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True Risk Management: Physicians' Liability Risk and the Practice of Patient-Centered Medicine

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TRUE RISK MANAGEMENT: PHYSICIANS' LIABILITY RISK AND THE PRACTICE OF PATIENT-CENTERED MEDICINE

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[The New York Times] With your heavy patient load, do you get to know any of them personally?

[Dr. Benjamin Carson] Oh, absolutely. That's important. Getting emotionally involved, I think, is a good thing. Of course, when there's a bad outcome, it's difficult.

Just a few weeks ago, I cried right in the operating room because the patient was brain dead. I had grown so close to that family that I had a picture of the little boy in my pocket. And yet, we had done everything we could possibly do. The family knew that. The parents were in no way bitter. There were hugs all around. It really is difficult.

By the same token, I've never spent a day in court.⁴

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⁴CLAUDIA DREIFUS, SCIENTIFIC CONVERSATIONS 199 (2001).

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I. INTRODUCTION

The late Dr. Avedis Donabedian, a leading evaluator of health care quality, captured the essence of quality care by describing the “technical” and “interpersonal” skills upon which physicians must rely.⁵ “The quality of technical care,” he stated, “consists in the application of medical science and technology in a manner that maximizes its benefits to health without correspondingly increasing its risks. The degree of quality is, therefore, the extent to which the care provided is expected to achieve the most favorable balance of risks and benefits.”⁶

“Interpersonal competence,” on the other hand, requires that “the management of the interpersonal relationship must meet socially defined values and norms that govern the interaction of individuals in general and in particular situations. These norms are reinforced in part by the ethical dicta of health professions, and by the expectations and aspirations of individual patients.”⁷

While most physicians understand that a serious deficiency in technical care increases their risk of liability, too often their risk management behavior indicates that they do not fully appreciate the impact that poor interpersonal skills have on patients’ motivations to sue. Ironically, many of these physicians have taken risk management steps that have increased, rather than reduced, their exposure to lawsuits.

In this paper, we argue that a strong legal and factual claim does not invariably explain patients’ decisions to sue. Dissatisfaction with the physician’s interpersonal care as well as with the clinical outcome is often a factor. Conversely, patients with a potentially meritorious claim may forego legal action due to the strength of the relationship with the physician.

In view of patients’ motivations to sue, we advocate a more broadly conceived approach to reducing liability risk, one that honors the ethical aspirations of medicine instead of the secretive counsels of misguided risk management. To be sure, strategies to reduce technical error are necessary, but they are not sufficient. Errors causing harm will inevitably occur. The first step in the liability path is the patient’s decision to transform the fact of harm into a legal claim. Whether this crucial first step is taken, as research has shown, can be strongly influenced by the physician’s interpersonal competence: the more open and honest physicians are towards their patients, the less likely these patients will pursue litigation.⁸ Thus, we argue that

⁵AVEDIS DONABEDIAN, EXPLORATIONS IN QUALITY ASSESSMENT AND MONITORING THE DEFINITION OF QUALITY AND APPROACHES TO ITS ASSESSMENT 4 (1980).

⁶*Id.* at 5.

⁷*Id.* at 5.

⁸Our discussion presupposes the patient’s awareness of a decision to be made. As a practical matter, however, many patients who have been harmed may lack the capacity even to recognize the harm, or to consider the possibility of redress. According to one study of hospitalized patients who were victims of negligence, 97% did not file suit. The researchers found that most of these patients were advanced in age and poor. They posited that these patients were less likely to obtain legal services. See DM Studdert, *Negligent Care and Malpractice Claiming Behavior in Utah and Colorado*, 38 MED. CARE 250-260 (2000).

physicians should seek to establish strong relationships with their patients and avoid questionable “defensive medicine” practices that can harm these relationships.

II. BACKGROUND

A. *Physician Perception of Litigation Risk*

Physicians correctly perceive that they are at greater risk of facing legal action today than in the past. Malpractice lawsuits have dramatically increased over the last three decades. For example, 80% of all claims between 1935 and 1975 occurred after 1970,⁹ and the number of annual claims grew from 2.5 to 16 per one hundred doctors between 1976 and 1984, respectively.¹⁰ Although the frequency of claims in recent years has trended downward,¹¹ the data show that over time more suits have been brought. In addition, the task of plaintiffs’ lawyers has been made somewhat easier by scrutiny of lists such as the National Practitioner Data Bank¹² and documents compiled by states detailing prior malpractice claims histories.

