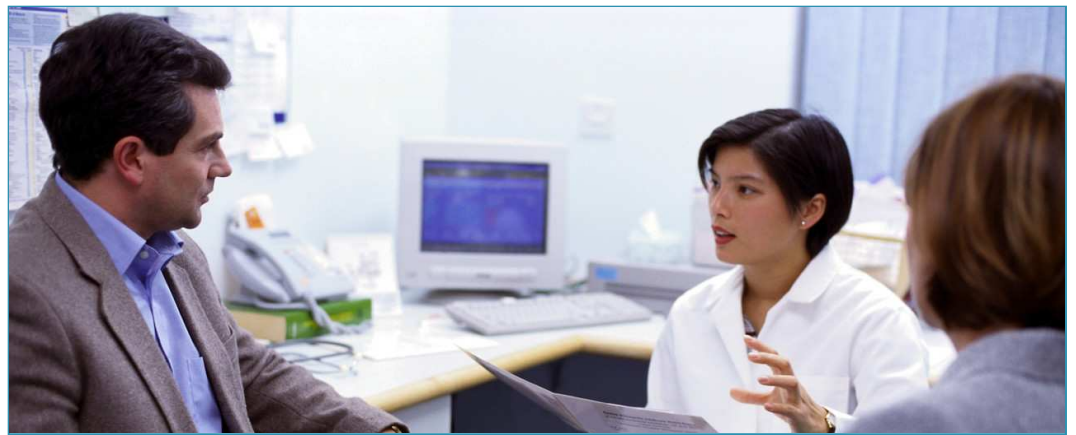
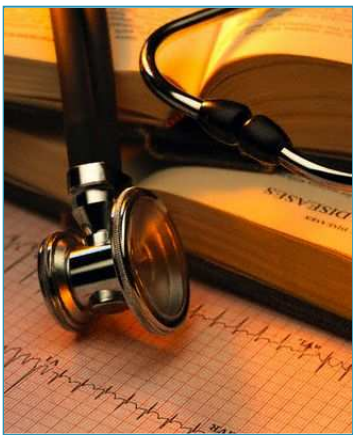




Three Myths of Medical Malpractice that Drive Up Your Costs



A Whitepaper by
Tim Dawes
President, Interplay, Inc.



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The costs of medical malpractice are well known. But the causes are largely misunderstood. In particular, there are three common myths about medical malpractice that cost you money, time, and frustration. Because of these myths, many organizations are

- discouraged that patient safety initiatives are failing to reduce claims by any significant measure,
- taking actions to combat malpractice claims that actually increase risk and cost, and
- unaware of actions they could take that would reduce claims, reduce costs, and provide a better experience of care.

If your practice is like most, you cannot significantly reduce your malpractice claims using your current strategies

In this brief, we'll layout the cost of liability loss, expose the three myths of malpractice, explain the true source of most of your malpractice claims, and explain how a program of empathy skills could help you

- reduce malpractice claims far more effectively than your patient safety program
 - provide better care to patients
 - increase your patient loyalty and revenue
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Physicians and risk managers “under siege”

Nationwide, the cost of malpractice will top \$25 billion this year.¹ The average jury award in 2002 was \$3.9 million, with 54% of awards amounting to \$1 million or more.² The average 150 (acute care) bed hospital will need to cover \$2.58 million in liability losses this year.³ Even in cases you win, it could cost you an average of \$25,000 to prepare your defense.⁴ And if you have a large facility, your case load reaches into the hundreds of claims.

The situation is equally grim for physicians. Prior to 1960, only 1 in 7 physicians were sued throughout their entire career. Experts now estimate that

about 1 in 7 physicians are sued every year.⁵ In New York for example, 60% of obstetricians, 60% of orthopedic surgeons, and 70% of neurosurgeons have been sued once or more in the past five years.⁶ Seventy percent of Maryland's OB/GYNs have been sued at least once for medical malpractice.⁷ Public advocacy groups publish lists of physicians who have been disciplined⁸ and the "worst" state medical boards, defined as those with the lowest rates of serious physician disciplinary actions.⁹ The average medical practice can expect a liability loss of almost \$16,000 per Class 1 physician.¹⁰ And when a physician is sued, even in cases they win, it costs an average of \$77,000 for them to defend themselves.¹¹

In this brief, we'll outline the ways that empathy skills can address the problem of escalating malpractice costs. And do it more effectively than most strategies widely in practice today.

