Ep64 | The "Invisible Hand" Series - The Effect of Medical Malpractice on Health Care with Dr. St... Transcript

(Transcripts are generated by AI and may contain errors)

Conflict in Healthcare and the SPARC Framework

If [music] you work in healthcare, you already know this. Conflict is everywhere. In the O, [music] in labor and delivery, in committee meetings, between physicians, nurses, administrators, and teams that are all trying to do the right thing. But here's [music] the problem. Most of us were never trained to handle conflict well. We learned procedures. We learned diagnostics. But we didn't learn how to [music] navigate the moment when Q professionals strongly disagree.

That's why I developed the SPARC framework. Spark stands for stop, pause, ask, don't assume, reflect, and respond, and create a path forward. It's a practical [music] system designed specifically for highstakes healthc care environments through keynote [music] talks, residency workshops, and spark master classes. I teach physicians, [music] nurses, and healthcare teams how to turn destructive conflict into productive [music] conversations that strengthen teams and improve care. If your hospital, residency program, or medical conference is looking for a speaker on conflict, communication, [music] and leadership in healthcare, I'd love to work with you. You can learn more in the show notes. Because in medicine, conflict is inevitable, but handled well, it can make teams stronger.

Episode Introduction and Guest Background

Quick question. Are you paying more in taxes than you should? Most high earning physicians overpay by tens of thousands [music] because their CPA only looks backward, not forward. Guilt is different. Dedicated CPAs powered by AI [music] that work year round, not just at filing time. tax [music] strategy and proactive planning for practice owners, investors, [music] and physicians with complex financial lives. Built specifically for professionals who want to keep more of what they earn. Check out joing guilt.com. That's j o i n gt.com.

Before we begin today's conversation, I have one important request. If you haven't already listened to episode 51, the invisible hands on the scalpel, I encourage you to pause this episode and start there. In that episode, we explore a powerful idea that the forces that are shaping medicine today are far more reaching than what goes on in the operating room, the office, or the hallways in hospitals. There's malpractice, administration, insurance, all affecting the decisions that we make every single day. Those unseen influences affect not only patient care, but also our relationships with our colleagues, our leadership, and the conflicts we experience in medicine. Today's guest, Dr. Steven Cohen, brings this concept to life. Our conversation today builds directly on the foundation laid in episode 51, exploring how the world of medical malpractice affects our surgical judgment, our communication, our professional growth in our ability to provide care to patients. If you've already listened to episode 51, welcome back. You're exactly where you need to be. This is part one of my conversation with Dr. Steven Cohen.

>> [music] >> In every operating room, in every [music] ward, in every clinic and every team meeting, a silent battle bruise, conflict, negotiation, identity. [music] Welcome to the Scalpel and Sword podcast, where I, Dr. Lee Chararma, physician and conflict analyst, [music] explore the hidden negotiations beyond modern medicine. Let's trade burnout for boundaries and learn the art of healing with precision and [music] power.

Hello my peaceful warriors and welcome to the Scalpel and Sword podcast. I'm your host Dr. Lee Chararma, physician and conflict analyst. And if this is your first time listening to the Scout of the Sword, welcome. I'm so glad you're here and joining our ranks. But if you've never listened before, I would love for you to pause this episode and go back and listen to episode 51, which is called the invisible hand on the scalpel. And we get in that episode into the idea that there are so many forces that are shaping medicine. And unfortunately, these are forces that are not just led and directed by us as health care professionals. It's administration, it's insurance, and very, very importantly, medical malpractice and the concept of it. And there is nobody I can think of that I'd rather have the conversation about how this is shaping healthcare than our guest today, Dr. Steven Cohen. Dr. Cohen also has an MBA. He is well-versed as an expert witness. He is the chief of general surgery at the Veteran Administration

Hospital in Richmond, Virginia. He's also on faculty at the Virginia Commonwealth University. He has spoken to numerous audiences and if you do not follow him on LinkedIn, please go follow him. We will put his LinkedIn tag in the show notes because the things that he talks about definitely are things that we all need to be looking at as physicians. Stephen, welcome. >> Thank you. I'm excited to be back again for another fun episode. >> You are the first repeat guest on scalpel and sword. So, you are the first to get that designation. When I did this episode on the invisible hand on the scalpel, I don't think I was prepared for the amount of attention that episode would draw.

How Malpractice Changes Physician Behavior

I had so many people reach out to me saying that episode resonated with them. I actually did have a guest say, "I want to do an episode with you talking about the effect of insurance." But that guest is anonymous. That person would not identify themselves because they were really giving very insightful comments about the effects of insurance.

