

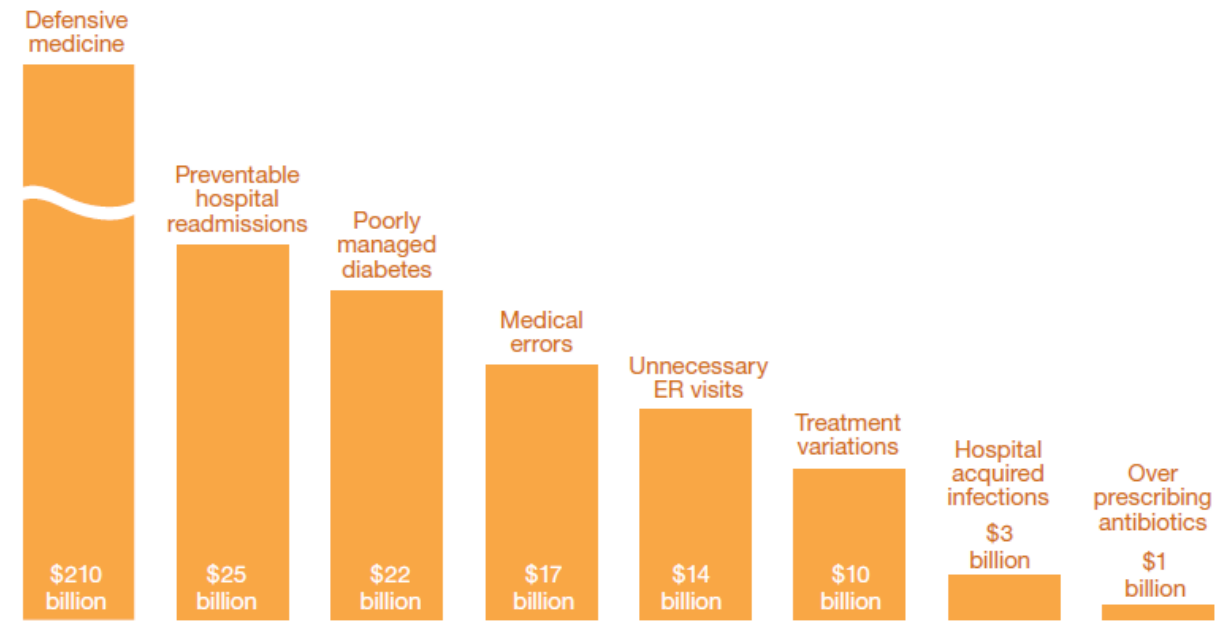
## Defensive Medicine – The Problem and One Solution

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### The Cost:

PricewaterhouseCoopers published a monograph (summer 2009) called the Price of Excess.<sup>1</sup> The study identified sources of “waste” in the U.S. healthcare system. The largest category was defensive medicine. The cost: \$210 billion. To put this in perspective, costs associated with unnecessary ER visits were estimated at \$14 billion. And costs associated with medical errors were estimated at \$17 billion. Addressing the practice of defensive medicine is fertile ground for finding tremendous savings in our healthcare system.

Exhibit 5: Annual excess costs in clinical services



Source: Institute of Medicine (1999), "The Factors Fueling Rising Healthcare Costs 2006", PricewaterhouseCoopers (2006), Medpac (2007), American Association of Endocrinologists (2006), Center for Disease Control and Prevention (2005), Solucient (2007), U.S Outcomes Research Group of Pfizer Inc (2005), National Committee for Quality Assurance (2005), Analysis by PricewaterhouseCoopers' Health Research Institute

### What is Defensive Medicine?

Defensive medicine eludes easy definition. It is understood as tests, referrals, hospital admissions, procedures, and other medical actions taken solely or primarily to defend against later charges against a doctor in a courtroom. The primary motivation is fear of litigation. The main benefit, then, accrues to the physician, and not the patient.

