "frivolous lawsuits" filed against medical professionals as driving up the overall cost of healthcare to Americans. The issue has been a significant component of the President's call for health care reform. In a speech given by President Bush at the Medical College of Wisconsin in February of 2002, the President stated to a receptive audience: "Frivolous lawsuits drive up insurance premiums for everybody, and discourage employers from offering employee coverage at all. It is really important to remember that we want to help doctors to heal, not encourage lawyers to sue." President George W. Bush, Address at The Medical College of Wisconsin (Feb. 11, 2002), *available at* <http://www.whitehouse.gov/news/releases/2002/02/20020211-4.html>.

² Mark Siegler, M.D., *Lessons from 30 Years of Teaching Clinical Ethics*, Virtual Mentor, at <http://www.ama-assn.org/ama/pub/category/6557.html> (last modified May 16, 2002) (quoting Plato, *The Laws* 104-05 (A.E. Taylor trans., Dent & Sons Ltd.) (1943)).

³ *Id.*

⁴ *Id.*

tort principle of *res ipsa loquitur*⁵ or the common knowledge rule.⁶ The scope of this analysis is limited to situations where all the elements necessary to support an action for medical malpractice on a theory of negligence may be established,⁷ and where the negligent act of the physician is not so egregious as to allow a jury to clearly find a breach of the medical standard of care without assistance from a medical expert. The principles of physician-patient interaction rarely shield an overtly negligent medical professional from patient retaliation, but systematic desensitization of doctors to the psychological needs of their patients is damaging more than just the reputation of the medical profession.

By establishing that compassion and attention beyond mere symptoms help to alleviate the threat of malpractice litigation in some circumstances, a critical element of the overall care of a patient may be improved by giving medical professionals an incentive they truly appreciate.

DEVELOPING TRUST

Doctors are traditionally respected for their dedication to a profession that is as demanding as it can be rewarding. Individuals who undertake the study of medicine in America dedicate a substantial portion of their lives to gaining minimum proficiency. For the same reason resident physicians have a rigorous and extensive training schedule, medicine is a mystical concept to the layperson. Aside from chicken soup when seasons

⁵ *See, e.g.*, *LeFaive v. Asselin*, 247 N.W. 911 (Mich. 1933).

⁶ *See, e.g.*, *Wolford v. St. Paul Fire & Marine Ins. Co.*, 961 S.W.2d 743 (Ark. 1998).

⁷ For an analysis of the elements of medical malpractice and further discussion of the common knowledge rule, *See, Locke v. Pachtman*, 521 N.W.2d 786 (Mich. 1994).

change and Tylenol to ease the pain, most individuals must trust their treating physician when serious illness or injury strikes.

But what happens when the patient stops trusting the doctor? With medical malpractice lawsuits attracting the attention of legislators and media, it is only natural for potential patients to question the once pervasive "doctor knows best" mentality.

One doctor writing for the New York Times encourages other physicians to inform their patients when they have made any error.⁸ Dr. Richard A. Friedman notes that when a doctor admits fault, they become human in the eyes of the patient and the interaction builds trust.⁹ It may seem awkward to suggest that acknowledging a mistake builds trust, but a physician's transparency may act as the most powerful defense against medical malpractice litigation. A treating physician typically receives no room to err by a patient when the physician holds herself out to be infallible.¹⁰ A physician humanized through admission of her faults, however, is afforded all characteristics of her human nature, including imperfection. A patient is, thus, less likely to file a grievance or institute a civil action when she is made aware of and chooses to accept the imperfections of her treating physician.

While Dr. Friedman's principle is sound in theory, the compulsive personalities and narcissistic traits of medical professionals cultivated throughout their medical

⁸ Richard A. Friedman, M.D., *Learning Words They Rarely Teach In Medical School: 'I'm Sorry'*, N.Y. Times, July 26, 2005.