Physicians’ fears of liability also have been fueled by rising malpractice insurance premiums, which are perceived by many physicians as the consequence of an increasing volume of malpractice litigation and high jury awards. Although this assessment tends to downplay other factors, it surely is not entirely off the mark. As the General Accounting Office recently reported, “Multiple factors have combined to increase medical malpractice premium rates over the past several years, but losses on medical malpractice claims appear to be the primary driver of increased premium rates in the long term.”¹³ To an unprecedented degree, physicians fear that a lawsuit might make their future practice economically unsustainable.

B. *Liability Risk and Technical Error*

Concurrent with the rise of malpractice action in the last forty years, more patients have fallen victim to iatrogenic (that is, treatment-caused) injuries. In a

⁹TESTIMONY BEFORE SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES, 98th Cong. 2nd Session (testimony of Elroy Haines, Associate Director, Professional Liability Department, American College of Obstetricians and Gynecologists, Washington, D.C.).

¹⁰Peter Huber, *Injury Litigation and Liability in Insurance Dynamics*, SCIENCE, Oct. 2, 1987, at 31.

¹¹Public Citizen, *Quick Facts on Medical Malpractice Issues*, available at http://www.citizen.org/print_article.cfm?ID=9125. Public Citizen reports that malpractice claims declined by 4% from 1995 to 2000. Claims decreased from 90,212 in 1995 to 86,480 in 2000. These figures were based on the National Association of Insurance Commissioners’ Statistical Compilation of Annual Statement Information for Property/Casualty Insurance Companies in 2000, 2001.

¹²The National Practitioner Data Bank (NPDB) was created as part of the Health Care Improvement Act of 1986 (42 U.S.C. 11101 et. seq). Federal law mandates that select information on medical malpractice payments be reported to the NPDB. See <http://www.npdb-hipdb.com/npdb.html> for a summary of the legislation’s intent.

¹³UNITED STATES GENERAL ACCOUNTING OFFICE, MEDICAL MALPRACTICE INSURANCE: MULTIPLE FACTORS HAVE CONTRIBUTED TO INCREASED PREMIUM RATES,, GAO PUB. NO. 03-702, at 43 (June 2003); see also <http://www.gao.gov/cgi-bin/getrpt?GAO-03-702>.

1964 study, E. M. Schimmel found that 20% of patients sustained at least one iatrogenic injury after being admitted into a university hospital medical service.¹⁴ In 1981, Steel and colleagues found that iatrogenic injury had risen to 36% of patients studied in those same settings.¹⁵

Empirical evidence suggests that the increased incidence of iatrogenic injury is correlated with higher rates of medical error. For example, in a 1991 study, Bedell and colleagues found that 64% of cardiac arrests in one teaching hospital were avoidable.¹⁶ In that same year, Harvard researchers analyzed 30,000 discharges in 51 New York State acute care, non-psychiatric hospitals from 1984 and found that “adverse events” took place in 3.7% of these hospitalizations.¹⁷ These results were consistent with a later study of 15,000 discharges in Colorado and Utah, which found that adverse events occurred in 2.9% of hospitalizations.¹⁸ Compiling these and other findings, the Institute of Medicine estimated hospital error to be responsible for between 44,000 and 98,000 deaths per year.¹⁹ The IOM Report stated that medication errors by themselves were responsible for 7,391 deaths in 1993, up from 2,876 deaths in 1983.²⁰

The IOM Report also found that a significant percentage of these errors resulted from negligence. So, too, did the earlier studies. Of the adverse events documented in the Harvard Medical Practice Study, 27.6% were due to negligence.²¹ Similarly, an average of 30% of the adverse events found in Colorado and Utah were caused by negligent behavior.²²

Although high rates of negligence are not sufficient to explain why more patients are considering litigation, a breach in the standard of care is an essential component of any medical malpractice cause of action. Therefore, physicians have properly focused on minimizing technical errors, especially those caused by negligence, as a way to reduce their risk of liability.

¹⁴E.M. Schimmel, *The Hazards of Hospitalization*, 60 ANNALS OF INTERNAL MED. 100 (1964).

¹⁵K. Steel et al., *Iatrogenic Illness on a General Medical Service at a University Hospital*, 304 NEW ENG. J. MED. 638 (1981).

