

Better care is the best defense: High-value clinical practice vs defensive medicine

LOIS SNYDER SULMASY, JD

Director, Center for Ethics and Professionalism, American College of Physicians, Philadelphia, PA

STEVEN E. WEINBERGER, MD, FACP

Executive Vice President and CEO, American College of Physicians, Philadelphia, PA

I VIEW EVERY PATIENT as a potential lawsuit.” This statement is jolting. Yet more than 69% of neurosurgeons in a recent study said they agreed or strongly agreed with this survey question.¹ What are its implications for patients, for clinical practice, and for the US health care system?

See related article, page 462

There are many frustrations in the delivery of health care today, for patients as well as for physicians. For physicians, concern about medical liability is a large one, with secondary implications for both health care costs and quality. The Institute of Medicine has estimated that \$765 billion—or 30 cents out of every dollar spent on health care—is wasted annually in the United States, adding to the financial burden of health care without benefiting patients.² A significant portion of this waste, estimated at \$210 billion, is related to

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unnecessary services that are under the control of physicians, including overuse and misuse of diagnostic testing and treatment. This type of care is not only wasteful, but also has the potential to harm.

Factors thought to be responsible for this inappropriate care include the expectations of patients, physician or patient discomfort with uncertainty, and unnecessary and costly consultations. But the factor that physicians cite most often is concern about malpractice suits, raised by 76% of physicians responding to a survey.³

■ THE DILEMMAS ILLUSTRATED

Here are two cases—to which we will return later—that illustrate the dilemmas faced by physicians deciding how aggressively to pursue a diagnosis:

Patient 1. A 32-year-old woman comes to your office for evaluation of intermittent headaches over the past year. After a detailed history and a normal physical examination, you believe that these are tension headaches. Should you order an imaging study of the brain, just to avoid the risk of a malpractice suit in the unlikely event that this could be the presenting symptom of a brain tumor?

Patient 2. A 60-year-old man presents to the emergency room with pleuritic chest pain. Calculation of pretest probability by modified Wells criteria indicates that pulmonary embolus is unlikely. Because missing the diagnosis can lead to a malpractice suit, should you still order computed tomographic (CT) pulmonary angiography to rule out an embolus?

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■ JUST ONE MORE TEST CAN'T HURT...

Defensive medicine is the ordering or avoiding of tests or procedures primarily out of concern about malpractice liability.⁴ It increases health care costs, but by how much is unclear.⁵ It can harm the patient-physician relationship and trust and can also harm patients, especially if overtesting and treatment lead to false-positive results and more tests, which actually can result in liability. And it is not the highest-value care for patients.

Physicians have an ethical duty to do what is best for the individual patient; they also have a responsibility to society to practice effective health care that uses resources responsibly.⁶ And despite telling ourselves and our patients that one more test will give us confirmation of results and therefore comfort, a recent review found that tests performed based on symptoms with low risk of being caused by serious illness “do little to reassure patients, decrease their anxiety, or resolve their symptoms.”⁷

■ MALPRACTICE LIABILITY RISK: PERCEPTION AND REALITY

Physicians often overestimate their risk of liability. Only a small percentage (5%) of claims go to trial, and of those, 90% are won by the physician, according to a 2008 analysis by the Physician Insurers Association of America.⁸ A study of claims between 2002 and 2005 found that 4.5% of claims resulted in trial verdicts, of which 80% were in favor of the physician, with cases against internists and internal medicine-based subspecialists least likely to result in a trial verdict (2.7%).⁹

Even so, being sued is extremely stressful and is associated with distinct physical and emotional distress for most physicians.^{10,11} Charles has found that, “As a group, physicians are acutely sensitive to any suggestions that they have failed to meet the standard of care or are not ‘good’ doctors... This accusation of failure represents a personal assault.”¹¹

Physician concerns about liability are not very different in states with tort reforms such as damage caps compared with those without.⁵ Some posit that physicians may overestimate the risk of liability as part of the human tendency to overestimate the risk of rare events

that are difficult to experience and difficult to control.¹²

In the study of neurosurgeons cited previously, 72% of respondents said they ordered imaging, 67% did laboratory tests, and 66% referred patients for consults “solely” to “minimize the risk of a lawsuit.”¹¹ The authors of the study maintain that, over time, this affects the standard of care. “While physicians in the past may have used a thorough history and physical to guide imaging, in this study, 72% of neurosurgeons surveyed stated that they order additional imaging studies solely to mitigate liability risk. This suggests that in reality, imaging is becoming a standard part of the initial workup.”¹¹ Unfortunately, this new standard of care is based on false assumptions and is artificially and inappropriately changed. That perception of liability risk deeply influences practice.

■ DO THE RIGHT THING: AVOIDING UNNECESSARY TESTING

But physicians also acknowledge the need to follow practice guidelines and to avoid unnecessary testing. In one survey,¹³ 79% strongly or moderately agreed with the statement that physicians “should adhere to clinical guidelines that discourage the use of interventions that have a small proven advantage over standard intervention but cost much more”; 89% strongly or moderately agreed that “doctors need to take a more prominent role in limiting use of unnecessary tests”; and 78% said they “should be solely devoted to individual patients’ best interests, even if that is expensive.”¹³

This may be summarized as, “Provide the clinically appropriate care to the patient based on the best evidence.” But of course, this is easier said than done.