⁹ *Id.*

¹⁰ Plato described the physician practicing slave medicine as: "The physician never gives the slave any account of his complaints, nor asks for any; he gives some empiric treatment with an air of knowledge in the brusque fashion of a dictator, and then is off in haste to the next ailing slave...." Mark Siegler, M.D., *Lessons from 30 Years of Teaching Clinical Ethics*, Virtual Mentor, at <http://www.ama-assn.org/ama/pub/category/6557.html> (last modified May 16, 2002) (quoting Plato, *The Laws* 104-05 (A.E. Taylor trans., Dent & Sons Ltd.) (1943)).

training make "I'm sorry" a significant challenge.¹¹ John Banja, a clinical ethicist at Emory University describes error as a problem related to the psychology of the physician.¹² If a physician is forced to apologize, "he must confess his incompetence [and] withstand the recriminations of his or her conscience."¹³ In order to be an effective physician, doctors must acknowledge their ability to err and humble themselves through apology. An individual defined by the practice of medicine cannot withstand the humiliation of medical error. The frustration and perception of incompetence is repressed and ultimately transferred onto the patient through rude and impatient behavioral manifestations. The repression and subsequent transference destroys the doctor-patient trust and subjects the physician to malpractice litigation.

Physicians must deal with questions of identity very early in their careers to act as effective patient-centered healthcare providers. Acknowledging physical and mental limitations is an essential component of resolving questions of identity. By embracing his own humanity, a physician not only relieves his psyche of a tremendous burden, but also potentially diffuses the resentment otherwise fostered by affected patients.

Despite suggestions by clinical ethicists and practicing physicians, medical professionals rarely see themselves as the root of the medical malpractice crisis.¹⁴ Without assuming responsibility, physicians and other healthcare professionals are turning to methods of protection that foreshadow severe consequences in healthcare.

¹¹ Philip Hébert, MD, *Medical Errors and Medical Narcissism*, 294 *Journal of the American Medical Association* 1, 115-16 (July 6, 2005) (book review).

¹² JOHN BANJA, *MEDICAL ERRORS AND MEDICAL NARCISSISM* 197 (2005).

¹³ *Id.*

¹⁴ Surgeon Michael Woods, founder of Doctors In Touch, a firm designed to improve the bedside manner of physicians, reports that in his focus groups practitioners unanimously agree that poor communication is a problem. Dr. Woods further reports that practitioners unanimously agree that they don't suffer from poor communication skills with their own patients. Sarah A. Klein, *Tough sell: good bedside manner; Few docs think they need help communicating*, *Crain's Chicago Business*, Sep. 25, 2004, available at http://www.doctorsintouch.com/publications_michael_woods.htm.

DOCTORS REACTIONS CREATE ADVERSARIAL RELATIONSHIPS

In an article written for the International Risk Management Institute in 2004, Charles Kolodkin of The Cleveland Clinic describes different tactics medical professionals are trying in response to the seemingly never-ending climb in insurance premiums.¹⁵ Doctors have responded over the years by publicizing their concerns, seeking rate relief from insurance regulators, and lobbying legislatures for tort reform, but new tactics advocated by insurance providers and hospitals are more direct and potentially disabling to the profession.¹⁶

For example, advisors instruct physicians to evaluate a prospective client's propensity to sue prior to offering treatment.¹⁷ Healthcare providers are asking patients to sign a form prior to treatment whereby they agree not to litigate in the event of medical error.¹⁸ Some doctors avoid patients who have sued for medical malpractice in the past regardless of the merits of the previously filed claim.¹⁹ These new tactics provide case-by-case solutions to an industry-wide problem, not to mention the severe civil liberties implications presented through screening techniques. The new tactics discussed by Kolodkin may, though likely do not, help shield an individual doctor from liability in some cases. However, the psychological effect that such tactics have on patients cannot be overlooked.

The new screening mechanisms pre-dispose a patient to an adversarial relationship between doctor and patient. The psychological principle of primacy suggests

¹⁵ Charles Kolodkin, *Physicians: Frustrated and Fighting Back*, International Risk Management Institute (May 2004), at <http://www.irmi.com/Expert/Articles/2004/Kolodkin05.aspx>.