¹⁶S.E. Bedell et al., *Incidence and Characteristics of Preventable Iatrogenic Cardiac Arrests*, 265 JAMA 2819 (1991).

¹⁷ See Troyan A. Brennan et al., *Incidence of Adverse Events and Negligence Care in Hospitalized Patients*, 324 NEW ENG. J. MED. 370-376 (1991). The researchers defined adverse event as “an injury that was caused by medical management (rather than underlying disease) and that prolonged the hospitalization, produced a disability at the time of the discharge, or both.”

¹⁸See EJ Thomas et al., *Incidence and Types of Adverse Events and Negligent Care in Utah and Colorado*, 38 MED. CARE. 261-271 (2000).

¹⁹See Linda T. Kohn et al., INSTITUTE OF MEDICINE, TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM, at 1(1999) (hereafter “IOM Report”).

²⁰*Id.* at 27-28.

²¹See Brennan et al., *supra* note 17, at 371.

²²See Thomas et al., *supra* note 18, at 261.

C. Responses to the Increased Risk of Liability

Awareness of legal risk reinforces what in any event would be physicians' focus on avoiding technical error. It is well documented that a "culture of infallibility"²³ exists in many medical settings. This culture may be rooted in the way physicians are socialized to professional norms during their training in medical school and residency programs.²⁴ Physicians do not want to be subjected to the shame and embarrassment before colleagues that often accompany admitting to medical errors.²⁵ The authors of one analysis summarized their findings by stating that, "In a profession that values perfection, error is virtually forbidden."²⁶ Consequently, it is unsurprising that "some of the words that clinicians used to describe their responses to their own mistakes [included] 'devastated,' 'heartsick, . . . demoralized, worthless.'"²⁷

Intolerance of mistake in the medical profession may be unrealistic, as some errors are inevitable in any human endeavor. We maintain, however, that physicians are ethically obliged to try to minimize these errors to the best of their ability. Moreover, as stated in the previous section, attempts to minimize technical error may be legally beneficial. Yet, if this focus becomes single-minded, as manifested in an uncritical "defensive medicine" approach, the ironic result may be an *increased* likelihood that patients will file suit when inevitable errors do occur.

D. The Practice of Defensive Medicine

Defensive medicine occurs "when doctors order tests, procedures, primarily (but not necessarily solely) to reduce their exposure to malpractice liability. When physicians do extra tests or procedures primarily to reduce malpractice liability, they are practicing positive defensive medicine. When they avoid certain patients or procedures, they are practicing negative defensive medicine."²⁸

²³See Marshall B. Kapp, *Medical Error Versus Malpractice*, 1 DEPAUL J. HEALTH CARE L. 750 (1997).

²⁴See John F. Christenson et al., Wendy Levinson, & Patrick Dunn, *The Heart of Darkness: The Impact of Perceived Mistakes on Physicians*, 7 J. GENERAL INTERNAL MED. 430 (1992).

²⁵*Id.* at 430; see also Jamie Dickey et al., *Our Surgical Culture of Blame: A Time for Change*, 126 J. THORACIC & CARDIOVASCULAR SURG. 1259 (2003); Wendy Levinson & Patrick M. Dunn, *A Piece of My Mind: Coping with Fallibility*, 261 JAMA 2252 (1989).

²⁶See MC Newman, *The Emotional Impact of Mistakes on Family Physicians*, 5 ARCH. FAMILY MED. 74 (1996).

²⁷See Nancy Berlinger, *Avoiding Cheap Grace: Medical Harm, Patient Safety, and the Culture(s) of Forgiveness*, 33 HASTINGS CENTER REP. 28, 34 (Nov.-Dec. 2003).

²⁸See U.S. CONGRESS, OFFICE OF TECHNOLOGY ASSESSMENT, *DEFENSIVE MEDICINE AND MEDICAL MALPRACTICE*, 301-804/17414, at 13 (1994) (hereinafter "OTA").