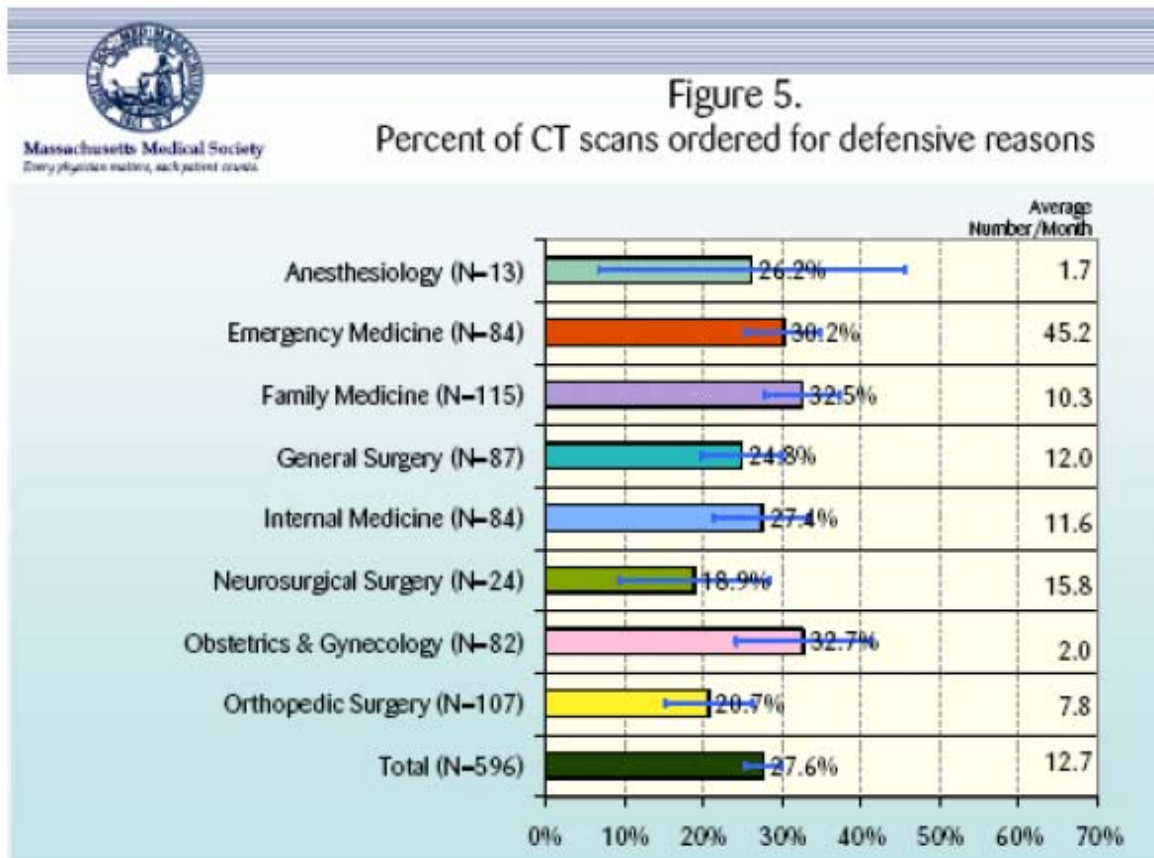
<sup>1</sup> PricewaterhouseCoopers. The price of excess. July 2009. <http://pwchealth.com/cgi-local/hregister.cgi?link=reg/waste.pdf> (last accessed August 26, 2009).

Arguably, some defensive medicine provides benefit for patients; some paradoxically provides additional risk. Much of the time, no benefit or risk occurs, just cost. The challenge is providing the best balance of cost to benefit.