¹⁶ *Id.*

¹⁷ *Id.*

¹⁸ *Id.* The forms force any claims of malpractice to go through arbitration.

¹⁹ *Id.*

that if the patient is given a reason to distrust or resent the doctor within the context of their initial meeting, the doctor will have a difficult time regaining the patient's trust thereafter.²⁰ Further, if a patient feels they are not trusted, they are likely to more critically evaluate actions taken by the physician throughout treatment. Thus, while the screening procedures may give physicians piece of mind by allowing them to take an active role in malpractice litigation prevention, the bad blood created by pitting a physician against a patient may inadvertently increase litigation.

A better alternative is to foster a compassionate relationship to relax the patient. If a treating physician gains the trust of the patient, they are less likely to be under the microscope throughout treatment. It is relatively easy to acknowledge that regardless of a patient's propensity to sue, a calm patient that feels their emotional and physical needs are met is less likely to sue than a patient faced with an adversarial patient-physician relationship.

After discussing the various methods employed by doctors and hospitals to shield themselves from potential claims of medical malpractice, Kolodkin rejects the new tactics and suggests alternatives he considers more helpful in fighting back.²¹ Kolodkin recognizes that appropriate bedside manner goes a long way in reducing a healthcare provider's exposure to liability. However, in his analysis of "risk management", he combines principles of litigation prevention with those of litigation preparation.²² Kolodkin suggests that appropriate bedside manner and comprehensive documentation of

²⁰ "A primacy effect occurs when the items at the beginning of a list are learned faster and remembered better." James R. Ogden & Don Sharpsteen, *The Psychology Problem Solver* 110 (Research & Education Association 2003) (1980).

²¹ Kolodkin, *supra* note 15, at ¶ 9.

²² *Id.* at ¶ 10-11.

patient treatment should both be considered methods of risk management.²³ While both methods are certainly beneficial to a physician, the methods become relevant at different stages of a malpractice analysis. Better patient-physician relationships decrease the filing of malpractice actions, while comprehensive documentation of patient care is crucial to defense against malpractice actions. The more cost-effective strategy addresses the filing of malpractice actions, not the mere likelihood of success, since pre-trial malpractice defense expenses are substantial. For this reason, medical professionals should adopt methods to strengthen patient-physician relationships. Adopting proper bedside manner techniques and improving communication between physician and patient will not only reduce the number of medical malpractice actions filed, but will also decrease the number of errors made by physicians.²⁴

Kolodkin inadvertently raises an important issue for healthcare providers interested in fighting back against medical malpractice lawsuits. Before choosing an action, a physician or administrative body is responsible for determining whether the goal is to adopt procedures to prevent malpractice litigation, or malpractice liability. While the analysis herein does not necessarily reach methods beyond improving patient-doctor interaction to prevent liability, mere prevention of liability does not remove the cost of litigation that ultimately sustains insurance premiums.

The profound benefits of proper bedside manner and communication skills are particularly attractive as a means to prevent litigation, but the principles also prevent liability. Improving the physician-patient relationship, therefore, is a unique and cost-effective alternative to address the medical malpractice crisis.

²³ *Id.*

²⁴ Byron Spice, *Pitt wants to improve how doctors talk, listen to patients*, Pittsburgh Post-Gazette, August 27, 2003.

BEDSIDE MANNER HELPS JURORS UNDERSTAND THE STANDARD OF CARE

Jurisdictions differ on which standard of care is used to determine a physician's liability, but many states examine whether or not the physician acted "acceptably" or "reasonably".²⁵ The law, thus, recognizes that medicine is not an exact science, a concept that may be subconsciously ignored by members of a jury. In a case of negligence as grounds for medical malpractice, a doctor presented to the jury as cold and indifferent may be characterized as a machine and held to a standard of perfection. The subjective "reasonable care" standard in medical malpractice litigation would therefore be abandoned by members of the jury in favor of an injury = liability mentality. The defendant doctor, in this situation, is expected to have performed flawlessly, as opposed to reasonably, as the standard requires.