And when I floated this idea to you, we were talking about this before we started recording. You sent me a two-page document about all of the ways that you see that medical malpractice has shaped healthcare. So, this is something that you've obviously spent time thinking about.

>> Yeah, I've now been in practice 33 years. I have been on plaintiff cases. I've been on defense cases. And oh, by the way, I have been suited five times.

So, I've seen the emotional toll that it takes on all of us. And one of the problems is this is a topic that nobody wants to talk about, right? Because when you get served the lawsuit, you're told, "Don't talk to anybody." And the shame and the fear and the disappointment. I mean, you go down a rabbit hole of I'm the worst doctor ever. You feel like you did everything right because, as you know, most malpractice cases are bad outcome. They look at it with retrospective analysis and they don't put themselves in the provider at the time what he or she knew. And that's the only way that you should look at these cases because I've said it a hundred times, outcome is irrelevant in standard of care. you can do everything right and you can still have a bad outcome.

>> There's so much in there that I think really does and we talked about this, you know, the effect of medical malpractice is not just systemic. It's on the individual and it's a profound effect on the individual. And I think people like you, people like Gita Pensa and the work that you guys are doing, you are really shining a light on that very concept. The idea that going through a medical malpractice process, we feel so much shame. We are so hard on ourselves, we really do like, I really thought I did everything right, but then you start to question every decision you make after that because it's like, well, if I did everything right and this can still happen to me, I mean, my gosh, how can I do anything else? And I think especially as surgeons, that resonates so hard with us. So, you've spent a lot of time not just being the witness, but you've also been in that place as well. Which one of those do you feel like had a bigger impact on you as a physician? Being the witness or going through that malpractice process? >> Oh boy. I mean certainly going through the process you understand and you know the first one's the hardest but after that you realize and I've said this a lot much to the chagrin of both sides defense or plaintiff it's a game to now right it's a game because the rule and the object for either side is to win even if it's on a technicality and the problem I've done a ton of defense cases where the outcome is the patient died that's a problem, right? Again, I can do everything right. Patient dies, it's a problem. So, it's the catastrophic outcome. And remember, as a surgeon, I'm the one that told the patient they need an operation. They walked into the office to me, they have a colon cancer. We talk about the risks and benefits of surgery. We see them pre-operatively. We see them through surgery. They're in the hospital two to a week. We see them in the outpatient. And when there's a problem, we feel that, right? No physician goes out to harm a patient, right? But sometimes on the plaintiff's side, they make it seem like you purposely harmed the patient, right? Because they're using the emotional connection if and when they get to a jury to make their case.

>> And that emotionality, that emotional connection that they're using for that, that is something we feel so deeply for our patients. But as you said, for the attorneys, it's literally the game. And I think the first time that I really had this sort of light shine on this. I was talking with you before, my daughter's an attorney, and before she started when just living in in all of area, there were attorneys who were kind enough to let her follow them. So, she's in probably early college and she's following these two attorneys that are doing a divorce proceeding and they're

screaming at each other. They're yelling at each other and Rachel's, "Oh my gosh, this is so toxic. This is so terrible." And then after it's over, the attorney that she was shadowing says, "Hey, do you want to get lunch?" And Rachel's like, "Okay." And who comes with them?

The other attorney that she was yelling at 10 minutes ago. And they're joking over having chicken salad, nice tea, just like they're big friends because they are. And then they go right back into it in the afternoon. And those are the things that we don't see as doctors. That transparency. We understand the idea that transparency is necessary in medicine. I think I agree with you that early on with malpractice, we were told to shut up. If that's something you're going through, don't talk about it. Don't tell it. And so when your colleague would come to you and say, "Hey, I need to share with you I'm going through this malpractice process." And they're not sharing that with anybody else cuz they were told not to. That lack of transparency just compounds the shame and the isolated feeling that we get from going through that process. But we don't get to see the gamification that the attorneys have going through that. >> Exactly. And again, I feel more comfortable in an operating room than I do in a courtroom. Right. It's not my world, right? I don't understand all the legal terms. They throw out these things and the different jurisdictions have different rules, things they can bring up, things they can't bring up. And we've all watched TV, right? You see these Law and Order shows. Why can't they talk about that? that might be relevant to one side or the other, but it's an unknown for people. I actually give a talk every year to the residents about what it's like to get sued.