Rising malpractice costs come from rising malpractice claims

You don't have to be a researcher to see the effect of large settlements on the medical industry. The Chicago Business Wire for example recently quoted Theresa Bourdon, managing director and actuary, AON Actuarial and Analytics Practice. "This year's analysis reinforces our findings in prior studies that the driving factor underlying the continued increase in the cost of hospital and physician professional liability is escalating claim sizes."¹²

Helena's Independent Record recently took some pains to figure out why malpractice insurance rates in Montana have been skyrocketing. In 2002, Montana's medical liability premium rates increased 118 percent for family physicians, 196 percent for obstetricians and 211 percent for neurologists. The same year, one of two major hospitals in Billings saw its premium costs climb from \$300,000 to \$3 million. Their conclusion? In Montana at least, it's the high cost of settling claims out of court.¹³

Authoritative research and solid analysis back up your common sense conclusion: increasing malpractice costs come from rising malpractice claims. It's beyond this point that things get murky.

These myths drive up costs and cast doubt on worthwhile initiatives

The confusion stems from our assumptions as to why malpractice claims are on the rise—and how to stop them. Reasonable people make reasonable leaps in logic that, put end-to-end, lead to myths.

Persuasive myths. They cost your organization a lot of money, undermine your commitment to worthwhile programs, and lead you to overlook strategies that might actually reduce malpractice. Here are four common ones:

Myths

1. Malpractice claims come primarily from medical negligence
2. Malpractice claims are random acts
3. Malpractice claims are filed by opportunistic patients

We'll look at each of these myths in turn, uncover their roots, and expose the mistakes inherent in each of them. Then we'll present solutions for effectively addressing medical malpractice.

Myth # 1: Malpractice claims come primarily from medical negligence

What could be more obvious or logical? If people are claiming medical malpractice, they must have experienced medical negligence. You'll certainly find anecdotal support for the belief.

And there's research that seems to back it up. But let's take a closer look.

Recent findings on the relationship between medical negligence and malpractice may seem to lend support to this belief. The numbers are often

drawn from two large studies carried out by Harvard researchers in the past 20 years. The researchers showed that about one percent of hospital visits end in medical negligence. They also calculated that the injured one percent are 20 times more likely to sue than are the other 99 percent.¹⁴

While the research is sound, readers have jumped to the erroneous conclusion that the majority of suits must come from injured patients. The great majority patients who file malpractice claims have not been injured through negligence. In fact, only about twenty percent of your malpractice claims come from patients who have been injured through negligence.¹⁵ And the great majority of patients who have suffered negligent injury don't sue.¹⁶ "An average care organization that reduces its error rate by half should see a reduction in claims of less than 10 percent", according to the Harvard analysis.¹⁷

The problems this myth causes you:

- 1. It leads you to depend on patient safety initiatives to reduce malpractice costs. In most cases that won't pay off.**
- 2. When your patient safety program fails to reduce malpractice claims significantly, it can undermine your commitment to and your business case for this worthwhile initiative.**
- 3. By confusing the causes of medical negligence and the drivers of malpractice claims, it makes you overlook actions you could take that would be effective in lowering claiming.**

Myth #2: Malpractice claims are random acts

You can see how a different interpretation of the statistics above could lead you to believe that claims are random acts. Harvard researchers who examined medical charts from 40,000 patients found very little overlap between the pool of people who were injured through negligence and

the people who sued. In fact, 80 percent of claimants did not actually suffer a negligent injury.¹⁸ Consequently, many people have concluded that malpractice claims can't be anticipated or addressed systematically.

In fact, malpractice claiming is not random. As you saw above, patients who suffered injury are 20 times more likely to sue than those who don't. And there are other patterns we'll explore below that will help you manage costs while providing a better experience of care.

