Communication, Defensive Medicine Persist as Malpractice Armor

By Michael Stone | Sept. 7, 2016

While the total number of malpractice claims has fallen over the past decade, the risk still lingers for physicians, with 154,621 paid claims between 2004 and 2014 (or about 38 a day) listed by the National Practitioner Data Bank.

And despite the drop in total claims, the size of the ones actually paid has been climbing slightly, said Dr. Anupam Jena, an associate professor at Harvard Medical School who studies malpractice.

"It could certainly be that overall quality of care is improving," Jena said of why total claims have fallen, or it could be that lawyers are focusing more on winnable and larger suits, which could explain the swelling of individual payouts.

However, if recent history's trend holds true, health care could indeed soon see a spike in quantity of paid claims, said Michelle Mello, a Stanford professor of law and health research and policy who also studies malpractice. Such an uptick happened in the mid-`80s and again around the turn of the century, she said, so the U.S. might be due for another.

"About every 15 years, there's spike in them, and then things calm down after three or four years," Mello said, adding that there's no precise explanation for the cycle. "And we've been on a downtick for a while."

Are everyday physicians taking note of specific statistics and timelines? Maybe, maybe not. But it would appear, according to Jena, that they're at least approaching the broad hazard of malpractice suits with great caution.

Between 60 and 80 percent of doctors report having utilized defensive medicine within the last year, meaning they ordered additional tests, procedures and consultations with other physicians to reduce the risk of getting sued later.

Defensive medicine accounts for between 2 and 5 percent of total health care spending, Jena said, and year over year, though there hasn't been supportive research, such spending has been "probably pretty constant."

There are a host of reasons of why physicians get sued in the first place: diagnosis errors, medication errors, procedural errors, problems from relatively new technologies, such as electronic health records and telemedicine.

Though nearly all of them have their respective safeguards against lawsuits, one method sticks out more than all others as the most widely accepted and applicable malpractice protection.

"Evidence shows," Mello said, "that communication is the strongest protective measure that a physician can take: communicating well with the patient in advance of care … good communication about risks, good communication in the sense of establishing a trusting and caring relationship ahead of undergoing a procedure that involves risk.

"Because we know that patients who have good feelings about their physicians in general are less likely to sue them in the face of a bad outcome."

Jena agrees: "One thing that people frequently say is that a good repertoire with a patient will lead to lower rates of malpractice. It makes intuitive sense, so we shouldn't discount that."

Conversely, studies show that strained physician-patient relationships are more likely to result in malpractice cases, he said.

To provide patients with a better sense of wholehearted care, Florida Coastal School of Law professor and medical malpractice consultant Alan Williams offered some tips

in a 2008 edition of the publication Risk Rx. (The tips do borderline commonsensical but reemphasize motions that can be lost in day-to-day practice.)

1. Sit down while talking with the patient. Even if a physician spends the same amount of time as she or he would while standing, sitting makes visits seem longer in the patient's eyes.

2. Listen to the patient. This, compared to possible devaluation of what she or he has to say by interrupting.

3. Face and look at the patient. A patient has better impressions if the physician is positioned toward her or him, and eye contact from the physician improves patient comprehension. ("A lot of malpractice lawsuits involve bad outcomes that actually weren't due to negligence but patients who sign an informed consent form and [didn't] really internalize all of the risks that could happen," Mello said separately.)

4. Review documents prior to the examination room. A patient's first impression is likely to be negative — and possibly lasting — if the first thing she or he sees is the top of a physician's head scanning papers.

5. Be overly respectful during the examination. Because the examination can be a hard-to-handle situation for the patient (and one that could prompt a lawsuit), the physician should be exceedingly mindful to ensure dignity and privacy.

Yet if a physician believes these tactics and good communication overall aren't bulletproof enough — especially when it comes to riskier procedures — defensive medicine can again come into play.

Jena was the lead author in 2015 *British Medical Journal* paper that suggested more defensive-medicine spending reduced the odds of a suit. The study determined this after looking at malpractice claims from 2000 to 2009 among 24,637 Florida physicians.

"We can't take [our] findings and then immediately say that this means as a doctor, you should order more consultations and order more tests … but it certainly does raise the specter that that's a possibility," he said.

One other safety measure at a physician's disposal is attending a malpractice workshop put on by an insurer, trade organization or her or his own medical institution.

Insurer ProAssurance, for example, offers seminars throughout the country that have the learning objectives of: understanding the litigation process, how expert witnesses can benefit or harm physicians, how documentation and communication stand to reduce claims, and how to implement risk-reduction strategies into a practice.

Despite all that can be done to protect against a suit, history would note that physicians getting slapped with them is inevitable. In the 1850s, for instance, malprac-

tice cases got so bad that many physicians left their practices altogether, concluding that medical lawsuits are here to stay.

One thing that might be different between then and now, though, is that tort reforms and other evolutions have helped most to stick it out.

It's easy to find anecdotes of physicians scaling back, retiring or moving to a state in which liability insurance is less expensive, Mello said. But in looking at the population level, "we find them generally to be pretty small."

"We find lots of physicians saying they're likely to do this," she said, "but then when you look at their actual behavior, it's a relatively small number who actually do."

After all, it's not easy to lift up a practice and move it, retire early or eliminate more lucrative procedures, Mello said.

"There are all kinds of barriers" to making adjustments based solely on malpractice suits, she said. "But certainly, physicians feel the squeeze when insurance costs go up and reimbursement is flat, and they have to make some really hard decisions about whether the juice is worth the squeeze, staying in practice and performing procedures that can result in a lawsuit."