Malpractice Claims: It’s a Crapsheet—Time to Stop the Self-Blame and Ask Different Questions

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Venkat et al remind us of the sobering fact that under the current US malpractice system, at least 75% of emergency physicians will be named in a malpractice lawsuit during their careers—and 95% if they practice until aged 65 years. The US malpractice system as a whole fails to serve the best interests of our patients, who most often do not receive satisfactory explanations or any compensation when injured, and still sabotages the patient-physician relationship. Malpractice allegations induce self-doubt, anger, and often depression. We may suffer for years from a form of posttraumatic stress disorder termed malpractice stress syndrome. Lawsuits may taint our future interactions with patients and threaten our well-being at work for years and potentially for the duration of our careers.

With this as a backdrop, many authors have researched methods to avoid malpractice claims. The majority of previous research in the emergency medicine literature examines series of claims cases and in doing so cannot accurately determine the risk associated with the studied variables. One way to think about this is to consider that these previous studies were limited to variables in the numerator (cases with lawsuits) and did not incorporate the denominator (all patients treated during the time and location from which the cases arose). As a result, the variables found to be associated with malpractice risk may be just as common in cases without lawsuits as in cases with them; the case series methodology can’t determine whether a difference exists. Studies comparing physicians with multiple lawsuits (as cases) with those with only one lawsuit (as controls) lack utility in uncovering potentially predictive variables because the majority of physicians will have only one lawsuit in a 4- to 10-year database. What is found may not be generalizable because it focuses on the rare event of a physician with multiple lawsuits, who likely is not representative of most physicians facing lawsuits. Indeed, in the current Annals analysis, 92%
of emergency physicians accrued a single lawsuit. By using both numerator data and denominator data, the research by Venkat et al improves greatly on that of previous studies exploring risk factor associations. Their approach does have the ability to differentiate provider and practice factors associated with increased risk from the larger group of all emergency department (ED) visits.

In the present study, Venkat et al explored several independent variables that the previous research suggested might be associated with malpractice risk. The variables included years in practice, board certification, admission rate (a proxy for physician risk adversity), relative value units generated hourly, total patients treated, multiple facility work, night shift work, patient experience rank (per Press Ganey), and American College of Emergency Physicians (ACEP) state malpractice grade. The authors found only 2 elements statistically associated with risk of lawsuit: increased patient volume and years in clinical practice.

Other authors, using less robust methodology, have suggested physician behavior may be associated with lawsuits. Venkat et al have given us a gift with their careful study. Only exposure matters. Of course, there are limitations here. Venkat et al could not study all practice elements potentially associated with malpractice risk. Supervision, handoffs, and volume of tests ordered are all missing. Does this, then, provide impetus for yet more research exploring other variables with larger data sets? Perhaps not. Perhaps we are now free to explore different questions.

In our desire to ascertain physician characteristics predisposing us to lawsuits, we may inadvertently perpetuate blame by asking what is wrong with us and looking for elements within our practices that we can we fix to avoid malpractice accusations. Perhaps our available literature thus far searches for elusive risk associations in vain. It may turn out that the variables most associated with malpractice allegations involve plaintiff lawyer-patient dyads rather than physicians and defendants. Perhaps the initiation of litigation has as much to do with plaintiffs’ attorney characteristics within a given locale as it does with physicians.

Venkat et al sought to include malpractice environment at a state level by including a dichotomous variable they derived from the ACEP state grade of the lawsuit location as a risk. ACEP based this report card on 22 discrete measurements, some that pertain only to expert witness requirements and cost of malpractice insurance that may not affect a lawyer-patient dyad from filing a lawsuit and others that have tremendous potential to affect the frequency of lawsuits. The authors acknowledge the extensive limitations of this as a proxy for legal environment. Only 2 of the 15 practice states attained a “good” grade: one a B+ and the other a B−. It is unclear whether this provides any meaningful difference from a C, D, or F. Perhaps claims do correlate with elements of legal environment, although these may be different from those incorporated into the ACEP state grade and simplified into this dichotomous variable. Furthermore, although it is easier to compile information by state, legal practice tends to vary by county and locality, and statewide assessment may suggest a false consistency.

Variables such as the amount of a medical bill for which the patient is responsible, patient insurance type, and the number and experience of local attorneys specializing in plaintiff malpractice may turn out to be the best predictors of claims. Should researchers turn efforts instead toward investigation of patient and attorney factors? If we knew that certain patient insurance status, race, sex, or chief complaint conferred an increased risk of lawsuits, would we change our encounter dynamics? If so, how would this bias affect our work and our concern for our patients? Likely this would create animosity, negatively affecting our patient relationships and work well-being. In the end, it might prove to be even more damaging to the practice of emergency medicine than exploring provider factors. Yet we must not underestimate the damage done by the way in which our own society currently channels patient remediation for adverse outcomes and our own responses to claims.

The most important information learned from the formative research by Venkat et al on malpractice risk is that it’s a crapshoot. Physicians who treat more patients are slightly more likely to be sued than colleagues who consistently treat fewer patients over the years. If you practice long enough, you will be sued—and this does not mean you are a bad physician. You have plenty of company. When your colleagues are sued, it does not mean they are bad physicians. They have plenty of company. Furthermore, continued exploration into provider factors associated with lawsuits merely reinforces our own extreme self-blame and perfectionist ideals. Exploring patient factors is equally challenged because it can damage our relationships with patients before we even meet them.

For our own well-being, we need to practice good medicine, work ethically, treat every patient with equal kindness, and uphold our Hippocratic oath. Short of sweeping reform in the way we compensate patients for
events currently handled by malpractice lawsuits, there appears to be little specific we as individuals can do to prevent the majority of malpractice claims. It is time that we teach the truth about this to our students, residents, and fellow emergency physicians. We need to cease pretending that a specific course, degree, or charting tip will prevent lawsuits. It is also time that we provide collegial and mental health support before, during, and after allegations. We cannot pretend to be the stereotypical ED cowboy or cowgirl who can tough out any horrific shift, terrible case, patient death, or self-doubt in the face of malpractice allegations. The cost to our own well-being and to that of our future patients is too great.

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REFERENCES