■ THE ROLE OF EVIDENCE-BASED GUIDELINES

Evidence-based practice guidelines can help support the provision of clinically (and ethically) appropriate care. Medical custom—the care expected of reasonable clinicians under similar circumstances—is generally the legal standard in determining whether a clinician has met a duty of care to a patient in a lawsuit.¹⁴ But practice guidelines can provide

Evidence-based guidelines can support the provision of clinically and ethically appropriate care

strong evidence of what constitutes reasonable care and can, over time, help set the standard for quality of care.

Clinical practice guidelines have grown in recent years, especially after the Institute of Medicine embraced them as a means to address variation in practice patterns and quality of care. But guidelines can conflict. Their effective implementation relies on clinical judgment. If a guideline is not appropriate in a particular case, documentation of why the guideline was not followed may prove prudent. Guidelines are not a safe harbor and have and will be used both defensively and offensively. They are not the last word, but rather another type of expert evidence.¹⁵ However, they are an important one. At the end of the day, the best care is the best defense.

Guidelines not only educate physicians, they also should be used by physicians to educate patients. In addition to developing guidelines for physicians, professional societies should develop and disseminate public education materials that inform patients and their families and caregivers about clinically appropriate care and the problems resulting from overuse and misuse of care.

■ GETTING BACK TO BASICS

Kroenke noted that preliminary data suggest that the history typically accounts for 75% or more of the diagnostic yield when evaluating common symptoms, the physical examination 10% to 15%, and testing generally less than 10%.¹⁶ Yet health care reimbursement in the United States contains incentives in precisely the reverse order. So, not surprisingly, we keep on testing away. Kroenke says that countering the rush to test will be as challenging and slow as trying to reverse a generation of antibiotic overprescribing.¹⁶

Over time, our reliance on technology as a diagnostic tool has increased, with less emphasis on the history and particularly on the physical examination to solve diagnostic puzzles. Yet most diagnostic errors in a study of outpatient primary care visits were related to breakdowns in the clinical interaction, including the taking of the medical history, the performance of the physical examination, and the ordering of tests. Technologies such

as the electronic health record, which can assist in the care of patients, are also a potential source of error and shortcuts in care, as when copying and pasting is used inappropriately.¹⁷ Recognizing the increasing use of technology in practice and team-based approaches to improving care, Singh et al have called for caution and for more “focus on basic clinical skills and related cognitive processes.”¹⁸

The erosion of physical examination skills, discomfort with diagnostic uncertainty, and fear of malpractice litigation have combined to create a perfect storm of technologic overuse and misuse. Unfortunately, this means that our modus operandi is all too frequently built around testing rather than touching.¹⁹

At the same time, it is well established that patients often sue because of dissatisfaction, especially with physician communication and interpersonal skills.¹⁴ Emphasizing the basic skills that include taking a carefully crafted history, performing a skillful physical examination, and communicating effectively and compassionately with patients at every encounter is probably the most successful strategy for simultaneously avoiding malpractice litigation, reducing overused and misused diagnostic testing, and conserving precious health care resources.

Another part of the strategy should include routinely considering a number of straightforward questions before ordering diagnostic tests, such as “Will the test result change my care of the patient?” and “How does ordering this test compare in value with other management strategies for the patient?”^{20,21}

■ RETURNING TO THE CASES

Regarding patient 1, the 32-year-old woman with intermittent headaches, the American College of Radiology identified imaging for headache in its list of five areas submitted to the Choosing Wisely campaign in which care may be overused or misused. Specifically, the American College of Radiology says, “Don’t do imaging for uncomplicated headache” in the absence of specific risk factors for structural disease, noting that “incidental findings lead to additional medical procedures and expense that do not improve patient well-being.”²²

The basic principles of beneficence and nonmaleficence align with doing the right thing

For patient 2, the 60-year-old man with pleuritic chest pain, both the American College of Physicians and the American College of Radiology strongly recommend against CT pulmonary angiography for patients in whom calculation of pretest probability indicates a low pretest probability of pulmonary embolism.^{22,23} Patients such as these should undergo D-dimer testing rather than CT pulmonary angiography. In this setting, a negative D-dimer test effectively rules out pulmonary embolism and avoids both the radiation and cost associated with the unnecessary imaging study.

According to the *Ethics Manual* of the American College of Physicians,⁶ “physicians have an obligation to promote their patients’ welfare in an increasingly complex health care system. This entails forthrightly helping patients to understand clinical recommendations and make informed choices among all appropriate care options... It also includes stewardship of finite health care resources so that as many health care needs as possible can

be met, whether in the physician’s office, in the hospital or long-term care facility, or at home.”⁶ The basic principles of beneficence and nonmaleficence are aligned with doing the right thing for our patients—ie, providing the appropriate care at the right time and avoiding too much care or too little care. Guided by scientific evidence as well as by guidelines and official recommendations based on such evidence, we are in the best position to provide optimal care for our patients while simultaneously minimizing the risk of malpractice litigation.