Prevalence:

Defensive medicine is believed to be widely pervasive. When a select group of physicians in Pennsylvania were asked if they practiced defensively, 93% answered yes, prompting one cynic to conclude that the other 7% were liars.<sup>2</sup>

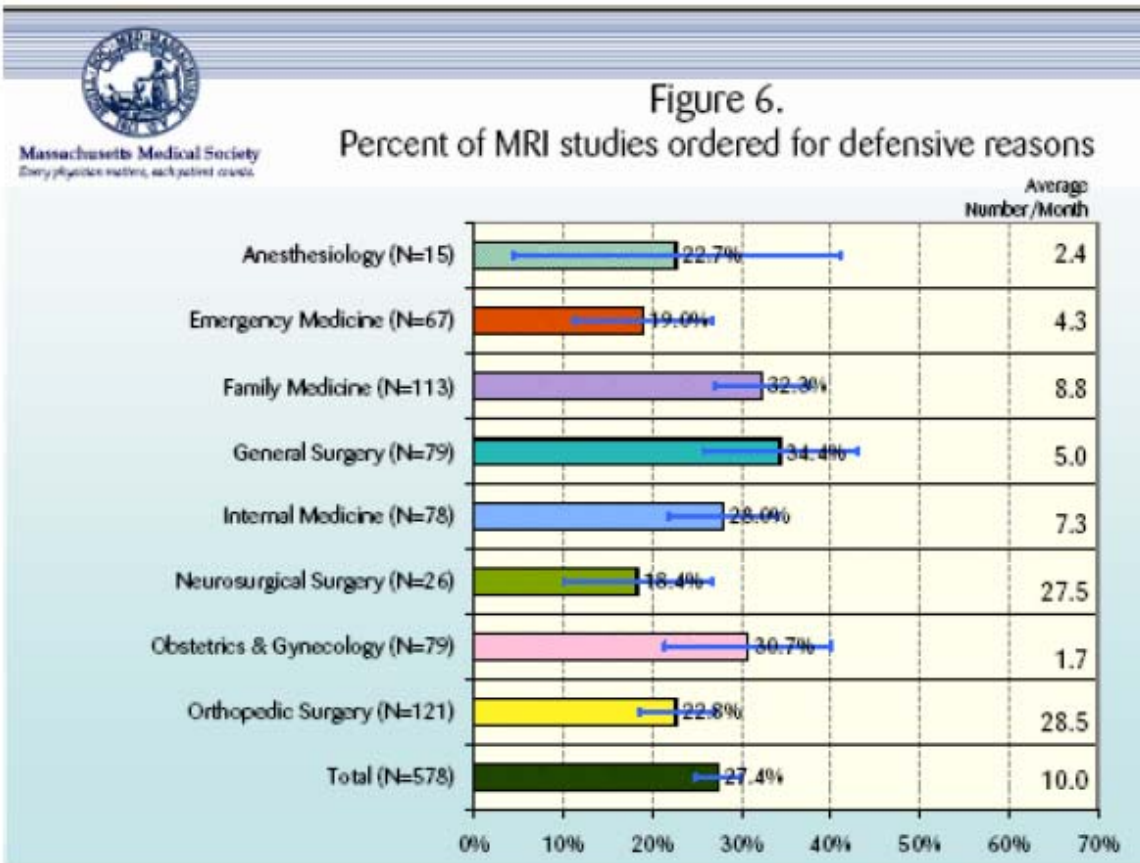
A study published by the Massachusetts Medical Society surveyed physicians in eight specialty areas. 83% of these physicians reported they practiced defensive medicine. Up to 13% of all hospital admissions and 30% of MR scans, CT scans, and referrals solely for the purpose of defending if the doctor was later sued.<sup>3</sup>



<sup>2</sup> Studdert DM, Mello MM, Sage WM, DesRoches CM, Peugh J, Zapert K, Brennan TA. Defensive medicine among high-risk specialist physicians in a volatile malpractice environment. JAMA. 2005;293:2609–2617.