They're all scared to death, and that translates to how we take care of patients. And we talked about that before. It's ordering more tests. It's getting more of the medical doctors involved. They have a fever, get infectious disease.

Documentation, Training, and Informed Consent

That doesn't prevent lawsuits, but certainly the way I practice now that my previous lawsuits has shaped how I do it, when I do it, what I tell the patient, my documentation has gotten a lot better. I can tell you that some of the cases I review, that's the thing that saved the surgeon. They documented so detailed. Not just abdominal pain, I'm treating one, but how are you ruling out the other things, right? That's really, really important. And I try to emphasize that to the residents that someday that routine operation, somebody may blow it up on a screen and have 12 people that have no idea about medicine, which is not their fault, to determine what you did and why they did it. >> Yeah. So this is one of the things that I think this also too when you talk to a lot of plaintiff attorneys that do this work. One of the things I've heard some of them say is that they have had physicians that have called them after being sued by them and said, you know, I forever now change how I document how I practice. I change how I do X thing because this was the thing I was sued about and now I no longer do it this way. And so one of the arguments that I think that comes out of the medical malpractice industry and specifically with claim attorneys is that they do help to make the clinical practice of medicine better and more precise.

They're essentially making us better doctors. And so I don't want to call it a justification, but that's sort of the reason why that they do what they do. So you definitely sound like you've seen that in your own practice, not just as a physician, but as a witness. >> Oh, absolutely. And one of the things I talk about to the residents and everybody thinks that when you get sued the first time, you're done. Your career is over. If there's a settlement, you get reported to the National Practitioner Data Bank. That's a black mark. That is really not true. Again, I've been sued five times. Two of them were dropped. Three of them were settlements. And remember, settlement doesn't mean you did anything wrong, right? 90% of medical malpractice cases in this country settle. There's a lot of different reasons for that, right? One of the reasons is it's a business decision for them. For the defense attorneys, they're paid hourly. Plaintiff attorneys usually are not paid unless they win, right? So, they're usually more aggressive. And I've talked to defense attorneys and I want them to be a bulldog, especially if they're defending me. I feel like when I'm on the defense side, I'm defending myself, right? Electomy. I did two recent cases, diverticulitis, surgery was indicated, everything was perfect in surgery. Patient went home on day four. Two days later, leak at the anastmosis, sepsis, and died. And I had to tell the plaintiff attorney, there's no breach. I know it's a bad outcome. It's a terrible outcome, but most leaks serve days 7 to 10. The patient met discharge criteria.

Operation was indicated. They did everything right. What I'll tell you is I get some criticism obviously from my colleagues for talking to plaintiff attorneys, but about 40 to 50% of the time, like the case I just said, they're not going to get sued, right? Because it's not a breach in the standard of care. But there's a lot of different reasons why cases are settled and we can go into that even if you do everything right. A lot of times it's not up to us.

I said to my defense attorney, I did nothing wrong. I have experts on my side that said this is how we manage patients. Yes, it's a bad outcome. Defense attorney and the insurance adjuster which is usually make the decision says we can save money if we just so and you don't have a lot of say.

They told me if you want to go to trial and the jury finds against you and it's above your maximum, you're writing a check for that. What doctor is going to say that? >> Right? There's no way, right? Just like car insurance. That's why you have it. Another colleague said to me, "If you can solve a problem by writing a check, definitely write the check." And it's not your money. You're paying the money in. But >> right, >> certainly it's not the end of your career being on the national practitioner datab bank. Patients don't have access. It's only people have access to that if I get asked on deposition or if I go to apply to another job, another hospital. I've been on credentiing committees. I've seen lots of doctors sue. you justify it.

What happened? Why? And it's really not the end of your career. And that's important because everybody feels like it's going to be. >> Yes. And I also think it's so great that you actually talk about that because I do think so many people carry that fear with them into the operating room. They carry it with them into the clinic. And so the message of yes, this industry exists, yes, this happens is not career ending. It is not something that's going to take that away from you. I think is a really important message. So people don't know that. also because you we're talking about the economics of this process and I think that's something that if you're talking about the effect of medical malpractice and litigation on health care you have to get into the economics of it the idea that if we are ordering more tests if we are doing more things if we are getting more consultants doing a little more of this than maybe we did before maybe had that awareness of hey I had a colleague who got sued for X so let me just go ahead and make sure that I've thought through that is that a significant financial pressure on our healthare system what medical malpractice has created >> there has been studies that's looked at that it's not significant it is a driver of health care costs but it's low it's not as high as you would think and I think the reason being is that even in training right if you have somebody with abdominal pain comes to the emergency room they're getting a cat scan right I think the process in the last 30 years has changed of how we manage how we work up what we look at 30 years ago we never did a cat scan for a app to appendicitis, right? It's a clinical diagnosis. Yes, we took out a lot more negative appendecttomies, but we didn't miss it. >> Back 30 years ago, 20% negative appendecttomy rate was reasonable. We didn't do cat scans. We did them occasionally. But now everybody gets them. But even then, right, I recent case patient came in with classic signs of appendicitis. CAT scan was normal.

