Allegations: Current Trends in Medical Malpractice, Part 2

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In part 1, the authors focused on alternative proposals to traditional tort law. In part 2, they discuss strategies emergency physicians can use to reduce their risk of malpractice claims.

Most medical malpractice cases are still resolved in a courtroom—typically after years of preparation and personal torment. Yet, overall rates of paid medical malpractice claims among all physicians have been steadily decreasing over the past two decades, with reports showing decreases of 30% to 50% in paid claims since 2000.[1-3] At the same time, while median payments and insurance premiums continued to increase until the mid-2000s, they now appear to have plateaued.[1]

None of these changes occurred in isolation. More than 30 states now have caps on noneconomic or total damages.[2] As noted in part 1, since 2000, some states have enacted comprehensive tort reform.[4] However, whether these changes in malpractice patterns can be attributed directly to specific policy changes remains a hotly contested issue.

Malpractice Risk in Emergency Medicine

To what extent do the trends in medical malpractice apply to emergency medicine

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(EM)? While emergency physicians' (EPs') perception of malpractice risk ranks higher than any other medical specialty,[5] in a review of a large sample of malpractice claims from 1991 through 2005, EPs ranked in the middle among specialties with respect to annual risk of a malpractice claim.[6] Moreover, the annual risk of a claim for EPs is just under 8%, compared to 7.4% for all physicians. Yet, for neurosurgery and cardiothoracic surgery—the specialties with the highest overall risk of malpractice claims—the annual risk approaches 20%.[6] Regarding payout statistics, less than one-fifth of the claims against EPs resulted in payment.[6] In a review of a separate insurance database of closed claims, EPs were named as the primary defendant in only 19% of cases.[7]

Despite the discrepancies between perceived risk and absolute risk of malpractice claims among EPs, malpractice lawsuits continue to affect the practice of EM. This is evidenced in several surveys, in which the majority of EP participants admitted to practicing "defensive medicine" by ordering tests that were felt to be unnecessary and did so in response to perceived malpractice risk.[8-10] Perceived risk also accounts for the significant variation in decision-making in the ED with respect to diagnostic testing and hospitalization of patients.[11] One would expect that lowering malpractice risk would result in less so-called unnecessary testing, but whether or not this is truly the case remains to be seen.

Effects of Malpractice Reform

A study by Waxman et al[12] on the effects of significant malpractice tort reform in ED care in Texas, Georgia, and South Carolina found no difference in rates of imaging studies, charges, or patient admissions. Furthermore, legislation reform did not increase plaintiff onus to prove proximate "gross negligence" rather than simply a breach from "reasonably skillful and careful" medicine.[12] These findings suggest that perception of malpractice risk might simply be serving as a proxy for physicians' underlying risk tolerance, and be less subject to influence by external forces.

Areas Associated With Malpractice Risk

A number of closed-claim databases attempted to identify the characteristics of patient encounters that can lead to malpractice claims, including patient conditions and sources of error. Diagnostic errors have consistently been found to be the leading cause of malpractice claims, accounting for 28% to 65% of claims, followed by inappropriate management of medical treatment and improper performance of a procedure.[7,13-16] A January 2016 benchmarking system report by CRICO Strategies found that 30% of 23,658 medical malpractice claims filed between 2009 through 2013 cited failures in communication as a factor.[17] The report also revealed that among these failed communications, those that occurred between health care providers are more likely to result in payout compared to miscommunications between providers and patients.[17] This report further noted 70% to 80% of claims closed without payment.[7,16] Closed claims were significantly more likely to involve serious injuries or death.[7,18] Leading conditions that resulted in claims include myocardial infarction, nonspecific chest pain, symptoms involving the abdomen or pelvis, appendicitis, and orthopedic injuries.[7,13,16]

Diagnostic Errors

Errors in diagnosis have been attributed to multiple factors in the ED. The two most common factors were failure to order tests and failure to perform an adequate history and physical examination, both of which contribute to rationalization of the practice of defensive medicine under the current tort system.[13] Other significant factors associated with errors in diagnosis include misinterpretation of test results or imaging studies and failure to obtain an appropriate consultation. Processes contributing

Table. Top Factors That Contribute to Patient Injury[15]

Problems with clinical judgment
Technical skills
Communication
Patient behaviors
System failures
Documentation

to each of these potential errors include mistakes in judgment, lack of knowledge, miscommunication, and insufficient documentation (**Table**).[15]

Strategies for Reducing Malpractice Risk

In part 1, we listed several strategies EPs could adopt to help reduce malpractice risk. In this section, we will discuss in further detail how these strategies help mitigate malpractice claims.

Patient Communication

Open communication with patients is paramount in reducing the risk of a malpractice allegation. Patients are more likely to become angry or frustrated if they sense a physician is not listening to or addressing their concerns. These patients are in turn more likely to file a complaint if they are harmed or experience a bad outcome during their stay in the ED.

Situations in which patients are unable to provide pertinent information also place the EP at significant risk, as the provider must make decisions without full knowledge of the case. Communication with potential resources such as nursing home staff, the patient's family, and emergency medical service providers to obtain additional information can help reduce risk.

