

# Most Doctors Face a Malpractice Claim by Age 65

BY FRANCES CORREA

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Although physicians in high-risk specialties face a near certainty of a malpractice claim at some point in their careers, only a small minority will end up making an indemnity payment to a patient.

The probability of facing a malpractice claim increases with length of time in practice, based on data from 1991 through 2005 from a large national malpractice carrier insuring more than 40,000 physicians in all 50 states and the District of Columbia.

Among physicians in high-risk specialties such as neurosurgery, general

surgery, and obstetrics/gynecology, an estimated 88% were projected to face their first claim by age 45 and an estimated 99% by age 65. In low-risk specialties such as family medicine, pediatrics, and psychiatry, 36% of physicians were projected to face their first claim by age 45 years and 75% by age 65 years, Dr. Anupam Jena of Harvard Medical School and his colleagues wrote.

In contrast, the projected rates of indemnity claims paid to plaintiffs were lower. By age 45, 33% of physicians in high-risk specialties were projected to have had a claim paid, rising to 71% by age 65. For physicians in low-risk specialties, 5% were projected to have had a claim paid by age 45, rising to 19% by age 65 years (*N. Engl. J. Med.* 2011;365:629-36).

"If you've hit 65 and you haven't had a claim, that's rare; that's almost impossible in our data," Dr. Jena said in an interview, adding that high-risk specialties often come with higher salaries, which could be what balances out the risk factor for physicians.

Overall, 7.4% of physicians were sued for malpractice each year of the study, with 1.6% having an indemnity payment made each year.

Dr. Jena and colleagues also found that specialties in which physicians were more likely to face a malpractice claim were not the ones where indemnity payments were most prevalent.

For example, although neurosurgeons had a higher yearly risk of being sued than did pediatricians (19.1% vs.

3.1%), the average indemnity payment for neurosurgeons was \$344,811, lower than the average of \$520,924 for pediatricians. Neurologists' yearly risk of being sued was about 8%, with an average indemnity payment of about \$240,000.

Among all specialties, thoracic-cardiovascular surgery had the second highest yearly risk of being sued (18.9%), followed by general surgery (15.3%). Specialties with the lowest yearly risk of being sued included psychiatry (2.6%), pediatrics (3.1%), and family medicine (5.2%). The average payment for all specialties was \$273,887.

While few claims resulted in payment, researchers said they were surprised by how many physicians face malpractice claims every year.

"A lot of those claims do not resolve in a payment to the patient, but they still involve significant monetary costs to both the physician and the insurer," Dr. Jena said. "The physician has loss of productivity because they're not able to see patients as they defend cases ... and then there are all sorts of nonmonetary costs that we simply cannot measure," Dr. Jena said in an interview.

Some lawmakers and health care organizations have advocated for national medical malpractice reform, or tort reform, as a means of lowering health care costs; California and Texas already have \$250,000 caps noneconomic damages. However, there's little evidence that proves these measures are lowering health care costs. Even without tort reform, Dr. Jena said that he believes the best solution is one that roots out frivolous claims. ■

## Malpractice Caps: The Texas Experience

While the results of this study may not be surprising, Texas has found one solution to the issue. Since Texas instituted a \$250,000 cap on noneconomic damages in 2003, nuisance suits have been significantly reduced. The wasteful process of a medical liability trial has also been reduced, as true cases of malpractice are typically resolved through a settlement. Also, legitimate cases of malpractice can still be awarded the compensation they deserve. In addition to the \$250,000 maximum payment for pain and suffering (per physi-

cian, hospital, and/or third party, equaling up to \$750,000), patients can also be compensated for past and future medical expenses. In addition, trial lawyers seeking a large payoff can no longer afford to litigate cases with very few damages. Therefore, nuisance cases are reduced to complaints before the Texas Medical Board where they can be handled responsibly in a more cost-effective manner.

Without the concerns of facing a nuisance suit, hospitals in Texas can now redirect those funds to improving care, like funding safety systems or

electronic medical records. Physicians can invest in their practices too, improving patient care. They can provide more charity care as well. The change has also brought thousands of doctors to Texas and improved access to quality care. As family practitioners face high overhead costs and low reimbursement rates, just saving on medical liability has allowed some doctors to continue their work where otherwise they may not have been able to.

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VIEW ON THE NEWS

## CMS Eases E-Prescribing Requirements, Adds Exemptions

BY FRANCES CORREA

FROM THE CENTERS FOR MEDICARE AND MEDICAID SERVICES

Based on feedback from physicians and health care providers, the final federal e-prescribing regulations released at the end of August are more flexible and contain more exemptions, the Centers for Medicare and Medicaid Services announced.

The changes come after concern that the program criteria should be more aligned with the Medicaid incentive program for electronic health records, according to CMS officials.

"[The changes] will encourage more doctors and other health care professionals to adopt this technology and give them the added flexibility to help them succeed," Dr. Patrick Conway, chief medical officer at CMS and director of the agency's Office of Clinical Standards and Quality, wrote in a blog post announcing the change. "With electronic prescribing, providers can better manage patient prescriptions, reducing drug interactions or other preventable prescription errors." Under the Medicare Electronic Prescribing Incentive Program, eligible prescribers who meet the e-prescribing criteria will get a 1% bonus payment for 2011 and 2012 and a 0.5% bonus in 2013. Those who do not meet the criteria in 2012 will be penalized 1% of Medicare payments; the penalty will escalate in 2013 and 2014.

Under the final rule, prescribers who use certified

electronic health records can claim this as a "qualified" e-prescribing system. This move was designed to more closely align the e-prescribing program with the program that offers incentives for meaningful use of electronic health records, CMS officials said.

The final rule, which goes into effect 30 days after its official publication in the Federal Register, contains hardship exemptions for those who live in a rural area without high-speed Internet access and those who work where there are not enough pharmacies that can take electronic prescriptions.

Also, the final rule creates additional hardship exemption categories. Eligible professionals have to demonstrate that they have:

- ▶ registered to participate in the Medicare or Medicaid EHR incentive program and have adopted certified EHR technology,
- ▶ an inability to electronically prescribe due to local, state, or federal law (this primarily applies to prescribing of narcotics),
- ▶ very limited prescribing activity, or
- ▶ insufficient opportunities to report the e-prescribing measure.

The deadline to apply for a hardship exemption has been extended until Nov. 1, 2011, according to CMS officials.

Even with the changes, however, some physicians still have concerns.

The American Medical Association said it is worried about the amount of time physicians will have to apply for the exemptions.

"We remain concerned that physicians will be hit with a penalty and are not being given enough time to comply with the e-prescribing program criteria to avoid this penalty," Dr. Cecil Wilson, AMA immediate past president, said in a statement. ■

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