Despite the inherent difficulty²⁹ in quantifying defensive medicine, the Office of Technology Assessment (OTA) found evidence of the practice in responses to clinical surveys from members of three professional societies: the American College of Cardiology, the American College of Surgeons, and the American College of Obstetricians and Gynecologists. From 4.9% to 29% of responding members stated that malpractice concerns were foremost in their minds when opting for an “interventionist”³⁰ procedure. A median of 8% of these “interventionist actions” were chosen because of fears about malpractice.³¹ These survey data led the OTA to conclude that, “if physicians actually practice as they say they would in these surveys, positive defensive medicine does exist – although not to the extent suggested by anecdotal evidence or direct physician surveys.”³² With respect to negative defensive medicine, the OTA found from 16.2% to 64% of physicians either withheld or decided against pursuing high-risk procedures because of malpractice fears.³³

Based on these data, the OTA concluded that, “[t]aken together, the findings from studies reviewed . . . suggest that defensive medicine is a real phenomenon that has a discernable influence in certain select clinical situations.”³⁴ Although some argue that one person’s “careful medicine” is another person’s “defensive medicine,”³⁵ studies show that its practice may be harmful to the patient and may make physicians more susceptible to lawsuits.

III. DISCUSSION

A. Consequences of Defensive Medicine and Flawed Risk Management Strategies

Thus far, we have shown that physicians correctly perceive their liability risk, and some have responded to their fears of liability by practicing positive or negative defensive medicine. In this section, we turn to the consequences of this practice and other questionable risk management strategies employed by physicians. Although a

²⁹The authors of one study cited three potential weaknesses of surveys that measure defensive medicine. These include: (1) “response bias”; (2) an exaggeration of the costs of defensive medicine; and (3) a “noncausal” relationship between a physician’s increasing concerns about liability and his or her’s purported defensive medicine practices. Daniel P. Kessler & Mark B. McClellan, *Medical Malpractice: External Influences and Controls*, 60 *LAW & CONTEMP. PROBS.* 81 (1997).

³⁰These are defined by the OTA as “actions other than waiting or doing nothing.”

³¹See OTA, *supra* note 28, at 56.

³²OTA relied primarily on survey data because few empirical studies have been conducted on the extent of defensive medicine. Of the three studies the OTA reviewed, only one found a relationship between malpractice risk and physician behavior. Localio et al. found that patients in hospitals with high malpractice claim rates were 32% more likely to have a Caesarean operation. See OTA, *supra* note 28, at 56.

³³*Id.*

³⁴*Id.*

³⁵See Mary McNaughton Collins et al., *Medical Malpractice Implications of PSA Testing for Early Detection of Prostate Cancer*, 25 *J. L. MED. & ETHICS* 234-242 (1997).

phenomenon with many factors cannot be simplified to one or two, the evidence suggests that, contrary to many physicians' assumptions, the practice of defensive medicine and certain risk management approaches *increase* the likelihood that physicians will get sued.

Isolating the motivations that underlie patients' decision-making about litigation is an inherently difficult task. Prospective research on the subject is particularly challenging, because negligence occurs in only a small fraction of physician-patient encounters, and, of these, relatively few result in litigation. Thus, retrospective evaluations are more common, albeit the results of these studies may be slightly biased; patients queried may be more likely to remember a situation in a negative light in order to justify pending legal action.³⁶

Even with these limitations, however, enough research has been conducted to support the commonsense proposition that a patient's sense of alienation from the physician is a major reason for pursuing a lawsuit. In other words, even given apparent error, a physician's interpersonal skills may be the deciding factor in whether or not the physician becomes a malpractice defendant.

B. The Importance of Communication

Patients value their relationships with their physicians. Consequently, the extent and quality of communication between patient and physician likely impact patients' decisions whether to sue. The link between poor patient-physician communication and litigiousness on the part of patients is not a new observation. Many qualitative studies and articles in the 1970s and 1980s hypothesized a connection.³⁷ In the 1990s, these hypotheses were subjected to empirical analyses.

An influential study by Lester and Smith in 1993 measured the "litigious feelings" of 160 adults.³⁸ The research subjects were randomly assigned to view a videotape in either of two groups. The tape for one group portrayed physicians using "positive communication behaviors";³⁹ the tape for other group, "negative communication behaviors."⁴⁰ Then, the subjects were questioned about their

³⁶Gerald B. Hickson et al., *Factors That Prompted Families to File Medical Malpractice Claims Following Perinatal Injuries*, 267 JAMA 1359, 1362 (1992).