Of course, when evaluating and treating patients, the EP should always take the time to listen to the patient's concerns during the encounter to ensure his or her needs have been addressed. In the event of a patient allegation or complaint, the EP should make the effort to explore and de-escalate the situation before the patient is discharged.

Discharge Care and Instructions

According to CRICO, premature discharge as a factor in medical malpractice liability results from inadequate assessment and missed opportunities in 41% of diagnosis-related ED cases.[16] The following situation illustrates a brief example of such a missed opportunity: A provider makes a diagnosis of urinary tract infection (UTI) in a patient presenting with fever and abdominal pain but whose urinalysis is suspect for contamination and in whom no pelvic examination was performed to rule out other etiologies. When the same patient later returns to the ED with worse abdominal pain, a sterile urine culture invalidates the diagnosis of UTI, and further evaluation leads to a final diagnosis of ruptured appendix.

Prior to discharging any patient, the EP should provide clear and concise at-home care instructions in a manner in which the patient can understand. Clear instructions on how the patient is to manage his or her care after discharge are vital, and failure to do so in terms the patient can understand can create problems if a harmful result occurs. This is especially important in patients with whom there is a communication barrier—eg, language barrier, hearing impairment, cognitive deficit, intoxication, or violent or irrational behavior. In these situations, the EP should always take advantage of available resources and tools such as language lines, interpreters, discharge planners, psychiatric staff, and supportive family members to help reconcile any communication barriers. These measures will in turn optimize patient outcome and reduce the risk of a later malpractice allegation.

Board Certification

All physicians should maintain their respective board certification and specialty training requirements. Efforts in this area help providers to stay up to date in current practice standards and new developments, thus reducing one's risk of incurring a malpractice claim.

Patient Safety

All members of the care team should engender an environment that is focused on patient safety, including open communication between providers and with nursing staff and technical support teams. Although interruptions can be detrimental to patient care, simply having an understanding of this phenomenon among all staff members can alleviate some of the working stressors in the ED. Effort must be made to create an environment that allows for clarification between nursing staff and physicians without causing undue antagonism. Fostering supportive communication, having a questioning attitude, and seeking clarification can only enhance patient safety.

The importance of the supervisory role of attending physicians to trainees, physician extenders, and nursing staff must be emphasized, and appropriate guidance from the ED attending is germane in keeping patients safe in teaching environments. Additionally, in departments that suffer the burden of high numbers of admitted patient boarders in the ED, attention must be given to the transitional period between decision to admit and termination of ED care and the acquisition of care of the admitting physician. A clear plan of responsibility must be in place for these high-risk situations.

Policies and Procedures

Departmental policies and procedures should be designed to identify and address all late laboratory results data, radiological discrepancies, and culture results in a timely and uniform manner. Since unaddressed results and discrepancies can result in patient harm, patient-callback processes should be designed to reduce risk by addressing these hazards regularly, thoroughly, and in a timely fashion.

Cognitive Biases

An awareness of inherent biases in the medical decision-making process is also helpful to maintain mindfulness in the routine practice of EM and avoid medical errors. The EP should take care not to be influenced by recent events and diagnostic information that is easy to recall or common, and to ensure the differential addresses possibilities beyond the readily available diagnoses. Further, reliance on an existing opinion may be misleading if subsequent judgments are based on this "anchor," whether it is true or false.

If the data points of the case do not line up as expected, or if there are unexplained outliers, the EP should expand the frame of reference to seek more appropriate possibilities, and avoid attempts to make the data fit a preferred or favored conclusion.

When one fails to recognize that data do not fit the diagnostic presumption, the true diagnosis can be undermined. Such confirmation bias in turn challenges diagnostic success. Hasty judgment without considering and seeking out relevant information can set up diagnostic failure and premature closure.

Remembering the Basics

Finally, providers should follow the basic principles for every patient. Vital signs are vital for a reason, and all abnormal data must be accounted for prior to patient hand off or discharge. Patient turnover is a high-risk occasion, and demands careful attention to case details between the offgoing physician, the accepting physician, and the patient.

All patients presenting to the ED for care should leave the ED at their baseline functional level (ie, if they walk independently, they should still walk independently

at discharge). If not, the reason should be sought out and clarified with appropriate recommendations for treatment and follow-up.

Patients and staff should always be treated with respect, which in turn will encourage effective communication. Providers should be honest with patients, document truthfully, respect privacy and confidentiality, practice within one's competence, confirm information, and avoid assumptions. Compassion goes hand in hand with respectful and open communication. Physicians perceived as compassionate and trustworthy are less likely to be the target of a malpractice suit, even when harm has occurred.

Conclusion

Even though the number of paid medical malpractice claims has continued to decrease over the past 20 years, a discrepancy between perceived and absolute risk persists among EPs—one that perpetuates the practice of defensive medicine and continues to affect EM. Despite the current perceptions and climate, EPs can allay their risk of incurring a malpractice claim by employing the strategies outlined above.

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