THE ROLE OF DOCTOR-PATIENT COMMUNICATION IN PREVENTING MALPRACTICE COMPLAINTS

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Abstract

An efficient doctor-patient communication represents a clinical obligation for any physician, an essential part of the therapeutic act, with the purpose of contributing to establish a doctor-patient relationship based on trust, generating benefits for the physical and mental health state of the patient. Malpractice complaints are a real burden for the health system, with negative consequences on the doctors, patients and the whole society. Thus, all the health systems in the world are constantly concerned with identifying new methods of preventing and diminishing the risk of malpractice complaints. The research in this field showed the importance of establishing an efficient doctor-patient communication because of its positive influence on the therapeutic act and also because of its potential to decrease the risk of malpractice complaints. An efficient doctor-patient communication is favoured mainly by the degree of education – both of the doctor and of the patient.

Keywords: *communication, malpractice, risk, physician, patient, education*.

1. INTRODUCTION

Malpractice complaints represent an important burden for the health system and for society through their economic and non-economic consequences. The economic consequences refer to the compensations granted to patients for the damages suffered and the practice of a defensive medicine which leads to increasing costs for further laboratory investigations and an increase in the number of days spent in the hospital. The non-economic consequences concern on the one hand the physicians who show frustrations, feelings of helplessness in the case of unjustified malpractice complaints and a lack of professional satisfaction that can lead to abandoning their job (especially in the specialties with an increased risk) and on the other hand the society by reducing access to certain medical services because of the doctors' fear of possible malpractice complaints.

In these conditions, preventing the situations that can lead to malpractice complaints is an important and constant preoccupation of health systems all over the world (HICKSON *et al.*, 1992).

2. THE IMPORTANCE OF DOCTOR-PATIENT COMMUNICATION IN CONTEMPORARY MEDICINE

Communication in medical practice is an obligation of the physician that cannot be delegated because much of the information that is essential for establishing the correct diagnostic and adequate therapy is obtained during the clinical interview and during the doctor-patient interaction. Besides that, the doctor's interpersonal skills influence a great deal the patient's satisfaction, his adherence to treatment, also influencing in a positive way the results of the treatment. For example, blood pressure decreases more for the patients who could express their concern about their health state without interruptions during their interaction with the physician. If the doctor collaborates with the patient when identifying the nature and gravity of the patient's health problems, this will lead to a decrease in their impact or even to solving them. Also, if the doctor explains and the patient understands the care provided, this may not solve the patient's health problems, but will lead to an increased therapeutic adherence on the one

hand and will decrease duration of hospitalization and further morbidity, on the other hand (AMBADY *et al*., 2002, SIMPSON *et al*., 1991).

The problems in doctor-patient communication are frequent and they influence in a negative way the therapeutic management of the patient, as they may be generated by the short amount of time allocated to the discussion and also by its quality and results. For example, studies have shown that the physician interrupts the patient's speech after an average of 18 seconds, which does not allow the patient to contribute efficiently to the act of communication. The physician often perceives in a wrong way the type and quantity of information the patient wants to receive and many times uses an unclear language either as a result of a too technical vocabulary, or because they give the relatively common words different meanings. Cultural differences can, in their turn, prevent communication with the patient. All these things make many patients neither understand nor remember what their physician said about the diagnostic and treatment (ADAMSON *et al*., 1989, AMBADY *et al*., 2002).

Poor doctor-patient communication also has a larger impact, as it contributes a lot to the increasing dissatisfaction of the public towards the medical profession (AMBADY *et al*., 2002).

3. THE POOR DOCTOR-PATIENT COMMUNICATION AND THE RISK FOR MALPRACTICE COMPLAINTS

Traditionally it is considered that the risk of a malpractice complaint is motivated by factors that are related to the doctor, work volume or the occurrence of some unpredictable circumstances. This approach has been reconsidered in the light of recent research that has shown that the risk appears not to be predicted by the characteristics of the patient, the complexity of the disease, and even the physician's knowledge and skills but mainly by the patient's dissatisfaction regarding the physician's ability to establish a relationship, provide treatment in line with his/her expectations and communicate effectively (HICKSON *et al*., 2002). Generally the patient's decision to sue the doctor for malpractice is influenced by the quality of the doctor - patient / family relationship (LESTER & SMITH, 1993) and most patients' complaints are not related to the professional behaviour of the doctor but to communication problems. Often, the patient's anxiety and dissatisfaction are related to uncertainty and lack of information, explanation and feedback from the doctor (ADAMSON *et al*., 1989, AMBADY *et al*., 2002).

Although professional competence is essential for the good conduct of the medical act, it correlates only to a small extent with malpractice complaints. There are, therefore, other factors that initiate them, such as the quality of doctor-patient communication, the perception of the patient that the doctor is guilty of the unfavourable outcome of the treatment provided, which generates the patient's desire to turn against the doctor, regardless of his professional competence (MOORE *et al*., 2000).