Steve Forbes, in a recent editorial comment, suggests that members of a jury lacking medical training contribute substantially to the success of legally non-meritorious claims and irrational awards.²⁶ Forbes also states that President Bush's proposed cap on non-economic damages addresses the crisis, but does not effectively get to the root of frivolous malpractice litigation to the same degree that impartial experts of an independent tribunal could.²⁷ Forbes, along with Senators from Wyoming, Montana, and Texas support legislation creating medical courts, much like those of tax, bankruptcy and patents.²⁸ The medical courts may prove more effective at limiting excessive awards and

²⁵ For examples of the law in Pennsylvania and Michigan, See, e.g., *Jones v. Chidester*, 610 A.2d 964 (Pa. 1992), *Locke*, 521 N.W.2d 786.

²⁶ Steve Forbes, *Junking Judicial Malpractice*, Forbes.com; Notes and Comments, ¶ 7 (Sep. 21, 2005), at <http://www.forbes.com/forbes/2005/1010/033.html>.

²⁷ *Id.*

²⁸ *Id.*

ferreting out non-meritorious claims, but they do not address the costs of litigation inherent in the initial defense of such claims.

Nonetheless, training medical professionals to be more effective in their interactions with patients addresses the concerns of Forbes and others, and further, limits the number of frivolous lawsuits initially filed. Doctors, by communicating more effectively with patients and humanizing themselves as a method to reduce medical malpractice litigation, will humanize the medical profession as a whole and allow individuals to better comprehend and apply the reasonable care standard.

COMMUNICATION SKILLS ESSENTIAL TO PROPER TREATMENT

In 2003, The University of Pittsburgh School of Medicine publicly recognized the benefits of clear patient communication when it opened the Institute for Doctor-Patient Communication.²⁹ The faculty of the University of Pittsburgh understands that effective communication skills are the best diagnostic tool a physician can hold.³⁰ In a statement announcing the new institute, Dr. Arthur S. Levine said, "The fundamental relationship between a doctor and his or her patients is really the soul of the medical profession."³¹

Dr. Robert M. Arnold illustrated the importance of proper communication by telling the story of a resident practicing under the doctor's supervision.³² The resident asked a patient, "[t]ell us about the pills you put in your mouth."³³ The resident then

²⁹ *Id.* The University of Pittsburgh School of Medicine lists as the top skill objective of the curriculum, "Conduct effective patient interviews and obtain a complete medical history using appropriate communication skills." *available at* <http://www.omed.pitt.edu/curriculum/publications/learnObj.html>

³⁰ *Id.*

³¹ *Id.* Dr. Arthur S. Levine is dean of the medical school and senior vice chancellor for health sciences.

³² Spice, *supra* note 24.

³³ *Id.* By phrasing the question in this way, as opposed to simply asking what medications the patient is taking, the question includes vitamins, herbs and complementary medicines the patient prescribes themselves that might otherwise be overlooked in a response.

asked the patient, "[a]re you having any trouble taking them?"³⁴ The follow-up question allowed the patient to relate that he had difficulty swallowing some of the pills and was breaking the capsules and eating the powder.³⁵ By breaking the capsules prior to taking the medication, however, the patient negated any benefit of the drug.³⁶

Physicians avoid critical mistakes in diagnosis by effectively communicating with a patient. Proper patient care extends beyond the medical background check and diagnostic questions currently utilized by most physicians, although programs such as that developed by the University of Pittsburgh will certainly help improve overall patient care. A patient must feel comfortable enough to convey all potentially relevant information to the doctor, and a patient's comfort is necessarily contingent on a physician's bedside manner.