³⁷A 1984 study by Waitzkin summarized previous research on patient-physician communication and found that patients desired that their doctors provide them with more information. See H. Waitzkin, *Doctor-Patient Communication: Clinical Implications of Social Science Research*, 252 JAMA 2441-2446 (1984). In 1989, Shapiro et al. conducted a survey of suing patients who reported that better communication was the best way physicians could avoid a lawsuit. See Robyn S. Shapiro, et al., *A Survey of Sued and Nonsued Physicians and Suing Patients*, 149 INTERNAL MED. 2190 (1989).

³⁸See Gregory W. Lester & Susan G. Smith, *Listening and Talking to Patients: A Remedy for Malpractice Suits?*, 158 WEST. J. MED. 268 (1993).

³⁹*Id.* These behaviors include "eye contact, friendly tone of voice, presentation of information and requests for information, smiling, appropriate physical touch, self-disclosure, acknowledgement of verbalizations, reflections of affect, and a long period of contact."

⁴⁰*Id.* These behaviors include "no eye contact, harsh and clipped tones of voice, criticism, a minimal presentation and requests for information, non smiling expressions, no friendly physical contact, no acknowledgment of verbalizations, no reflection of affect, and a relatively short period of contact."

response to four possible outcome reports.⁴¹ In every scenario, the subjects' reaction varied with whether a physician practiced positive or negative communication behaviors. The authors concluded that physicians may have the ability "to affect their risk of lawsuits by changing the way they behave with patients." The authors added that "good communication behaviors . . . may prevent lawsuits, even when something has clearly gone wrong and even when it is clearly the physician's fault."⁴²

Subsequent research has validated many of Lester and Smith's findings. In a study of 104 obstetric patients in a university medical center, Moore and colleagues found a "direct, causal effect" of the physician-patient relationship on patients' motivations to file suit.⁴³ Once again, it was found that positive and negative communication behaviors affected patients' decisions whether to sue. Positive interactions with physicians mitigated patients' litigious intentions against hospitals and their doctors. Even when a "severe" outcome was reported, patients were more likely to harbor an intention to sue the hospital only. Furthermore, a good patient-physician relationship positively influenced patients' perceptions of physician "competence" and decreased their perceptions of physician fault when an undesirable outcome had occurred.⁴⁴

It appears that patient-physician communication has significance in various specialties as well. For example, in addition to Moore's data, a 1994 study by Hickson and colleagues reported that obstetricians' experiences with malpractice were related to the quality of their interpersonal relationships with patients.⁴⁵ Sued physicians were less accessible and less communicative with their patients.

Similarly, in a 1997 analysis of malpractice claims of 59 primary care physicians in Oregon and Colorado, Levinson and colleagues found important differences in the communication patterns physicians who were sued and those who were not.⁴⁶ Physicians who were not sued spent more time with patients, provided "orienting"⁴⁷ statements that helped guide patient expectations, and skillfully used humor in their interactions.

⁴¹*Id.* These include a good outcome (correct diagnosis), a bad outcome in which the physician was not at fault, a bad outcome in which it was unclear whether the physician bore responsibility, and a bad outcome in which the physician clearly bore responsibility.

⁴²See Lester & Smith, *supra* note 38.

⁴³See Phillip J. Moore et al., *Medical Malpractice: The Effect of Doctor-Patient Relations on Medical Patient Perceptions and Malpractice Intentions*, 173 WEST. J. MED. 248 (2000).

⁴⁴*Id.*

⁴⁵See Gerald B. Hickson et al., *Obstetricians' Prior Malpractice Experience and Patients' Satisfaction with Care*, 272 JAMA 1583 (1994).

⁴⁶See Wendy Levinson et al., *Physician-Patient Communication: The Relationship with Malpractice Claims Among Primary Care Physicians and Surgeons*, 277 JAMA 553 (1997). However, Levinson and colleagues also looked at communication behaviors of surgeons with and without claims against them and found that no statistically significant correlation to exist.

⁴⁷Levinson provides examples of these statements: "First I'll examine you and then we will talk the problem over" or "I will leave time for your questions."