The problems this myth causes you:

- 1. It leads some physicians to believe that there are poor incentives for practicing safely.**
- 2. By leading you to believe there is nothing your organization can do internally to stem malpractice claims, it causes you to overlook strategies that could be effective in lowering claiming.**

Myth #3: Malpractice claims are filed by opportunistic patients

With a broad brush, we paint our culture as litigious. It's not surprising that many physicians and risk managers believe that claimants are trying to make money through lawsuits. Undoubtedly, some are. I've heard from risk managers, especially in economically depressed areas, who feel the pinch from patients who literally fall in the parking lot.

There's plenty of research to demonstrate, though, that most patients who sue feel genuinely wronged by how they were treated.¹⁹ That feeling is something you can address, systematically. We'll give you some ideas about how to do that below.

Of the three myths, this one causes the most damage in your medical practice

The problems this myth causes you:

- 1. It causes physicians and risk managers to fear being sued.**
- 2. The fear of being sued in turn creates an environment in which physicians are less likely to practice good medicine.²⁰**
- 3. It leads physicians and risk managers to behave in ways that increase the likelihood of legal action.²¹**

The reality: the majority of medical malpractice cases come from emotional errors

If claims don't come from medical negligence, if they're not random, or a cynical act of opportunism, where do they come from?

In a study published in the *Archive of Internal Medicine*, researchers reviewed transcripts of depositions. In the depositions, the plaintiffs identified their reasons for filing malpractice suits. Four themes emerged. Patients sued because:

- they felt deserted,
- they felt that their views were devalued,
- they felt that information was delivered poorly, and
- they felt that their physician failed to understand their perspective.²²

In their review of research on malpractice risk and patient-centered medicine, Heidi Forster and her colleagues catalogue the reasons patients and their families sue.²³

- The decision by patients and families to sue was "determined not only by the original injury, but also by insensitive handling and poor communication after the original incident."²⁴
- "Patients taking legal action wanted greater honesty, an appreciation of the severity of the trauma they had suffered, and assurances that lessons had been learned from their experiences."²⁵

- Families claimed their physicians would not listen, would not talk openly, attempted to mislead them, and did not warn about long-term medical problems.²⁶

Significant payback on empathy skills

In the current climate of defensive medicine and defensive risk management, every bed in your hospital is a magnet for \$7,000 in liability loss.²⁷ Every claim you defend, even those in which you prevail, will cost you \$25,000 to \$77,000 to prepare. Even as you read this brief, your costs are rising. And the strategies most organizations employ to fight malpractice are *ineffective at best*. Mount a patient safety initiative that reduces medical error by 50% throughout your organization and you can expect to see less than a 10% drop in malpractice suits. And withholding information, avoiding patients, or misleading them—the strategies many physicians and risk managers feel they must fall back on—are the very reasons patients give for suing.

Because emotional errors are at the root of the problem, becoming skilled in emotional interactions is a major part of the solution. You can reduce legal risk by treating patients with respect and communicating in an honest, open, empathetic manner.²⁸ If your aim is to prevent liability loss, you may have more success communicating well and showing patients you value them than you will by reducing actual cases of malpractice.²⁹

You'll reduce more malpractice claims by showing empathy than by reducing malpractice? We can resolve the irony by looking at malpractice from a patient's perspective.

The hallmark of the patient experience may be feelings of illness and vulnerability, a sense of loss of control.³⁰ For most patients, clinical treatment is too complex and arcane to gauge. Patients judge the hospital by the way they're treated as a person, rather than the way they're treated for their

disease.³¹ If physicians or risk managers react to a medical error by avoiding patients and their families and withholding information, patients may judge that they are receiving poor care. And they may threaten a suit in an attempt to restore control, gain respect, and get information.³²

Bad outcomes are often not surprising for people to hear. You can reduce your litigation risk by reducing patients' feelings of confusion and helplessness,³³ reestablishing open communications, and showing empathy. There's even evidence that honest empathetic communications between doctors and patients may inoculate hospitals against malpractice to some degree. A good relationship with their physician leaves some patients with fewer concerns about their care.³⁴

Knowing what to do doesn't mean you can do it

Your staff doesn't need to *become compassionate*. They already are. Often, though, medical staffs have difficulty making their compassion visible to patients, especially when they need to most, in the midst of a crisis. Here's an example:

We were coaching a nurse through a live scenario with a father who was outraged. He felt the staff was trying to hustle him and his son out of the hospital. We wrote the scenario after an actual encounter in a hospital and hired a professional actor to play the father.