Lester and Smith, introduce the notions of "positive communication" and "negative communication."

Positive communication from the doctor denotes care and concern and is likely to lead to favourable outcomes for the patient's health and to reduce the risk of malpractice complaints because the doctor is perceived by the patient as taking care of him and acting in good faith.

The negative communication of the physician denotes a lack of care and violation of the humanistic values of the doctor-patient relationship. Under these circumstances, the patient may think that the doctor has done something wrong even before he knows the results of the treatment, which creates the premises for a malpractice complaint if the results are unfavourable. The doctor who establishes negative communication with the patient is perceived as more negligent than the one who uses positive communication, even if there is no negative result. Thus, negative doctor - patient communication is likely to diminish the perception of the doctor's competence and to favour the expressed intention to file a malpractice complaint. As a consequence, the physician who communicates with the patient in a negative manner has a higher risk of being filed for malpractice than the one who communicates in a positive manner (MOORE *et al*., 2000).

Communication does not increase the quality of the medical act from a technical point of view, but it can prevent a malpractice complaint even when something is clearly wrong and even when the doctor's fault is clear.

Patients typically want more information than doctors provide. The latter may disregard the patients' concerns through: discouraging questions, disrupting the discourse, and focusing on getting medical history without being interested in psycho-social issues that may have an important impact on the results of the therapeutic act (ADAMSON *et al*., 1989).

Gardner believes that the most common reasons for malpractice complaints are patient dissatisfaction due to the disease they suffer and lack of communication with the doctor, which leads to the patient's inability to predict the pain level and cost of treatment. Thus, a key element for preventing malpractice complaints is open, honest communication in any situation, especially when the treatment outcomes are not favourable (ADAMSON *et al*., 1989).

Moore et al. show, in a research from 2000, that the positive doctor-patient relationship increased the favourable appreciation of the physician's behaviour, reduced the patients' perception of the doctor's responsibility for a negative result, and decreased their intention to file a malpractice complaint against the doctor or the hospital. According to this study, the quality of the doctor - patient relationship is the main element in the patient's assessment of the treatment, which makes a positive relationship have lower risks of malpractice complaints compared to a negative one (MOORE *et al*., 2000).

Interpersonal interaction between the doctor and the patient is a critical aspect in the care of the latter (AMBADY *et al*., 2002). Although a more unfavourable outcome may not lead to a malpractice complaint, a less favourable outcome may not be sufficient to prevent a malpractice complaint when the doctor-patient relationship is of low quality (LESTER & SMITH, 1993).

A study conducted in Florida between 1986 and 1989, which included 127 women whose children suffered perinatal lesions with disability or death and who filed complaints of malpractice, showed that the motives for malpractice complaints are varied. Doctor-patient communication problems are common, leading to the patient's dissatisfaction with the level of information received from the doctor. This study shows that even if the physician provides technical details to patients or their families, they still look for answers to questions that, if not satisfied (even in patients who do not have side effects of the treatment), generate frustration and lack of satisfaction with the medical care received. Patients want to be heard, to feel that they are involved in making important decisions concerning their healthcare. Other factors behind the formulation of a malpractice complaint were: the patient's perception of being misinformed, the use by the doctor of terms or phrases that are understood differently by the doctor and the patient, such as "birth trauma," a phrase that was widely understood by many participants as a criticism regarding the medical services, even when this was not the intention of the doctor. Some physicians have been perceived as not being honest with the families about what happened to their children, in which case the integrity of the doctor was questioned, and he was suspected of misleading the parents of the children who had suffered perinatal lesions (HICKSON *et al*., 1992).

4. CAUSES FOR POOR DOCTOR-PATIENT COMMUNICATION

There is a variety of causes that lead to a poor communication between physicians and patients. These may be generated on the one hand by physicians and on the other hand by patients and / or their families.

Often doctors are not willing or lack the ability to communicate bad news; they want to inspire hope for patients or their families, which is why they may hide details about the disease.

The patients and their families often do not understand medical terms and lack the courage to ask for clarifications on certain medical aspects (due to cultural factors or the intimidating attitude of physicians). Communicating bad news can induce the patient or his / her family a denial reaction that causes negative information not to be retained, and later denied. This situation shows the importance of documented records

with information provided to patients and their families, especially those related to the unfortunate prognostic of the patient (HICKSON *et al*., 1992).