Patients often do not know what information is relevant to a diagnosis and may inadvertently withhold facts critical to an accurate diagnosis or treatment plan. By communicating with the patient and engaging in conversation rather than simply reviewing charts and intake information, doctors and other health care professionals make the patient an important component of the diagnostic process. A cursory review of existing documents and line item questions effectively remove the patient and their wealth of information from decisions effecting appropriate treatment. Without patient involvement, treating physicians are prone to err. Just as a defense attorney in a medical malpractice action benefits from comprehensive documentation of patient care,³⁷ a doctor is much better prepared to accurately diagnose and treat patient illness when the patient

³⁴ *Id.*

³⁵ *Id.*

³⁶ *Id.*

³⁷ Kolodkin, *supra* note 15, at ¶ 10.

and doctor effectively communicate. Effective communication, thus, not only creates comfort for the patient and trust in the doctor, it serves to eliminate preventable physician mistakes facilitated by the demands of managed healthcare.

THIS CALL *SHOULD* BE MONITORED

Research as early as 1995 indicates that whether or not a malpractice suit is filed against a doctor is related more to the interpersonal skills of the doctor than to their actual negligent performance.³⁸ For example, Vanderbilt researchers interviewed 963 Florida women regarding their level of satisfaction with their obstetrician-gynecologist.³⁹ The doctors were then placed into 4 groups, reflecting how frequently they had been sued for malpractice.⁴⁰ A panel of experts were given the medical records of the various doctors without any indication of the doctors group assignment.⁴¹ The panel reviewed records for indications of competence, but were ultimately unable to find any difference in the quality of care offered by the physicians who had been sued least and those physicians who had been sued most.⁴² Significant differences, however, were readily apparent when researchers examined the responses of the female patients. "The doctors who were sued the most elicited twice as many complaints from the women as those who had never been sued. Invariably, the women felt that they were rushed or ignored on their visits, or that their questions were not answered."⁴³

³⁸ Psychology Today Staff, *Only the rude get sued*, Psychology Today, May-June 1995.

³⁹ *Id.*

⁴⁰ *Id.*

⁴¹ *Id.*

⁴² *Id.*

⁴³ Psychology Today, *supra* note 38.

Patient care must be broadened to include the concept that patients actually care. Hospitals must take notice of the fact that a patient's satisfaction with their treatment extends beyond accurate diagnosis and resolution or prevention of illness. Admittedly, notions of privacy are elevated in the context of a patient-gynecologist relationship, but the overarching principle, nonetheless, remains. Patients are demanding to be treated with respect and individual attention. The above-referenced research conducted by Dr. Gerald Hickson and others at Vanderbilt University provides a powerful incentive for hospital administration and managed healthcare executives to monitor the interactions their doctors have with patients. A cost-benefit analysis may prove that eliminating brilliant but rude doctors is more effective at limiting costs associated with medical malpractice litigation than eliminating those patients with a propensity to sue.⁴⁴

"CRISIS"

Some commentators challenge the notion that a crisis exists concerning medical malpractice litigation.⁴⁵ In the midst of President George W. Bush pushing for a hard-cap of \$250,000 on medical malpractice awards for non-economic damages, a fifteen-year analysis in the President's home state of Texas attempts to offer evidence that no crisis exists in that state.⁴⁶ The study, conducted from 1988 to 2002, found that the number of claims per physician actually declined from 1995 to 2002.⁴⁷ The researchers further

⁴⁴ For an analysis of tactics being used by medical professionals to limit liability such as eliminating patients with a propensity to sue, *See* Kolodkin, *supra* note 15.

⁴⁵ Ceci Connolly, *Malpractice Situation Not Dire, Study Finds: Analysis of Texas Claims Finds 'Sea of Calm,' Overall Stability in Tort System*, Washington Post, March 10, 2005, at A08.

