LETTERS TO THE EDITOR

ARE THE BEST DOCTORS SUED MORE?

To the Editor:

I am certain that you easily identified the illogical premise of your headline ("Malpractice claims against family physicians: Are the best doctors sued more?"[1]). Whether someone may be categorized as the "best" is dependent on the term's definition. I practiced family and emergency room medicine for nearly 20 years before pursuing a career in law. I have been involved in medical-legal litigation for 25 years, first as an expert witness, and now I evaluate cases and work on the strategy side of medical negligence litigation. I have made my share of medical mistakes and had my share of unfortunate outcomes. In my experience, the best doctors don't get sued.

Drawing from my personal and professional experiences, I have found characteristics that exemplify defendants in medical negligence cases: arrogant doctors who won't question; ones who don't return telephone calls; docs who "punt" late at night rather than seeing the patient; physicians who shade the truth, and those who modify medical records; doctors who don't pay attention to what patients say; health care professionals who fail to observe the obvious; doctors who manipulate the patient, those who overcharge, and those who persist in collection attempts; doctors who forgot long ago what caring means; those who attempt to embellish the physician-patient relationship with personal attention that crosses the well-established lines; and doctors who phone-treat and who prescribe or renew medicines without doing what should be done.

There was a whiny, why-me tone to both the article and the associated editorial.[2] Actually, the law is elastic with respect to medical negligence, and it only requires that a physician act reasonably in a situation—nothing more. Clearly, cognitive abilities do not separate those who get sued from those who do not, and I would agree that the fact of a suit is not evidence of incompetence, depending on the facts of the case. That being said, however, when a jury finds culpability, that may indicate incompetence, because juries, in general, tell it like it is.

In my opinion, *very* few suits contain technical errors where the negligence occurred because of a fundamental lack of scientific knowledge on behalf of the actor. On the other hand, many suits occur because the physician failed to apply his knowledge in a timely manner, or he applied the knowledge at the wrong time, when he shouldn't have acted.

In a recent case in the South, 3 board-certified physicians—a family physician, a surgeon, and a gastroenterologist—failed to discover that a man had acute appendicitis, and even though they knew his bowel had perforated, they operated 24 hours too late. The man died. One might ask why this happened, since an acute abdomen shouldn't be terribly difficult to diagnose and treat in modern times. No practitioner performed a rectal examination on this patient; it was Fourth of July weekend; it was the South; the man was African American; and the doctors were white. None of these doctors had any trouble with the science; it was the implementation of the science that made them stumble and killed this patient. Nonmedical issues caused this death.

What the Ely and colleagues article concludes is a simple medical and legal conclusion: Becoming a defendant in a medical negligence case requires a disregard for the rules, the standard of care. If the practitioner follows the rules, it is unlikely that he will become a defendant. Even if he becomes a defendant, his conduct in all likelihood will form an impenetrable defense. Without testimony that the defendant departed from the standard of care, there cannot be a plaintiff's verdict.

Lawyers cannot sue without medical disasters. If doctors would only spend that additional moment to listen and analyze, there would be fewer disasters.

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REFERENCES

1. Ely JW, Dawson JD, Young PR, et al. Malpractice claims against family physicians: are the best doctors sued more? J Fam Pract 1999; 48:23-30.
2. Victoroff MS. What is so good about being the best? J Fam Pract 1999; 48:21-2.

The preceding letter was referred to Dr Ely and colleagues, who respond as follows:

We appreciate the difficulty of knowing how to interpret the paradoxical associations we reported, and we are not surprised that they would be met with skepticism. It just does not make sense that the most knowledgeable physicians would be sued the most. We welcome comments from those who would challenge our methods or point to conflicting data, but little is served by perpetuating widely held beliefs based only on opinion and anecdote.

Dr Oppenheim cites the common

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assumptions: the best doctors don't get sued; many suits occur because the physician failed to apply his knowledge in a timely manner; becoming a defendant in a medical negligence case requires a disregard for the rules. These assumptions lack supporting data, but they could be recast as testable hypotheses. We invite Dr Oppenheim and others to study these assertions using rigorous epidemiologic methods.