Patient got better with a GI cocktail. went home two days later a perforated appendix. Right? So you could do all the rag tests and still miss it. I don't think that's a breach of the standard of care. Patient met discharge criteria.

The ER doctor did everything right. Ran it by the surgeon said, "Look, it's normal. Patient's better. CAT scan's normal. White count's normal. Their pain got better. What else are you supposed to do?" Yet that's going to be a malpractice case because they're going to look at it retrospective reasoning that came back two days later, obviously miss it.

>> Yeah. And I think it's so important to emphasize and I'm glad you emphasized it. This idea that outcome is not necessarily an indicator of malpractice that clinical courses are clinical courses, things happen, presentations occur. And what our most important thing is that we do as clinicians is we do our due diligence with workup with history and especially in terms of surgery that we are making sure that we are bringing the patient into that collaborative decision-making process. That's it.

Probably one of the things that she talked about when you had sent me your response that I was like, "Oh my gosh, I can't wait to talk to you about this is the concept of medical malpractice changing us from a more paternalistic style of medical practice to something that's more inclusive in terms of informed consent with the patient. So do you see Medau as being a driver of how that occurred because it definitely occurs now." >> Oh, there's no doubt joint decision-m is very important. You have to explain and this has come up in some other cases I reviewed where you know it's risk benefit ratio of the procedure itself whatever we're doing but also what's the outcome if you don't do the procedure right does a patient have enough informed decision of what happens and I another recent case that I did a patient had a very small carcinoid tumor of the distal appendix it was completely excised there was some question of this t-staging And the surgeon said you need a right callectomy.

What happened? Right callectctomy bleak sepsis death. Right? But again I'm not looking at the outcome based on the guidelines. When you look at that informed consent we know a carcinoid tumor less than 2 cm there's no outcome in life expectancy. Nobody was told that. He was just told he needed surgery.

Checklists and Surgical Safety

So that became an informed consent >> issue where you didn't explain what happens if I don't have surgery right and that's very important obviously if they have colon cancer there's no option right certain things there's no option but I do a lot of benign disease I do rectal prolapse surgery I do fecal incontinence I do functional constipation you don't need surgery you can live forever with that and I think that's really important especially in surgery when you're talking to patients about what the risks of surgery are but what are the risks of not doing the surgery. That's really important that you need to document that and that has saved a lot of physicians when they did have a bad outcome that it was a collaborative joint decisionmaking and the patient opted for that. That's fine.

Both of those are within the standard of care for sure. >> We've come back to this topic and you've mentioned that is it made you a better document. I had mentioned before we went on mic about one of my daughter's law school classmates Trevor Allen who is now in St. Lewis who was an EMS provider before he went to went to law school and actually did some medal work and when he was on the podcast that was one of the things that he talked about is like he honestly had such a better eye to documentation because he had been through a process of legal education. He understood how important it was and as an expert witness having been through this process you understand it as well.

Is it possible to communicate that to clinicians who haven't been through this process? More or less just because I've been through it. I know how scary it is.

Yes, I'm an expert witness. I would still rather be in an O than a courtroom. Let me show you how you can document so that this doesn't happen to you. Is that a message that people receive when you give these lectures?

>> Oh, absolutely. But I really think that goes back to the teaching, training, and educating that I do every day to the surgery residents because that was taught to us when we were a resident, right? And I think part of the problem is the way that most of us practice, not me now in the VA system, >> but if you're an RVU based and you're working with residents and it's mortases or surgery and your salary sides that you may not let the resident do a lot of that stuff, right? In our facility, I want the resident to dictate it. I'm not signing off on it till I read it, make sure it's accurate. They miss lots of things because they're not used to dictating cases and then I go over it with them. So, that really needs to go back to the education. But we should give them that, right? They should know that there's certain things in surgery with procedures, what standard of care, you're doing a right callectomy, did you see the right urer, did you see the douadum, right? Did you make sure all the lap pads were out at the end of the case? Those types of things that are to me surgery 101 when you're teaching residents how to do surgery should be taught at that level. But the problem is a lot of the cheap residents that come through, you know, even at month 58, 59, 60, the last three months, they don't know how to dictate an operation. And that's a problem, right? Because they haven't done it, >> right? It's a problem because now you're in practice. Now you're in charge. You have to dictate. you miss some key steps, there's going to be the problem. So, I think it goes back to the educators to really emphasize that and teach them. I mean, my only job when they spend five plus years with me and the rest of the group is to create safe surgeons. Well, creating safe surgeons is knowing the preop indication, knowing what to do in surgery, knowing to look for the posttop complications, right?