⁴⁶ *Id.*

⁴⁷ *Id.*

disputed any claim of a crisis by tracking a six million dollar annual decrease in total payouts resulting from medical malpractice lawsuits.⁴⁸

While the results of the study may seem enlightening at a time when White House officials site Texas as among the top twelve states where the crisis rages on, the research has several limitations. First, the researchers do not account for defensive medicine practices employed by physicians to counteract the threat of medical malpractice litigation.⁴⁹ Second, the research focuses attention on the decrease in annual payouts resulting from malpractice suits, but does not evaluate the costs associated with measures taken by healthcare providers to mitigate suits or defend against unsuccessful suits.⁵⁰ The authors of the research actually concede that although the frequency of claims decreased, legal defense costs rose.⁵¹

Even research suggesting a decrease in the claims filed against healthcare professionals can be misleading. Doctors practicing in fields associated with high rates of failure are losing incentives to remain in areas prone to malpractice litigation, since they cannot afford malpractice insurance in those areas. In response to the perceived crisis, the Texas legislature capped non-economic damages in 2003.⁵² In the 18 months following the cap, one major insurer reduced malpractice premiums by seventeen percent.⁵³

Empirical evidence regarding malpractice litigation is easily misleading considering the intricacies that affect pressures felt by healthcare professionals.

⁴⁸ *Id.*

⁴⁹ *Id.*

⁵⁰ Connolly, *supra* note 45.

⁵¹ *Id.*

⁵² *Id.*

⁵³ *Id.*

Regardless of the significance or limitations of the longitudinal studies, the fact remains that an overwhelming number of physicians are lobbying for tort reform, and the same pressures have not been applied with similar force to insurance providers.

While recent research suggests that the frequency of medical malpractice claims will decrease by 1% overall in 2006, the same research predicts that the average size of medical malpractice claims will increase by 7.5%.⁵⁴ An assistant director and actuary for Aon, the Illinois-based insurance brokerage firm responsible for the study, expects the frequency of medical malpractice claims to decrease in Pennsylvania, Texas, Florida, and California, four states that have enacted legislative reforms to limit malpractice claims.⁵⁵ The representative for Aon further suggested that states who have not enacted such legislation can expect continued increase in medical malpractice claims.⁵⁶ Earlier this year, the governors of Illinois, Maryland, Mississippi, and Texas individually addressed the need for action in response to the medical malpractice litigation crisis in their respective states.⁵⁷

The American people, nonetheless, are not convinced that a medical malpractice litigation crisis exists. A publication by the Association of Trial Lawyers of America notes that in a recent survey, malpractice lawsuits were the second-to-last of twelve

⁵⁴ Medical News Today, *Medical Malpractice Claims on the Decline, Study Says, USA* (Oct. 20, 2005), at <http://www.medicalnewstoday.com/medicalnews.php?newsid=32267>.

⁵⁵ *Id.*

⁵⁶ *Id.*

⁵⁷ The governors of the four states designated portions of their 2005 State of the State Address to the medical malpractice crisis and the need for reform. Rod R. Blagojevich, Illinois State of the State Address (Feb. 3, 2005), available at www.illinois.gov/gov/sosspeech2005.cfm. Robert L. Ehrlich, Jr., Maryland State of the State Address (Jan. 27, 2005), available at www.gov.state.md.us/speeches/sots2005WEB.html. Rick Perry, Texas State of the State Address (Jan. 26, 2005), available at www.governor.state.tx.us/divisions/press/speeches/speech_012605. Haley Barbour, Mississippi State of the State Address (Jan. 11, 2005), available at www.governorbarbour.com/StateoftheState.htm.

health-related concerns that Americans say need addressed by the Bush administration.⁵⁸ Regardless of American perceptions surrounding medical malpractice litigation in the country, medical professionals are uniformly concerned with the rising medical malpractice insurance premiums they are forced to pay. Nearly two-thirds of Americans surveyed ranked lowering the cost of healthcare and health insurance their top concern.⁵⁹ By initiating programs that reduce medical malpractice litigation, or by convincing doctors to adopt certain principles of patient-client interaction to reduce malpractice litigation, malpractice insurance premiums will likely decrease. Americans likely overlook the fact that economic benefit to medical professionals will ultimately resurface as economic benefit to the public. Thus, by addressing concerns of malpractice litigation, the number one health-related goal of the American public will be achieved.

