Journal Club Synopsis

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Host: Dr. Fieg

Why do we practice defensive medicine? Is Tort reform in the near future? And would it make a difference?

Clinical Scenario:

65 y/o female that fell at home hitting her head on the tile in the kitchen. No loss of consciousness, no evidence of trauma on exam (lacs/abrasions) and patient has been acting normally and has no complaints. Patient is on aspirin but no other blood thinners. Hx of HTN, Hyperlipidemia, DM. No previous strokes or intracranial bleeds. Neuro exam is normal. You are considering sending the patient home without scanning but remember that your colleague just got sued for missing a head bleed after a fall. You can't remember what the circumstances of that patient were but you think they looked a lot like this patient. To make matters worse the family is asking you if their grandma needs a "CAT scan"? What do you do?

Introduction:

Defensive Medicine and Tort Reform are terms that are thrown around a lot. I chose this set of articles to try to provide some clarity on these topics and how they relate to each other and to our practice in the emergency room. The articles were picked from a larger sample to give a perspective on defensive medicine, tort reform and other possible ways of decreasing liability and defensive medicine. Our discussion began by asking the group at large by show of hands who would scan the patient mentioned in the clinical scenario and everyone present raised their hands. After this we broke into groups to take a look at each of the articles.

Article 1:

Defensive Medicine, Cost Containment, and Reform. Hermer, LD., et al, J Gen Intern Med 25(5):470, May 2010

This article was more of an informative article and not a scientific study. It focused on describing the point of view of physicians and analysts in relation to defensive medicine and tort reform. It did provide bits of data from several studies. It commented on the definition of defensive medicine and the several possible reasons why physicians practice defensive medicine. In the end, the article made the argument that while tort reform is necessary, the percentage of total health costs that would decrease from tort reform would likely be negligible.

Article 2:

Diagnostic Imaging Rates for Head Injury in the ED and States Medical Malpractice Tort Reforms. Smith-Bindman, R., et al, Am J Emerg Med 29(6):656, July 2011

The object of this article was to look at the association between states' medical malpractice tort reforms and neurologic imaging rates for patient's in the emergency department with mild head trauma. The study analyzed data from a national sample but limited itself to 10 states and women who were 65 years or older. They focused on 4 specific tort reforms and the 10 states that were chosen had between 1-4 of these reforms. The data showed that liability reform laws were significantly associated with the likelihood of imaging. States with more tort reforms had up to a 40% lower odds of imaging patients with mild head trauma. They also found that the greater the number of laws, the lower the odds of imaging. They did find that one specific tort reform actually showed an increase in the odds of ordering of imaging and had a hard time explaining this. The article had many limitations and was forthright in bringing these up and explaining them. Ultimately they concluded that tort reforms were associated with a lower likelihood to image in patients with mild head trauma and further stipulated that further tort reform could lead to less defensive medicine practices.

Article 3:

Liability Claims and Costs Before and After Implementation of a Medical Error Disclosure Program. Kachalia, A., et al, Ann Intern Med 153(4): 213, August 17, 2010.

This article compared liability claims and costs before and after the implementation of a disclosure-with-offer program at the University of Michigan Health system. This was a retrospective before-after analysis analyzing data from 1995-2007. The focus was to see if the liability claims and costs would increase or decrease following this implementation. Specifically, in 2001 the hospital system began responding to all open and new malpractice claims by admitting fault and offering compensation when an internal investigation revealed medical error. The results showed that there was a statistically significant drop in the monthly rate of new claims, the monthly rate of lawsuits, the median time to resolution and monthly costs for total liability. They admitted that this study could not establish causality and there were plenty of confounders but ultimately concluded that the implemented full disclosure program was able to offer compensation without increasing its total claims or liability costs.

Overall Discussion:

The overall discussion started with everyone agreeing that they would order a CT head on the patient from the clinical scenario. Everyone freely admitted that we practice defensive medicine, though several people mentioned other reasons for why we might do it. Specifically the idea of practicing defensive medicine, not out of fear of being sued (though this is always something we are forced to consider) but

out of the hope that we can do the most for our patients and that the worst thing that could happen is that harm would come to one of our patients.

While the group as a whole poked many holes in the second article and agreed that its limitations were lengthy, a general consensus was reached that tort reform did seem to have an effect on liability and claims but may not have as much of an affect on practicing defensive medicine. We were fortunate to have a guest attending physician at our journal club who was able to provide some thoughts on the topic as the leader in his emergency medicine group for areas of this nature. He talked about Ohio Tort Reform and the positive effect it has had over the past 10 years on liability claims and costs. He was also able to tell a story as it related to the third article where he and a fellow physician talked to a patient and their family after a medical error was found and the impact it had on them as well as the patient and family and the fact that no lawsuit was ever brought.

In the end the group was once again asked if they would spin the patient in the clinical scenario and again all but one person raised their hands. We then slowly made changes to the scenario to see what the circumstances would need to be before people would be willing to not order a CT. Dropping aspirin from the med list had almost no affect. When the age of the patient was dropped to 59 about half of the group dropped their hands and when the age dropped to 50 the remainder of the group lowered their hands.

Bottom line - We all practice defensive medicine and likely have our own reasons for doing so. Whether it is out of fear of being sued, trying to do the most for each patient, because of the current standard of care in your area of practice, to comply with patient and family requests or for any number of other reasons. It is likely that defensive medicine is here to stay. It is possible, however, that tort reform and other forms of liability management may help create an environment that allows practitioners to practice more based on what they want to do and what they think is best for the patient than out of fear.