The Medical Liability Environment: Is It Really Any Worse for Hospitalists?

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Although malpractice "crises" come and go, liability fears persist near top of mind for most physicians.[1] Liability insurance premiums have plateaued in recent years, but remain at high levels, and the prospect of being reported to the National Practitioner Data Bank (NPDB) or listed on a state medical board's website for a paid liability claim is unsettling. The high-acuity setting and the absence of longitudinal patient relationships in hospital medicine may theoretically raise malpractice risk, yet hospitalists' liability risk remains understudied.[2]

The contribution by Schaffer and colleagues[3] in this issue of the *Journal of Hospital Medicine* is thus welcome and illuminating. The researchers examine the liability risk of hospitalists compared to that of other specialties by utilizing a large database of malpractice claims compiled from multiple insurers across a decade.[3] In a field of research plagued by inadequate data, the Comparative Benchmarking System (CBS) built by CRICO/RMF is a treasure. Unlike the primary national database of malpractice claims, the NPDB, the CBS contains information on claims that did not result in a payment, as well as physicians' specialty and detailed information on the allegations, injuries, and their causes. The CBS contains almost a third of all medical liability claims made in the United States during the study period, supporting generalizability.

Schaffer and colleagues[1] found that hospitalists had a lower claims rate than physicians in emergency medicine or neurosurgery. The rate was on par with that for non-hospital general internists, even though hospitalists often care for higher-acuity patients. Although claims rates dropped over the study period for physicians in neurosurgery, emergency medicine, psychiatry, and internal medicine subspecialties, the rate for hospitalists did not change significantly. Further, the median payout on claims against hospitalists was the highest of all the specialties examined, except neurosurgery. This reflects higher injury severity in hospitalist cases: half the claims against hospitalists involved death and three-quarters were high severity.

The study is not without limitations. Due to missing data, only a fraction of the claims (8.2% to 11%) in the full dataset are used in the claims rate analysis. Regression models predicting a payment are based on a small number of payments for hospitalists (n = 363). Further, the authors advance, as a potential explanation for hospitalists' higher liability risk, that hospitalists are disproportionately young compared to other specialists, but the dataset lacks age data. These limitations suggest caution in the authors' overall conclusion that "the malpractice environment for hospitalists is becoming less favorable."

Nevertheless, several important insights emerge from their analysis. The very existence of claims demonstrates that patient harm continues. The contributing factors and judgment errors found in these claims demonstrate that much of this harm is potentially preventable and a risk to patient safety. Whether or not the authors' young-hospitalist hypothesis is ultimately proven, it is difficult to argue with more mentorship as a means to improve safety. Also, preventing or intercepting judgment errors remains a vexing challenge in medicine that undoubtedly calls for creative clinical decision support solutions. Schaffer and colleagues[1] also note that hospitalists are increasingly co-managing patients with other specialties, such as orthopedic surgery. Whether this new practice model drives hospitalist liability risk because hospitalists are practicing in areas in which they have less experience (as the authors posit) or whether hospitalists are simply more likely to be named in a suit as part of a specialty team with higher liability risk remains unknown and merits further investigation.

Ultimately, regardless of whether the liability environment is worsening for hospitalists, the need to improve our liability system is clear. There is room to improve the system on a number of metrics, including properly compensating negligently harmed patients without unduly burdening providers. The system also induces defensive medicine and has not driven safety improvements as expected. The liability environment, as a result, remains challenging not just for hospitalists, but for all patients and physicians as well.

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