As is the case with overprescribing, we must look critically at the inappropriate use of tests and other care applied under the rationale of not wanting to “miss anything”—and the unspoken drivers of financial incentives, new or advanced tests and procedures, and defensive medicine. We know what needs to be done. And nothing short of evidence-based high-value care will do. ■

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■ REFERENCES

1. Nahed BV, Babu MA, Smith TR, Heary RF. Malpractice liability and defensive medicine: a national survey of neurosurgeons. *PLoS One* 2012; 7:e39237.
2. Institute of Medicine. *The Healthcare Imperative: Lowering Costs and Improving Outcomes: Workshop Series Summary*. Washington, DC: The National Academies Press, 2010.
3. Sirovich BE, Woloshin S, Schwartz LM. Too Little? Too Much? Primary care physicians’ views on US health care: a brief report. *Arch Intern Med* 2011; 171:1582–1585.
4. US Congress, Office of Technology Assessment. *Defensive Medicine and Medical Malpractice, OTA-H–602*. Washington, DC: US Government Printing Office, 1994.
5. Carrier ER, Reschovsky JD, Katz DA, Mello MM. High physician concern about malpractice risk predicts more aggressive diagnostic testing in office-based practice. *Health Aff (Millwood)* 2013; 32:1383–1391.
6. Snyder L; American College of Physicians Ethics, Professionalism, and Human Rights Committee. *American College of Physicians Ethics Manual: sixth edition*. *Ann Intern Med* 2012; 156:73–104.
7. Rolfe A, Burton C. Reassurance after diagnostic testing with a low pretest probability of serious disease: systematic review and meta-analysis. *JAMA Intern Med* 2013; 173:407–416.
8. Kane CK. Policy research perspectives: medical liability claim frequency: a 2007–2008 snapshot of physicians. American Medical Association, 2010. Available at www.ama-assn.org. Accessed July 2, 2014.
9. Jena AB, Chandra A, Lakdawalla D, Seabury S. Outcomes of medical malpractice litigation against US physicians. *Arch Intern Med* 2012; 172:892–894.
10. Charles SC, Pyskoty CE, Nelson A. Physicians on trial—self-reported reactions to malpractice trials. *West J Med* 1988; 148:358–360.
11. Charles SC. Coping with a medical malpractice suit. *West J Med* 2001; 174:55–58.
12. Carrier ER, Reschovsky JD, Mello MM, Mayrell RC, Katz D. Physicians’ fears of malpractice lawsuits are not assuaged by tort reforms. *Health Aff (Millwood)* 2010; 29:1585–1592.

13. Tilburt JC, Wynia MK, Sheeler RD, et al. Views of US physicians about controlling health care costs. *JAMA* 2013; 310:380–388.
14. Studdert DM, Mello MM, Brennan TA. Medical malpractice. *N Engl J Med* 2004; 350:283–292.
15. Mehlman MJ. Medical practice guidelines as malpractice safe harbors: illusion or deceit? *J Law Med Ethics* 2012; 40:286–300.
16. Kroenke K. Diagnostic testing and the illusory reassurance of normal results: comment on “Reassurance after diagnostic testing with a low pretest probability of serious disease.” *JAMA Intern Med* 2013; 173:416–417.
17. Rattner S, Mathes M, Siegler E. Copy and pasted and misdiagnosed (or cloned notes and blind alleys). *ACP Ethics Case Study CME program*. Available at https://www.acponline.org/running_practice/ethics/case_studies/. Accessed July 2, 2014.
18. Singh H, Giardina TD, Meyer AN, Forjuoh SN, Reis MD, Thomas EJ. Types and origins of diagnostic errors in primary care settings. *JAMA Intern Med* 2013; 173:418–425.
19. Vergheze A, Brady E, Kapur CC, Horwitz RI. The bedside evaluation: ritual and reason. *Ann Intern Med* 2011; 155:550–553.
20. Laine C. High-value testing begins with a few simple questions. *Ann Intern Med* 2012; 156:162–163.
21. Weinberger SE. Providing high-value, cost-conscious care: a critical seventh general competency for physicians. *Ann Intern Med* 2011; 155:386–388.
22. American College of Radiology (ACR). *Choosing Wisely. Five things physicians and patients should question*. <http://www.choosingwisely.org/doctor-patient-lists/american-college-of-radiology/>. Accessed July 2, 2014.
23. American College of Physicians (ACP). *Choosing Wisely. Five things physicians and patients should question*. <http://www.choosingwisely.org/doctor-patient-lists/american-college-of-physicians/>. Accessed July 2, 2014.

ADDRESS: Lois Snyder Sulmasy, JD, Center for Ethics and Professionalism, American College of Physicians, 190 N. Independence Mall West, Philadelphia, PA 19106; e-mail: lsnyder@acponline.org