The New Normal of Medical Malpractice and How We Are Making it Worse

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I am tangentially involved in a medical malpractice suit in which the physician in question complied completely with the standard of care. Her documentation was great, her care exceptional, there was no discrepancy between her charting and the nurses' charting, the doctor-to-doctor hand-off went well, and she communicated with the patient and family. Unfortunately, the ultimate patient outcome was horrible. In the aftermath, the physician was named in a wrongful death suit simply because of what another physician said to the family. Parenthetically, the information relayed by that physician to the family was completely false and outside the scope of the physician's knowledge base.

The malpractice climate clearly has changed over the past few years, as demonstrated by data from Medscape's 2013 Malpractice report.[1] Here are some highlights from the report, which is based on data from 3,480 respondents representing 25 specialties who discussed their malpractice history and perspective.

- Sixty percent of physicians surveyed reported they had never been named in a malpractice suit. Thirty-one percent claimed that they were one of many parties named in a suit, whereas 9% said they were the only party named.
- Specialties most often named: Internal medicine (15%), family medicine (13%) OB/GYN (89%), psychiatry (8%), cardiology (6%), gastroenterology (6%), pediatrics (5%), emergency medicine (4%). The primary reason for these numbers is that there are more primary care physicians than specialty physicians.
- Of those sued, 35% of the time it was for failure to diagnose, 17% for failure to treat, and 4% for failure to give informed consent. The rest were made up of other categories that I suspect included wrongful death, loss of consortium, loss of a chance, and battery.
- Sixteen percent of the cases went all the way through trial and verdict, 5% said the case settled prior to the verdict being rendered, 18% went to depositions before being dismissed from the case, 27% related that the case was settled after depositions, and 24% were dismissed from the suit before the depositions.
- Twenty-eight percent of those surveyed spent more than 40 hours preparing their defense and 30% of the respondents spent more than 40 hours in court and on trial-related matters.
- The majority of cases (61%) were settled in less than 2 years and 89% of the cases were completed in less than 5 years. Of all the suits filed, physicians were completely exonerated 48% of the time. For 38% of cases, settlement was reached at some point before the verdict. In 95% of the cases, the plaintiff received either no award or some number less than $1 million.
- Although many states have "I'm sorry" laws, 93% of physicians surveyed felt that saying they were sorry would not have helped.
- Seventy percent of the physician surveyed stated that the insurer did not require or force them to settle. Note: You should check your policy to see if it states that the insurer can settle without your consent or, conversely, that you are responsible for any award greater than the amount for which the case could have been settled. This is called a hammer clause and it is not always readily apparent in malpractice contracts.
- In only 2% of the cases, the physician had to pay out of pocket and in 1% of the cases, the physician had to cover the award personally. Generally speaking, when physi-

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cians have to pay the award personally it typically is due to alteration of the medical record, punitive damages, gaps in malpractice coverage, or if a choice to pay the damages personally. If the settlement is paid out of the provider's own funds rather than those of a professional corporation or business entity, it is not reportable to the National Practitioner Databank. Thus, on some occasions, physicians opt to pay personally as opposed to having the loss reported.

- Most physicians surveyed stated that their patients either didn't know about or were very supportive during the lawsuit process. In addition, most physicians believed that the suit had little effect if any upon their professional or employment relationships.
- Twenty-nine percent of those sued stated that they no longer trust patients and treat them differently. Six percent left the practice setting and 63% wrote that there was no change in how they practice or treated patients. Sixty-two percent of physicians surveyed felt that the results were fair.

Most importantly, when asked what advice they would give other doctors, the physicians who were sued offered the following advice:

- Follow-up on a patient's lab, pathology, and imaging reports even when you think the bases are covered.
- Practice defensive medicine. This may be somewhat taken out of context, inasmuch as we don't know the practice style before they were sued. For example, a physician may have been loath to document, provide informed consent, make appropriate referrals, or to order appropriate imaging.
- Document thoroughly and more often. Again, not knowing their baseline, the statement may be misleading.
- Dismiss patients in your practice who are rude, demanding or noncompliant.

Now let's get back to the malpractice case in which a colleague of mine was thrown under the proverbial bus by another physician. I'll often hear the plaintiff's bar say that the reason they do what they do is because we as physicians have "failed to police our own." A recent study published in *The Journal of General Internal Medicine*[2] seems to disprove this assertion, at least to the extent that we seem not to hesitate to be openly critical.

The authors of the study trained three actors on how to portray a patient with advanced lung cancer. The scenario the "pretend" patients gave was that they had recently moved to town after being treated by a physician who was ultimately unsure about their diagnosis and prognosis. Complete medical records were fabricated but all the documentation contained in the "pretend" records met or exceeded the applicable standard of care. These actors/patients made a total of 34 office visits among various primary care physicians and oncologists working in the community.

The actors were specifically told not to seek or to ask for opinions regarding the care rendered by their previous physician. Nevertheless, researchers found that in 41% of the cases, the physicians offered their opinion about the previously rendered care. Surprising, the vast majority of these opinions were harshly critical.

In my practice, I see this type of scenario play out almost daily. A patient presents from an urgent care and the emergency physician reviews the record, rolls his or her eyes, and says, "Wait, he sent you here for what?" Or, a consultant is called down to the emergency department (ED) and is overheard saying to the patient, "The ER doctor doesn't know what he's doing so they called me." Or, the patient is discharged from the ED and follows up with his or her primary care physician, who tells the patient that the diagnosis and treatment plan given in the ED was incorrect.

Why do we as professionals do this? Many of us were not trained in the team-based learning style popular today so we are not used to and were not trained in the supportive atmosphere of a team. Some of us may be in the habit of disparaging others to improve our own status or self-worth. Whatever the reason, overt or subconscious, the effect it has on our profession and our patients is very damaging. In fact, the Medscape Report on Malpractice recounts that denigration of the care of ambulatory care providers by physicians (generally hospital-based physicians) was cited as the prime causative factor in many malpractice suits.

Not to bring poor Rodney King into this (again) but why can't we all get along? Team-based care is for the betterment of our patients. Denigrating our own teammates, whether on our team or the competitor's team down the street, ultimately hurts the profession as a whole by sowing the seeds of distrust in our patients while providing a steady stream of cases for the plaintiff's bar. ■

References

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