and learning who's sick because you could have a patient on posttop day three that doesn't look so bad. Well, the creatine's up a little bit. They have a little bit hypotension. They relate it to dehydration.

Dehydration, your posttop day three, you've been giving them three liters a day. They're not dehydrated. What are you missing? Are you missing the PE? Are you missing the little leak? Are you missing the abscess? So, I think it goes back to education. And I think we need to do a better job when we have them to prepare them for day one. they're ready to go. And I think it's different now. I hate to say it was better 30 years ago, but I think it was better 30 years ago because we were given a lot more autonomy. Believe it or not, 30 years ago when I was in the operating room, the attending surgeon did not have to be in the hospital. God helped the patients when I was an intern doing

something on my own. The chief resident would take me through it. But now that's impossible. I have to be in the room the whole time just about. Right. So it's not different. And if I'm in the room, I'm old and cranky and I have no tolerance and I'm impatient, I'll take over the case, right? But that's not good training for them, right? So surgical training, I think, has suffered somewhat. We do the best we can to try to prepare them so they're safe, reliable surgeons at the end of the day once they graduate.

>> I'm going to 100% agree with you. I get medical students. I actually have a medical student starting in my service tomorrow and I had a bit of a gap in having them because the medical students I was getting that were fourth years.

They couldn't write a progress note. They didn't know how to write a prescription. So, you know, I have them in clinic and you know, we're seeing, let's say, for example, a vulvar lesion and it's like, okay, so I'm going to document in my note that they have no crepitus or no anesthesia. Tell me why I'm documenting that. >> And they kind of look at you. It's like, >> yeah, >> okay, let's talk about necroizing fasciitis. Let's talk about why you need to make sure that that's not what the patient has because that would be the worst case scenario. Whoever's reading this note 20 years from now needs to know that I thought about that and this is why I'm putting this in the note. And then the first time I sit them down when they're coming with me to surgery and it's like, okay, have you written an optoote? No, we're going to learn. And the problem is that does take you longer if you are the person who's the educator. It does take you longer. Yes, you could do it in a minute and a half, but this person needs to learn how. And that means you do have to stand there for a few minutes. And I actually had a guest on the podcast a few months ago who said that the five or 10 minutes you are investing in that person's training is going to be your work release 15 or 20 years from now. >> And you need to look at it that way. You need to look at it as you're taking the sum of your life experience, whatever experience you've had with medical malpractice, everything. You are going to take that extra 10 minutes and you are going to teach that to that medical student, intern or resident because you know that the dividend for that is 10 or 20 years from now. You are creating an independent safe practitioner. And we have to make that switch as educators that tag Nebbit, I could do this in 10 minutes. I really can. And then you really have to say to yourself, but dang it, I'm not gonna be practicing 10 years from now. I need to have safe people who can replace me. So, I 100% agree with you. I think that the way that we provide medical education has changed, but it doesn't mean that we can't still create safe, effective clinicians. It's just a question of how we're doing that in our current system. >> Well, I think you have to look at it. If you decide to be an educator at a teaching hospital, that is one of your responsibilities. You don't have to be in a teaching hospital. I spent 20 years in private practice. I did have some residents come through. When I was in Atlanta, but I was at the private hospital half the time. I didn't have residence. So, that's a whole different ballgame. You don't have to be an educator. You don't have to be a teacher, but if you're going to do it, you need to take that responsibility seriously. One of the things I say every month when I see the new nursing students on the floor, I always stop, introduce myself. I say, "Make sure you all know how to put the folding catheter in. One day you're going to do that to me and I want you to do it right." Hey, L. That's funny, but it's the truth. >> Right.