The assumption that bad doctors get sued more may be true, but we could find no evidence to support it and some evidence to refute it.[1-6]

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REFERENCES

1. Brennan TA, Sox CM, Burstin HR. Relation between negligent adverse events and the outcomes of medical-malpractice litigation. N Engl J Med 1996; 26:1963-7.
2. Localio AR, Lawthers AG, Brennan TA, et al. Relation between malpractice claims and adverse events due to negligence: results of the Harvard Medical Practice Study III. N Engl J Med 1991; 325:245-51.
3. Entman SS, Glass CA, Hickson GB, Githens PB, Whetten-Goldstein K, Sloan FA. The relationship between malpractice claims history and subsequent obstetric care. JAMA 1994; 272:1588-91.
4. Hickson GB, Clayton EW, Entman SS, et al. Obstetricians' prior malpractice experience and patients' satisfaction with care. JAMA 1994; 272:1583-7.
5. Neale G. Clinical analysis of 100 medicolegal cases. BMJ 1993; 307:1483-7.
6. Ely JW, Dawson JD, Young PR, et al. Malpractice claims against family physicians: are the best doctors sued more? J Fam Pract 1999; 48:23-30.

Dr Victoroff also responds:

Dr Oppenheim uses the term "best," but without the self-conscious irony of Ely and colleagues. Despite his experience, he is unaware of the best doctors being sued. This could only be valid if one defines best as "not sued." But the point of the article was that when defining best as "knowledgeable," this was contradicted. In the malpractice literature, the overwhelming message is that lawsuits do not correlate with fault. So, what are they associated with?

Lawsuits, fundamentally adversarial and belligerent by nature, require antipathy. Dr Oppenheim makes the excellent and supportable point that doctors who fail to generate sympathy for themselves invite suits. Ely and coworkers discussed this. I would encourage looking more closely at sympathy and antipathy toward the doctor as important factors in malpractice, and less at knowledge in future studies.

Attorney Oppenheim weakens the insight of Doctor Oppenheim. It's a treacherous misconception that juries "tell it like it is." I would say that juries tell it as they feel it. In the theater of the court, the terms "sympathy" and "antipathy" seem more relevant than knowledge. The language Dr Oppenheim uses to present his anecdote is illustrative.

I agree that the vices he lists are representative reasons why doctors are sued. For precisely this reason, I disagree that "standard of care" and "following the rules" have anything reliable to do with either being sued or winning a suit. And, there is a vast body of cases showing that these defenses are not impenetrable.

Finally, it's tautological to say that "without testimony that the defendant departed from the standard of care, there cannot be a plaintiff's verdict." Of course there will be someone giving testimony of this sort. But the outcome of a plaintiff's verdict has more to do with the nature of the injury and the plausible portrayal of the defendant as not respectable than any objective standards or facts. Keeping the affection and respect of the patient is the real rule that must not be broken. Ely and colleagues, by showing us an avenue to avoid in understanding malpractice, make it possible to aim our attentions at a truer mark.

Michael Victoroff, MD
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APPOINTMENTS, PROCEDURES, AND LAWSUIT FREQUENCY?

To the Editor:

In his editorial, Dr Victoroff[1] raised some interesting questions about why doctors get sued. But there is a question he did not raise, namely, is there a relationship between the number of patients a doctor sees in a day and the number of lawsuits he or she has in a given year? And is there a relationship between the number of procedures performed and the number of lawsuits?

I mention this because during the past 2 decades, office overhead has increased immensely. The increasing costs of supplies and staff salaries and the increasing amount of time spent on dealing with administrative red tape have made primary care doctors' practices less profitable than ever before. Some of them have responded by learning how to do procedures, such as colposcopy and colonoscopy, that formerly were done by specialists; others have expanded their office hours and see more patients. Thus, there may be a direct relationship between the economic challenge doctors face and their exposure to malpractice.

Although all categories of physicians in this era of cost-containment have seen their incomes diminish, primary care doctors have been affected the most. Should reimbursement schedules take this into account? Should primary care doctors not be performing some of the procedures and minor surgery that many of them seem so eager to learn?