OPTIONS

It is easy to suggest that doctors simply improve communication skills with patients as a means to decreasing the amount of medical malpractice litigation, but creating cost effective and efficient training programs for physicians is a more daunting task. Various medical schools across the nation, however, have taken the initiative to develop such programs in an attempt to sensitize their students to the psychological needs of patients.

For example, University of Minnesota students training to become pediatricians supplement communication skills training with the "Parents as Teachers Project."⁶⁰

⁵⁸ Rebecca Porter, *Malpractice Lawsuits are Low-Priority Health Care Issue, Survey Finds*, 41 *Journal of Trial Lawyers of America* 18, 18 (2005).

⁵⁹ *Id.*

⁶⁰ Rebecca A. Clay, *Psychologists help students curb medical machismo*, 29 *APA Monitor* 3, (1998).

Through the program, students visit the homes of patients with disabilities.⁶¹ Doctors are often frustrated by their inability to medically treat permanent disability, and their frustration sometimes translates into impatience.⁶² Students, by witnessing more natural child interactions with the environment, are able to observe the child in a capacity other than that of patient. With insight into the child's everyday life, the medical student is more likely to treat the patient, and also the parents of the patient, as people first and patients second.

Dr. Susan H. McDaniel of the University of Rochester School of Medicine and Dentistry suggests videotaping doctor-patient interactions to help alert patients to previously ignored habits.⁶³ The University of Rochester also encourages students in their medical programs to participate in small group discussions to communicate anxieties and the defenses they have developed to manage feelings.⁶⁴ The pressures of managed health care are very real to practicing physicians and medical school professors. The University of Rochester has acknowledged the importance of allowing young physicians to learn the intricacies of their own psyche so that they can become more effective in practice.

Programs like that instituted by the University of Rochester help students effectively manage their psychological reactions to the practice of medicine as they develop. Students are thus given the opportunity to understand themselves before they

⁶¹ *Id.*

⁶² *Id.*

⁶³ *Id.*

⁶⁴ *Id.*

retreat behind the impenetrable shield of indifference that subjects them to medical malpractice litigation.⁶⁵

Dr. James H. Bray, as an associate professor of family and community medicine at Baylor College of Medicine in Houston, heads a program that allows professors to watch students interact with patients live via video feed.⁶⁶ The student meets with professors before, once during, and immediately following the patient interactions for feedback - much like a graduate student of psychology is evaluated throughout actual sessions with clients.⁶⁷ The goal, says Bray, is to teach physicians basic psychology skills such as clear communication, problem-solving and behavioral interventions.⁶⁸ Social psychology is a broad field of study with strong relationships to professional service industries. It is clear that basic knowledge of psychological principles help physicians effectively communicate with patients. Convincing young physicians of the same, however, is a challenge.

Dr. Gerald P. Koocher, an associate professor of psychology at Harvard Medical School understands that medical students are unlikely to give psychological principles the weight they deserve.⁶⁹ In training physicians, Dr. Koocher translates inherently psychological principles into biomedical goals.⁷⁰ For example, instead of explaining the psychological responses a patient will have to line item monotone orders issued by their treating physician, Dr. Koocher explains to students that patients are more likely to follow their advice if the instructions are offered in a less authoritative manner.⁷¹

⁶⁵ For more information on the importance of physician psyche, *see* Banja, *supra* note 12.

⁶⁶ Clay, *supra* note 60.

⁶⁷ *Id.*

⁶⁸ *Id.*

⁶⁹ *Id.*

⁷⁰ *Id.*

⁷¹ Clay, *supra* note 60.