>> It's the truth. I'm going to be on the table someday and I want to make sure when I'm looking up that person knows what they're doing. >> 100%. Another thing you talked about when you sent me this document is the idea that the presence of lawsuits accelerated adoption of processes that helped with surgical safety. But one of the things that you mentioned was the WHO surgical safety checklist. So how do you see that those two are connected that lawsuits actually accelerate the application and the use of those kind of checklists? >> Yeah, that's an interesting concept because when I review surgical cases, remember everybody documents differently, right? And you have it together and I'm putting myself in the position of the provider what they knew and they should have not at the same time. Surgeon's going to document something. Anesthesia's got to document something. The nursing document something, right? I recently reviewed a case where there was a routine laparoscopic surgery. The varys needle went in, blood came out, the patient immediately CO2, entitle CO2 crashed.

>> Yeah. >> And nobody knew what to do, right? I mean, that is a CO2 embolis. There's nothing else that does that. They didn't do the right thing. The patient wind up dying. It was a disaster. But everybody documented something different, right? The timeline was messed up depending on who you talked about. So it made it very difficult to go through to see what the heck happened. Now I know things happen very quickly in the operating room. I get that. But some of those checklists are very important. You know the time out before surgery to make sure there's no wrong side surgery, which still happens in this country. I don't know how that can happen, but it still

does.

Yeah. Retain sponges. Who's responsible if there's a retained sponge? every retained foreign body case that I have reviewed, guess what? The count is always correct, right? Because if you tell me the count's not correct, I'm not stopping, right? >> Yep.

>> Well, I think those checklists are very important. It's just patient safety, right? Sometimes it seems redundant. We didn't do this 30 years ago, but we had drugs, right? So by doing this is definitely increase patient safety to do the right thing for the right patient at the right time and make sure everybody's on the same page. How many times have you had a patient in the preop area want to add something to the procedure? They've already been given their preop medication. Doc, I got this lesion on thing. Can you just No. Absolutely not.

Right. That's important. And again, I can't put every resident in a situation they're going to be in when they're by themselves. >> So the checklists are important for preops, for interop, for posttop. Did you take out the right specimen? I've done cases where they went in for a right colon cancer. The right colon was taken out. Nobody looked at the specimen. Guess what? The colon, the lesion was in the left side of the colon. That's a problem, right?

Closing Remarks and Part Two Preview

So, we have a process where the specimen is open. It is verified by the doctor, by the nurse, and those things are very helpful. The residents look at me like I'm crazy while do that. We could feel the lesion maybe. I said, "No, it was marked. Let's make sure. Let's open the specimen. It takes a second and everybody sees it." So, those checklists I think are very important. If if you don't do them, you're cutting corners and you're have to make a mistake. Not on purpose, but you have to make a mistake. The defense of that case of the right colon that was taken out was well the gastronurologist told me it was on the right side. Okay, the gastronurologist is not in the surgery. Once they go through those doors in the operating room, it is my responsibility, not the gastronurologist, right? I mean, we can't always tell and I do a lot of colonoscopy where the lesion is. I've had GI doctors tell me it's apatic flexure, it's in the sigmoid. I've had them tell me sigmoid, it's in the apatic flex. the colon telescopes. It's hard for me to tell. I can tell terminal ilium. I can tell rectum. Anything in between, I don't know. So, those checklists are very important to make sure you do the right thing at the right time for the right patient to prevent easy preventable complications, which should never happen.

>> As we close part one of my conversation with Dr. Steven Cohen. I hope this discussion has given you a deeper appreciation for the profound ways medical malpractice has shaped the practice of medicine beyond the courtroom. It influences how we communicate with patients, how we document, how we make decisions, and even how we experience the joy and purpose of being a physician. These are not easy conversations, but they're essential ones. We can't change what we refuse to examine. And understanding these forces is the first step toward building a healthier culture for both physicians and patients. Next week, we'll release part two of my conversation with Dr. Cohen. We'll live beyond how medical malpractice has changed medicine and explore where we go from here. If you enjoyed today's episode, be sure to subscribe so part two appears in your podcast feed as soon as it's released. And if this conversation sparked new thoughts or reminded you of your own experiences, please share this episode with a colleague and leave us a review. Those simple actions help us reach more healthc care professionals who care deeply about the future of medicine.

Until next time, peaceful warriors. I am Dr. Lee Chararma and this is the scalpel and sword. be at peace. [music] >> Every episode is an invitation to speak, [music] to negotiate, to choose. I'm Dr. Lee Chararma. Join the dialogue by subscribing [music] to Scalpel and Sword. Until next time, peaceful warriors, may your choices be sharp [music] and your voice be even sharper.

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