C. Disclosure of Mistakes

Successful physician-patient communication goes well beyond a doctor's bedside manner. Studies have consistently shown that patients desire openness and honesty, especially when it concerns medical error. For example, in one analysis, 98% of patients surveyed wanted physicians' "active acknowledgment"⁴⁸ of an error.⁴⁹ In another study of patients who visited an ophthalmologist's clinic for five weeks in 1998, 92% believed that they should always be informed of "complications."⁵⁰ Also, 81% of patients stated that "detailed information on possible adverse outcomes" was necessary.⁵¹ A 2003 analysis by Gallagher and colleagues confirmed these findings.⁵²

Although these and other studies have documented patients' preferences for full disclosure of mistakes, physicians have been reluctant to admit error to patients. Indeed, many physicians have made conscious decisions to be less than forthcoming with their patients. In one study, 87% of physicians surveyed stated that deception is permissible in certain instances.⁵³

Physicians' willingness to engage in deceptive practices by not disclosing error can be attributable to physicians' legal concerns. Many physicians fear that disclosing errors to patients will increase their liability risk.⁵⁴ Given this fear, to do so would strike many physicians as counterintuitive.⁵⁵ These fears are driven by assumptions that the legal system severely penalizes those who commit errors.⁵⁶ They are also based upon misguided risk management models that recommend less than full disclosure.⁵⁷ Even in instances where legal counsel recommends admission of error, rarely does this admission incorporate an apology for mistakes made.⁵⁸

⁴⁸This acknowledgment ranged from recognition of an error to a full apology.

⁴⁹Amy B. Witman et al., *How Do Patients Want Physicians to Handle Mistakes?: A Survey of Internal Medicine Patients in an Academic Setting*, 156 ARCHIV. INTERNAL MED. 2566 (1996).

⁵⁰Melanie Hingorani et al., *Patients' and Doctors' Attitudes to Amount of Information Given After Unintended Injury During Treatment: Cross Sectional, Questionnaire Survey*, BRIT. MED. J. 318 640 (1999).

⁵¹*Id.*

⁵²Thomas H. Gallagher et al., *Patients' and Physicians' Attitudes Regarding the Disclosure of Medical Errors*, 289 JAMA 1001 (2003).

⁵³Dennis H. Novack, Barbara et al., *Physicians' Attitudes Toward Using Deception to Resolve Difficult Ethical Problems*, 261 JAMA 2983 (1989).

⁵⁴See Kapp, *supra* note 23.

⁵⁵David M. Studdert et al., *Medical Malpractice*, 350 NEW ENG. J. MED. 283 (2004).

⁵⁶See Kapp, *supra* note 23.

⁵⁷Steve S. Kraman, *A Risk Management Program Based on Full Disclosure and Trust: Does Everyone Win?*, 27 COMPREHENSIVE THERAPY 254 (2001).

⁵⁸Daniel Finkelstein et al., *When a Physician Harms a Patient by a Medical Error: Ethical, Legal, and Risk Management Considerations*, 8 J. CLINICAL ETHICS 334 (1997).

The assumption that the disclosure of mistakes leads to an increased risk of litigation is inconsistent with relevant research findings. Indeed, research has shown that less than full disclosure of mistakes may increase the likelihood that patients will file suit. For example, a 1994 study by Vincent and colleagues cited patient dissatisfaction with physicians' explanation of "incidents" as a major reason for pursuing litigation.⁵⁹ Less than 40% of the explanations given were considered "sympathetic." An apology was offered and responsibility was taken in only 13% and 15% of these explanations, respectively.⁶⁰ Other studies have similarly drawn empirical links between physicians' lack of forthrightness and litigiousness among patients.⁶¹

A recent survey of health maintenance organization members suggested that full disclosure after a medical error not only "improves patient satisfaction, increases trust in the physician, and results in a more positive emotional response" but also, at least under some circumstances, "may . . . reduce the likelihood that patients will seek legal advice"⁶² The strength of these findings has prompted some physicians, hospitals, and insurers to call for new risk management strategies that emphasize complete and empathetic honesty in all patient-physicians interactions, even in the face of medical error.⁶³

D. A Patient-Centered Approach

We conclude with a brief account of an alternative to physicians' counterproductive defensive medicine practices and negative communication behaviors, which are intended to decrease but actually may increase tort risk. This approach, usually termed "patient-centered medicine," is the only mode of practice that can reduce physicians' risk of liability and at the same time exemplify the professional virtues that excellent physicians strive to attain.

There is no universal definition of patient-centered medicine. Rather, in contrast with traditional "physician-centered" medicine, it embodies the concept that patients should have the right to exercise greater control in their health care decisions.⁶⁴ Since the 1950s, patient-centered care has slowly gained a foothold in mainstream medicine. Over this period, several modifications have been proposed to the

⁵⁹See Charles Vincent et al., *Why Do People Sue Doctors: A Study of Patients and Relatives Taking Legal Action*, 343 *THE LANCET* 1611 (1994).