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REFERENCE

1. Victoroff MS. What is so good about being the best? J Fam Pract 1999; 48:21-2.

The preceding letter was referred to Dr Victoroff, who responds as follows:

Unquestionably, there is a limit to the rate at which a physician can see patients and still do a conscientious job. Our specialty is coy about setting a standard, but I'd support 4 to 5 encounters per hour as the theoretical maximum. I can make an argument on the basis of common courtesy and the ethics of informed consent that the briefest possible visit requires 10 minutes of "face time" plus 5 to 10 minutes of documentation and management to meet minimum defensible standards.

I'm an advocate of family physicians (FPs) performing procedures. And, I don't believe that FPs are becoming more procedural. Look back a generation. However, the procedures have shifted from surgical (tonsils, caesarians, D&Cs, and tubals) to more office-based procedures. But I don't accept that this is due to economic motivations. (This would be misguided, anyway. It's demonstrable that except for obstetrics which is, after all, just adding a night job, incomes of procedural and nonprocedural FPs are comparable.) There are plenty of good reasons to master a wide range of services that have nothing to do with generating fees.

Also, it's incorrect to say that primary care doctors have seen the most negative impact from cost-containment. FPs as a group have been relatively insulated from the decreases surgical specialties have experienced. An FP in group practice, with a good proportion of managed care patients, sees fewer patients per day, spends more time per encounter, performs more preventive measures, and has a higher income than a solo colleague taking exclusively fee-for-service patients. The former matches more FPs newly out of training. So, I can't verify the syllogism that FPs are financially driven to take on more procedures than are good for their patients. This probably describes some cases, but it's not a good generalization.

Michael Victoroff, MD
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Spirituality and Medicine

To the Editor:

I am writing in reference to the recent research articles[1,2] and editorial[3] about spirituality and medicine. I applaud the authors and the editorial staff for laying the groundwork and providing the forum for scientific exploration of this new field. I agree with the editorial, which stresses clarifying spirituality as something that is common to *all* human beings irrespective of religious or nonreligious background. Successful future study will depend on how we define health, religion, and spirituality.

There are so many research questions to consider: What do patients and physicians believe? Which spiritual factors are associated with health and overall well-being? Does discussing spirituality with patients make a difference in their health? Do specific spiritual practices promote better health? By what mechanisms do spiritual factors influence physical symptoms?

In our zeal to scientifically study, categorize, and measure spirituality, however, it will be important for us not to forget the essence of spirituality. Spirituality is ultimately about connections—to self, others, and a higher power. In medicine, its essence is in the therapeutic doctor-patient relationship.

How can we measure the look of gratitude and relief on the face of a patient who can share with her physician her innermost fears regarding the meaning of her suffering? How can we measure the tears on the faces of medical students or residents who tell us of patients whose courage and strength in the face of great adversity have touched their hearts and inspired them? These things are beyond mere emotion but rather speak to something that transcends both the physical and mental.

Spirituality in medicine is reaching out and connecting with other human beings; relieving suffering of all kinds; encouraging our patients to help heal themselves by connecting with their inner selves, others, and their God; and allowing ourselves to grow in compassion and understanding through our interaction with our patients.

This spiritual dimension is the true "art" and "heart" of medicine. It is possible to maintain a healthy balance between science and spirituality without sacrificing either. It is a compassionate heart coupled with a cool, analytic, well-trained mind that can be the most potent healing force in the future of medicine. I hope that with careful scientific study and minds open to new methods of studying "the immeasurable," we can harness the healing power of both science and spirituality.

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REFERENCES

1. Daaleman TP, Frey B. Spiritual and religious beliefs and practices of family physicians: a national survey. J Fam Pract 1999; 48:98-104.
2. Ellis MR, Vinson DC, Ewigman B. Addressing spiritual concerns of patients: family physicians' attitudes and practices. J Fam Pract 1999; 48:105-9.
3. Thompson CL, Brody H. Inclusive spirituality. J Fam Pract 1999; 48:96-7.