We paused the scenario just after the man blew up at the nurse. He told her that he worked all day and stayed at the hospital all night. And where did she think he was going to get the time to go through training before he took his son home? When our trainer asked her how she thought the man was feeling and what he needed, she suggested that he seemed overwhelmed and afraid, and that he might need some support.

When we suggested she ask the man if that's what he was

experiencing, she turned to him and said, "You need an appointment with a social worker. I'll set something up for you."

It's stressful being face-to-face with someone who's upset. Most people feel stress acutely. They intend to be open. They want to be frank. But they feel they can't. Generally if they're in medicine, they try to "fix the problem" instead. And when medical staff tries to fix problems before they've made a powerful connection with the patient, the fixing will be unwelcome. That's what happened in this case. The father had just said he didn't have time for training, and his nurse offered to schedule an appointment instead.

The nurse understood the father. She felt compassion. She tried to express it. And the father felt unheard, ignored, and undervalued. Discussions like that are taking place all through medical organizations. They create patient experiences that undo good clinical treatment and put hospitals at risk.

What you can do

The nurse above didn't need to learn compassion. She needed to learn to make her compassion visible to the father, even though he was angry and up close. Your staff can learn to make their natural compassion visible to patients, even in crises. Training helps. There are a variety of ways you can start. Here are some suggestions:

1. **Make empathy skills part of your fundamental program of patient care.** The more widespread the skills and vocabulary, the more powerful will be the results. Your best course of action is to get out ahead of the problem. Train your staff to identify patient feelings and needs, and negotiate solutions. So patients feel no need to make claims in the first place. You'll find the skills that reduce claims will also increase patient satisfaction.
2. **Train selected departments.** Some departments (obstetrics and neurology for example) attract malpractice suits.

3. **Train selected staff.** Some staffs (security services, social work, and risk management) work often with upset patients. Focus on staff in these areas to leverage a limited training budget or to model the skills for other employees.

In the case of medical malpractice, the best defense is not a good offense. It's a good collaboration. Your goal is to uncover your patients' needs and negotiate solutions that meet their needs *as well as* the needs of your hospital. And do it in a way your patients can see.

About Tim Dawes

Tim Dawes is President and Founder of Interplay, Inc., and author of the acclaimed "*Healing from the Heart* A Practical Guide to Creating Excellent Experiences for Patients and Their Families". His unique perspective comes from conducting custom trainings for hospitals, healthcare and social work trade associations, and university courses. The step-by-step process Interplay teaches helps care givers to increase revenue and decrease liability for their organizations by creating excellent experiences for patients and themselves. Interplay's training is based on Compassionate Communication (some call it nonviolent communication or NVC), originally developed by Marshall Rosenberg, PhD. NVC is a process for creating compassionate connection—not just communications—that's been field-tested internationally for over 45 years. The training technology Interplay uses—live standardized scenarios—was developed over the course of six years and in more than 500 training sessions at a major university.

You can order a copy of *Healing from the Heart*, inquire into retaining Interplay for live training, find special reports, mini-courses, and sign-up for monthly "how to" articles by visiting www.interplaygroup.com.

End Notes

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³ Hospital Professional Liability Benchmark Analysis, AON Risk Consultants, ASHRM October 19, 2004

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Aon Study Shows Insurance Rates for Hospital Professionals and Physicians May Slow in 2005

Aon's Hospital Professional Liability and Physician Liability Benchmark Analysis analyzes \$4 billion in claims

¹³ If you're tired of broad answers to this issue and want to see some stepwise analysis that really digs in, this is a terrific article. You can find it at Helenair.com, The Independent Record, Sunday, February 13, 2005, Lawyers, doctors, lawmakers working on malpractice bills By Chelsi Moy - IR State Bureau - 02/13/05 http://www.helenair.com/articles/2005/02/13/montana_top/a01021305_05.txt

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