⁶⁰*Id.*

⁶¹See, e.g., Witman et al., *supra* note 49; Hingorani et al., *supra* note 50; Vincent et al., *supra* note 59. This link is not limited to physicians. For example, one study examines the disclosure of mistakes in dentistry. See Gary T. Chiodo et al., *Disclosure of Mistakes*, 47 *GEN. DENT.* 24-28 (1999).

⁶²Kathleen Mazor et al., *Health Plan Members' Views about Disclosure of Medical Errors*, 140 *ANNALS INTERNAL MED.* 409, 416 (2004).

⁶³Rachel Zimmerman, *Doctors' New Tool to Fight Lawsuits: Saying 'I'm Sorry,'* *WALL ST. J.*, May 18, 2004, at A1; Steve S. Kraman & Ginny Hamm, *Risk Management: Extreme Honesty May Be the Best Policy*, 131 *ANNALS INTERNAL MED.* 963 (1999); see also Kraman, *supra* note 57.

⁶⁴Christine Laine & Frank Davidoff, *Patient-Centered Medicine: A Professional Evolution*, 275 *JAMA* 152 (1996).

traditional patient-physician relationship. For example, in 1956, Szasz and Hollender suggested that some patients should have a partnership role in the relationship.⁶⁵ In 1976, Lazare and colleagues advised a “negotiated approach” by which physicians integrate patients’ attitudes and values into their care.⁶⁶

Similarly, in 1992 Emanuel and Emanuel advocated a “deliberative model” that enables the patient to “consider, through dialogue, alternative health-related values, their worthiness, and their implications for treatment.”⁶⁷ In a subsequent article, Ezekiel Emanuel described the “ideal patient-physician relationship” as one that recognizes “respect for patient autonomy.” He explained that this relationship consists of six C’s – Choice, Competence, Communication, Compassion, Continuity, and (No) Conflict of Interest⁶⁸ – and serves “as the cornerstone for achieving, maintaining, and improving health.” Although few would claim that the ideal patient-physician relationship is regularly attained, likely the medical community is more accepting of greatly increased involvement of patients in decisions about the type of care they receive.⁶⁹

The patient-centered approach commends itself for two reasons. First, the practice of patient-centered medicine will reduce physicians’ risk of liability. Second, a patient-centered approach is in keeping with the ethical norms of the profession.

The weight of empirical data, summarized in Part III above, establishes that the quality of the patient-physician relationship is an important factor in patients’ decisions whether to sue. This relationship is enhanced through effective physician-patient communication, openness and honesty when medical errors occur, and responsiveness to patients’ treatment desires. The research findings suggest that high marks on these criteria lessen the chance that physicians will find themselves subject to a lawsuit. Patient satisfaction with the patient-physician relationship most likely is attained when physicians are practicing patient-centered medicine.

⁶⁵T.S. Szasz & M.H. Hollender, *The Doctor-Patient Relationship*, 97 ARCH. INTERNAL MED. 585-592 (1956).

⁶⁶A. Lazare et al., *Studies on a Negotiated Approach to Parenthood*, in THE DOCTOR-PATIENT RELATIONSHIP IN THE CHANGING HEALTH SCENE, PROCEEDINGS OF THE FOGARTY CENTER INTERNATIONAL CONFERENCE, U.S. Department of Health, Education, and Welfare, Pub. No. 78-183 (1976).

⁶⁷Ezekiel J. Emanuel & Linda L. Emanuel, *Four Models of the Physician-Patient Relationship*, 267 JAMA 2222 (1992).

⁶⁸Ezekiel J. Emanuel, *Preserving the Physician-Patient Relationship in the Era of Managed Care*, 273 JAMA 328 (1995).

⁶⁹This acceptance was accelerated by developments in the law of informed consent. See, e.g., *Canterbury v. Spence*, 464 F.2d 772, 787 (D.C. Cir. 1972), *cert denied*, *Spence v. Canterbury*, 409 U.S. 1064 (1972); *Cobb v. Grant*, 502 P.2d 1 (Cal. 1972). In the 1990s, the *Cruzan* case ushered in a new era of patient rights concerning end-of-life care. *Cruzan v. Director, Miss. Dep.*, 497 U.S. 261 (1990). In the aftermath of the Supreme Court decision, Congress passed the Patient Self-Determination Act, 42 U.S.C. §§ 1395cc(f)(1), which requires hospitals and other facilities to provide information to patients about their rights to accept or refuse surgical or medical treatments and to prepare advance directives.