<sup>3</sup> Massachusetts Medical Society. Investigation of Defensive Medicine in Massachusetts. Informational Report I-08-02. Nov. 2008

<http://www.massmed.org/AM/Template.cfm?Section=Home6&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=23557> (accessed August 26, 2009).



### Defensive Medicine – Illustrations:

Example 1 (Tangible costs – defensive medicine):

A patient had a routine insurance physical exam. His chest X-ray revealed a small calcification which looked like a classic calcified granuloma. Such granulomas are common and have an entirely benign natural history. Of course, any lesion in the lung can turn out to be cancer; but, calcified granulomas do not generally have the appearance of malignancies.

A reasonable course of action would have been to repeat the chest X-ray in 6 months to make sure the lesion had not grown.

What happened? “Just to be sure....” A CT scan was performed the following week. Then a MR scan was ordered; again, without altering the weighting of the diagnosis.

Then a needle biopsy was performed. The biopsy caused a pneumothorax requiring implantation of a chest tube. The patient was hospitalized until the lung healed. The chest tube scraped the intercostal nerve, causing pain that persisted long after the tube was removed.

The pathology study, when completed, revealed a calcified granuloma. Just as suspected on the initial low cost X-ray. Tens of thousands of dollars were expended just to satisfy the physician that the lesion was indeed a granuloma. Was the concern primarily patient safety? No, the physician did not want to live through an odious experience in the tort system. He simply did not want to be charged with missing a diagnosis of cancer, no matter how remote.

Example 2 (Intangible costs – defensive medicine):

A woman has a mammogram and is told she probably has fibrocystic disease. The appearance is typical and warrants little more than a follow-up mammogram in the future. Friday afternoon, the doctor says, “Let’s do a biopsy. Just to be sure. I doubt it’s anything.” The weekend is pure hell for the patient. She imagines mastectomy, chemotherapy, radiation, loss of hair, vomiting, etc. The comforting words “I doubt it’s anything” are ignored. Monday afternoon, the biopsy results are back. Benign fibrocystic disease. Recommend follow-up mammogram in one year. Relief. While the cost of the biopsy was not particularly steep, the psychic angst and anxiety provoked were immeasurable.

#### Practice Guidelines Can Be Used to Save Money while Preventing Harm to Patients:

Example:

In the United States, a person who experiences a minor concussion generally goes to an emergency room. Such a concussion might be associated with a brief loss of consciousness, nausea, headache, and the like. Nonetheless, on arrival in the emergency room, the patient is usually neurologically intact.

The challenge is to limit an imaging study only on those patients who either have or are likely to develop an intracranial abnormality without scanning everyone. Put a different way, the challenge is to minimize use of resources without causing harm. A prospective study identified five high-risk factors for intracranial pathology after minor head injury, including mechanism of injury and age. If the patient were involved in a motor vehicle accident, they would be scanned. If the patient was older than 65, they would be scanned. Using such criteria allows fewer patients to be scanned, but not at the expense of missing pathology. The five high-risk factors were 100% sensitive, 68.7% specific, and when followed, only required 32% of patients to be scanned.

Most patients who qualified for scanning had no pathology. However, no patient who would have been triaged away from the scanner had pathology. In other words, resources could be saved without causing harm.<sup>4</sup>

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<sup>4</sup> Stiell IG, Wells GA, Vandemheen K, Clement C, Lesiuk H, Laupacis A, McKnight RD, Verbeek R, Brison R, Cass D, Eisenhauer ME, Greenberg G, Worthington J. Canadian CT Head Rule for patients with minor head injury. *Lancet*. 2001;357:1391–1396.

## How Can Physicians Be Incentivized to Avoid Practicing Defensively?

Clinicians should be shielded from liability if they demonstrate the integration of evidence based medicine and/or clinical best practices into the care and treatment of patients. Such documentation would be exculpatory and presumptive evidence that the standard of care was followed. Practitioners should then be able to petition the court for a motion for summary judgment based on the use of evidence based medicine (“EBM”) and/or clinical best practices.