Koocher explains the psychological approach to bedside manner as, "... a question of the physician making patients partners in care rather than passive battlegrounds on which the war against disease is being fought."⁷²

Given the aversion to principles of social sciences that many physicians share, introducing courses in basic principles of psychology as a required portion of medical school curriculum helps to facilitate several of the suggested methods of reducing malpractice litigation. The administration and faculty of the institutions, however, must fully support the introduction of social science courses into the curriculum in order for students to take them seriously. Students form strong biases based on the preferences and beliefs of those responsible for their education, and apathy to the social sciences generally would poison any benefit to the healthcare industry the courses may bring. Educating the educators themselves as to the benefits of improved bedside manner and communication skills, therefore, may be the first step to acceptance of psychological methods in healthcare as a means to reducing medical malpractice litigation and liability.

CONCLUSION

Doctors feel like their backs are against the wall. They are required to log extraordinary hours and restrict defensive medicine practices in order to benefit from managed healthcare arrangements, while the threat of medical malpractice litigation seemingly consumes their thoughts and prosperity. It is almost as if in the complex business of medicine, the patient is lost. If healthcare professionals take the initiative to

⁷² *Id.* For additional suggestions for improving patient-doctor relationships and communication as a means to preventing medical malpractice litigation, See Wendy Levinson, MD et al., *Resolving Disagreements in the Patient-Physician Relationship*, 282 *Journal of the American Medical Association* 15, 1477 (1999).

recognize the patient as the center of medicine, however, they may get more than they bargained for.

Acknowledging the physical and emotional needs of patients has the potential to effectively stop the patient from demanding, through litigation, what they are currently not receiving... attention. This is not to suggest that all medical malpractice claims arise out of a selfish desire to be noticed. Doctors do, however, have a tremendous amount to do with patient satisfaction beyond mere relief of symptoms. Attention to a patient through listening skills, compassion, and other communication techniques not only reduces the risk of patient-doctor miscommunication leading to medical error, but also relaxes the patient and allows the doctor to properly influence recovery.

Patient care is an inclusive concept that incorporates patient comfort and trust. Without these essential elements, healthcare professionals leave themselves vulnerable to medical malpractice litigation. Medical schools and other institutions dedicated to improving the medical community have renewed their emphasis on complete patient care in light of increased medical malpractice litigation, but such emphasis is futile unless medical professionals begin to incorporate compassion and more effective communication into their everyday interactions with patients. For physicians to adopt principles of effective communication and appropriate bedside manner, they must penetrate the emotional calluses they have developed and admit there is a problem with their current methods of practice.

Physicians are forced to protect their emotions in a field where so much is at stake. A seemingly minor oversight has the potential to create severe medical consequences for any given patient. Faced with this reality, doctors build defenses. The

defenses sometimes strip the physician of the humanity that initially drove them to the practice of medicine. Pressures from managed healthcare organizations only add to the stress felt by practitioners and force physicians to hide further behind their emotional barriers.

Patients are reacting to those emotional barriers and defenses. Patients mistake the doctor's reality-protection for disinterest. It is essential for physicians to find healthier methods to cope with the pressures that accompany practicing medicine in increasingly complex healthcare systems. A physician's psychological foundation is a crucial component of effective patient care today, but regardless of a physician's willingness to soul-search, he or she must recognize the importance of improving physician-patient communication and adopting favorable bedside manner techniques.

The medical malpractice crisis is in many ways a patient-driven response to an industry-wide deviation from patient-centered care. Nearly 2,500 years ago Plato distinguished between "slave medicine" and "medicine for free men".⁷³ While the categories today may be appropriately labeled "medicine for men as inventory" and "medicine for free men", the distinction is no less instructive.

The patient will always be the center of medicine. Until the lessons of Plato are understood, patients will continue to demand the attention they deserve by hitting an industry scarred by capitalist tendencies where it hurts. By communicating effectively with patients and offering the psychological support they deserve, medical professionals can effectively return to practicing medicine for free men and in the process limit medical malpractice litigation.

⁷³ Siegler, *supra* note 2.