Patient-centered medicine allows for the truthfulness and the transparency between patient and physician that ethical practice requires.⁷⁰ This is especially true with respect to medical errors. When doctors decide against revealing mistakes, they are in violation of their professional responsibility.⁷¹ The profession's leading bodies have stated an ethical imperative to disclose unfavorable outcomes. These include the American Medical Association's Council on Ethical and Judicial Affairs, which has stated that "situations occasionally occur in which a patient suffers significant medical complications that may have resulted from the physician's mistake or judgement. In these situations, the physician is ethically required to inform the patient of all facts necessary to ensure understanding of what has happened."⁷² Also, according to the American College of Physicians' *Ethics Manual*, physicians should disclose to patients information about procedural or judgement errors made in the course of care, if such information is material to the patient's well-being.⁷³

IV. CONCLUSION

Sharply rising malpractice insurance premiums and the frequency of litigation directed against physicians garner most of the headlines in any debate concerning tort reform. The familiar arguments between the proponents and opponents of reform, however, do not address the nature of the relationship within which patients receive care.⁷⁴

Although the provision of quality care has generally been understood by physicians in terms of technical proficiency, we have focused attention on the interpersonal dimensions of care. Indeed, numerous studies have shown that patients' dissatisfaction with non-technical aspects of care is a key factor in their decisions whether or not to pursue litigation. In light of these data, we advocate for the practice of patient-centered medicine, which we believe to be the best legal and ethical means by which physicians should respond to their rational fears of being sued.

Our endorsement of a patient-centered approach to medicine is not without recognition of challenges to its practice. In this era of managed care, several important components of a successful patient-physician relationship have been compromised. Many patients have had to change physicians as their choices of health plans have been narrowed by employers, and some have joined the ranks of the uninsured. In addition, cost containment has placed an increased burden on primary care physicians. This increased workload has resulted in more patients per physician and shorter appointment times. Furthermore, the quest for efficiency

⁷⁰Albert W. Wu et al., *To Tell the Truth: Ethical and Practical Issues in Disclosing Medical Mistakes to Patients*, 12 J. GENERAL INTERNAL MED. 770 (1997).

⁷¹Phillip C. Herbert et al., *Bioethics for Clinicians: 23. Disclosure of Medical Error*, 164 CAN. MED. ASS'N J. 509 (2001).

⁷²AMERICAN MEDICAL ASSOCIATION, COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, CODE OF MEDICAL ETHICS, CURRENT OPINIONS 110 (2002).

⁷³Lois Snyder & Cathy Laffler, *Ethics Manual*, 142 ANNALS INTERNAL MED. 560, 563 (5th ed. 2005).

⁷⁴A description or analysis of the tort reform debate is beyond the scope of this paper.

produces tension in physicians who want to provide good care and also abide by their contractual obligations to the health plans.⁷⁵

Managed care has also fundamentally altered the role that physicians play as advocates for patients. As Professor William Sage states, this traditional role was uncontroversial: “[p]hysicians had a duty not to harm patients, to practice in patients’ best medical interests, to respect patients’ wishes, to put patients’ welfare above personal considerations, and to preserve patients’ confidences.”⁷⁶ Sage adds that, prior to the managed care era, physicians had “privileges” including the ability “to follow their own values and beliefs, to serve whom they chose, and to shield patients from bad news.”⁷⁷ Under managed care, however, physicians have often found themselves in an adversarial role with their patients. The constraints of cost have prompted physicians to treat their patients impersonally and as “consumers on insurance.”⁷⁸

Despite these challenges, we maintain that a successful patient-physician relationship is possible. Physicians should realize the perils of “defensive medicine” and other behaviors that do not treat the patient with respect and are inconsistent with the core tenets of good medicine. These behaviors will likely increase the liability risk that physicians face. Whatever the outcome of the tort reform debate, it is in physicians’ ethical *and* legal interest, to practice patient-centered medicine.

⁷⁵See Emanuel, *supra* note 67.

⁷⁶William M. Sage, *Physicians as Advocates*, 35 Hous. L. Rev. 1531 (1999).

⁷⁷*Id.*

⁷⁸*Id.* at 1532.