No less important is preserving the right of physicians to exercise their clinical judgment to make personalized decisions based on the circumstances of the patient and his/her condition. The physicians may choose to deviate from accepted algorithms, if in that case, it makes better clinical sense. In that scenario, the doctor would merely document he was aware of algorithms recommended by EBM but consciously chose a different path for specific reasons. This would serve two goals: (a) to prevent EBM from being abused as inculpatory evidence (that is, failure to embrace such algorithms being misconstrued as a violation of the standard of care); and (b) address the concern that blind adherence to EBM algorithms is “cookbook medicine” - applicable to all patients.

The goal is to take advantage of EBM where it benefits patients; but provide clinicians some latitude to use their judgment to deviate from these algorithms when it makes sense for patients. Documentation of the use of EBM or conscious deviation from EBM would both be exculpatory. Documentation of the use of EBM would be an absolute safe harbor. Documentation of conscious deviation of EBM for specific clinical reasons would be a qualified safe harbor.

As medical practices, clinics and health systems continue to integrate technology solutions into their everyday practice, clinicians will have even more opportunities to incorporate evidence-based medicine and clinical best practice into individual patient care. Electronic Medical Records (EMR) systems usually provide evidence-based medicine and clinical best-practice support systems from any number of medical content providers including the Mayo Clinic and EBSCO (Dynamed). Additionally, with electronic systems, physicians will be able to better document the use of best-practice medicine.

Using EBM is beneficial for both sides in professional liability cases. Plaintiffs’ attorneys can use it as a “black line” to avoid frivolous cases, and concentrate instead on those with merit. Physicians accused of negligence or malpractice can use EBM to defend their medical decisions and care. If EBM is allowed into evidence, judges and juries could rely on it instead of the often confusing and conflicting opinions of various expert witnesses (the so-called “battle of the experts”). The use of evidence-based medical testimony will result in fewer cases going to court, less money being wasted, and overall lower medical malpractice insurance rates.

### Details:

Representative Tom Price, an orthopaedic surgeon from Georgia, introduced HealthCare Overuse Reform Today Act HR 3372 on July 29<sup>th</sup>. That Resolution includes language which immunizes physicians from liability for noneconomic damages and punitive damages if they follow and document best practice guidelines.

The language of that Resolution describes the process for generating such guidelines. And the section title notes that guidelines are “an affirmative defense.” The language must be amended to expand the use of guidelines to explicitly enable summary judgment for any liability – not merely liability for noneconomic or punitive damages. Physicians will still practice defensively if they are liable for any damages (such as economic damages) in spite of following practice guidelines.

Safe harbor immunity should also be expanded to physicians who document awareness of such guidelines but consciously deviate from its implementation – because in a particular clinical situation, such use would be inferior to the course of treatment to be performed. This immunity would not be absolute, but qualified. The qualification would depend upon clear documentation that the guidelines are understood and that there is a clear evidence-based reason documented for choosing a different path. Further this reason must be explained to and understood by the patient – and the patient must explicitly agree with this different course of action.

#### Summary:

Physicians widely believe that healthcare reform cannot be accomplished with some type of tort reform. Physicians practice defensively and the costs associated with such behavior is significant. Physicians will do what they believe they must to avoid spending a day in court. These actions are based on fear and perception.

Health reformers can take advantage of that powerful emotion to persuade physicians to follow cost-efficient evidence based practices. This would have the twin effect of promoting patient safety and lowering costs. Further, physicians would be more inclined to consider allying behind other reforms.

While tort reform can mean many things, safe harbor immunity for physicians who follow evidence based practice guidelines is a concept finding backing among Democrats and Republicans. Former Senator Majority Leader Tom Daschle, Former Speaker of the House Newt Gingrich, and President Obama have all expressed support. Doctors would benefit. Patients would benefit. Payers would benefit. And arguably, even plaintiff’s attorneys would benefit.