Some physicians do not properly assess the patients' need for information, or even avoid communicating with them in case of an unfavourable evolution of the disease (HICKSON *et al*., 1992). In addition, physicians and patients have different perceptions regarding the type and amount of information that should be provided or received. The parents of seriously ill children have some needs of information and support that cannot be met by the doctor. For example, they may need information that goes beyond the medical field (for example how to deal with the condition of the child, the feeling of guilt, of loss etc.) or information that the doctor cannot provide due to the limited level of medical knowledge at a certain time, such as the parents' request for information about the cause of the child's illness, provided that there are not always clear scientific explanations. In this latter situation, physicians can openly admit that they do not have the required information, in which case the family may be unhappy, or physicians may try to seek and provide some information, sometimes uncertain; in this case, families may also be dissatisfied when things evolve in a different direction than the doctor said. Under these circumstances, parents may think that they can only find out what happened to their children through justice. Often, however, doctors do not speak openly with patients or their family members; they also do not listen to their complaints and concerns (AMBADY *et al*., 2002, HICKSON *et al*., 1992).

5. FACTORS THAT INFLUENCE THE IMPORTANCE OF DOCTOR-PATIENT COMMUNICATION IN THE CONTEXT OF MALPRACTICE COMPLAINTS RISK

The importance of communication and its correlation with the risk of a malpractice complaint depends on a number of factors, such as: medical specialty, length of doctor-patient interaction, previous malpractice complaints against the doctor, patients' gender and their level of education.

Levinson, in a study conducted in 1985 shows that 80% of the malpractice complaints against doctors in all specialties are caused by communication errors, more often involving clinicians and less frequently radiologists. Related to this, in a study conducted in 2013 in the USA, which consisted in analysing 4793 malpractice complaints against 2680 radiologists, it was found that the main causes of malpractice complaints were diagnostic errors and less communication errors, which mainly consisted of inappropriate communication with the patient or the physician who recommended radiological exploration. Complaints about the quality of doctor-patient communication were mainly focused on failing to promptly and clearly communicate the diagnosis (WHANG *et al*. 2013).

The duration of interaction is also important in physician-patient communication. For this reason, physicians who interact briefly with patients, such as the anaesthetist who communicates with the patients the day before surgery, should learn to establish rapid contact with patients in stressful preoperative situations (AMBADY *et al*., 2002).

There is a correlation between the patient's opinion regarding his communication with the doctor, the patient's gender and level of education and the existence of malpractice complaints in the professional history of the doctor. Thus, female patients and patients with higher levels of education are more satisfied to interact with doctors with fewer malpractice complaints, probably because they communicate better and these patients are more sensitive to the doctors' communication skills. Male patients and patients with lower education are particularly satisfied with doctors who have a richer history of malpractice complaints, possibly because these patients prefer a more authoritative relationship, of dependence on doctors. Doctors with no malpractice complaints provide patients with more guidance and facilitation information and use more humour than their peers who have malpractice complaints and are perceived to be more concerned about the patient's condition and willingness to answer questions (AMBADY *et al*., 2002, HICKSON *et al*., 2002).

The patient's level of education is important in reducing the risk of malpractice complaints.

Patients with higher levels of education reported less satisfaction in interacting with physicians than patients with lower levels of education. However, when patients are sufficiently informed to be sure that the negative result is not the fault of the doctor, the risk of a malpractice complaint decreases. Thus, it is important to educate the patient to ask the doctor questions. Patient education applied to a group of hypertensive patients has led to better communication with the physician as well as lowering blood pressure. It becomes obvious, therefore, that the physician needs to adapt his/her style of communication to the various educational and emotional needs of the patient without providing standard messages to all the patients (ADAMSON *et al*., 1989).

6. CONCLUSIONS

Clinical communication skills of a physician do not improve significantly through just clinical experience, but both technical and interpersonal skills can be learned.

Effective communication between physician and patient is essential in the practice of modern medicine. Communication does not increase the technical quality of the medical act, but it can prevent a malpractice complaint even when something is clearly wrong and even when the doctor's fault is clear. It is important for physicians to understand what their patients want to know and how to transmit information to them, to provide direct answers, to be honest even when they send unpleasant messages.

The importance of physician-patient communication for preventing malpractice complaints and for the good functioning of the relationship between them shows an educational need for physicians to develop their communication skills with their patients in different clinical situations.

Developing the physician's clinical communication skills should address various issues, such as: encouraging the patient to discuss the main concerns about his/her health without interrupting him/her; striving to understand the patient's perception of the disease, associated feelings and expectations; improving the skills of active listening and empathy; providing clear explanations, checking that the patient understood them, and discussing the treatment plan within the doctor-patient relationship.

Patient education is also important for reducing the risk of malpractice complaints. When patients are sufficiently informed to be sure that the negative result is not the fault of the doctor, the risk of a malpractice complaint decreases.

In conclusion, educating the physician's communication skills and educating the patient are essential in creating a doctor-patient relationship based on trust and effective communication that can withstand the pressure of a conflicting society (AMBADY *et al*., 2002).

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