Preventing Medical Errors, Avoiding Litigation
Not Easy To Do in 2004

For physicians who desire a better understanding of the current malpractice crisis in America, I suggest they read James Mohr’s article entitled “American Medical Malpractice Litigation in Historical Perspective,”1 in which Mohr reviews the medical and legal factors that have led to the dysfunctional medical malpractice system that currently prevails in the United States. I say dysfunctional because it is doubtful, though vigorously debated, particularly by trial lawyers, that malpractice litigation today achieves its presumed social goals: to deter unsafe medical practices, to fairly compensate patients injured by negligent practices, and to institute corrective justice.2 Mohr cites the following medical factors that have contributed to periodic malpractice crises3 in the last 150 years: the innovative pressures on American medicine, the spread of uniform standards, and the creation of medical malpractice liability insurance. Contributing legal factors include contingent fees, citizen juries, and the nature of tort pleading in the United States. I do not intend to review Mohr’s article here, but I would like to elaborate on the first factor, innovation in medicine, as an entry point to my discussion of Thomas McLean’s article in this issue of CHEST (see page 1672).

Mohr recounts how radiographic technology in the early 20th century significantly aided physicians by offering them greater opportunities to visualize abnormalities that could not previously be detected by history or physical examination. Physicians enthusiastically embraced the new technology, just as they embrace new technology today, because it gave them more power to perform their professional duties: cure patients and relieve suffering. However, the development of radiography also gave litigation lawyers more objective evidence of potential physician negligence: missed diagnoses, excessive radiation, and failure to act on a radiographic abnormality. “Objective” is the key word here: the previously undetectable lung mass can now be viewed on the screen by physicians and trial lawyers alike.

Lung cancer is the most common cause of cancer in men and women in the United States, with close to 170,000 cases diagnosed in 2002.4 Unless the cancer is discovered in the very early stages of disease, patients have a poor prognosis (overall 5-year survival rate is 15%).4 Today, the undetectable lung nodule on a routine radiograph can be seen on CT scans. Should we use this technology to screen smokers? The US Preventive Services Task Force recently concluded that evidence is insufficient to recommend for or against screening.5 Those physicians who choose to screen their patients will experience the same potential benefits (finding an early lung cancer) and the same potential risks of malpractice litigation (increased chance for missed diagnoses, and false-positive workups that may lead to medical complications) as early 20th century physicians did when x-rays were first introduced. Once again, physicians must carefully balance the benefits and harms of new technologies, not only for their patients, but also for themselves. In other words, ordering a CT scan for a smoker is not necessarily the right thing to do, either from a patient benefit or a defensive medicine point of view.

In his study, McLean set out to determine why physicians who treat lung cancer get sued. He retrospectively reviewed a publicly available database Lexis Nexis’ “Jury Verdict and Settlements, Combined” for all cases involving lung cancer and malpractice between January 1, 1999, and December 31, 2003. Verdicts and settlements were voluntarily submitted by lawyers. Data therefore represents a small, nonconsecutive, and select sample of cases. McLean then compared his data to the Physician Insurers Association of America (PIAA) Lung Cancer Study published in 1992.6 The results are as follows: radiologists (27% of all physicians sued in current study; 31% in the PIAA study) and primary care physicians (30% in current study; 42% in the PIAA study) were the most likely physicians to be sued, primarily for failure to diagnose lung cancer (the basis for suits in 80% of current study; 23.3% in the PIAA study). He also showed how the financial awards to plaintiffs have dramatically increased since the PIAA study (mean award was $172,272 in the PIAA study; $632,261 in the present study).6 Although McLean discovered that failure to diagnose lung cancer is the main reason doctors were sued, he does not explain why the PIAA study found this reason to be a much smaller percentage (23.3%). Data regarding other ostensible reasons for suits (surgical or chemotherapy complications, false-positive diagnoses) were not provided by the PIAA study.6

I suspect there are deeper reasons why these patients sued their doctors. Not every doctor who misses the diagnosis of lung cancer gets sued. What distinguishes doctors who are sued from the ones that are not sued? Worse outcomes? Poor communication? Unrealistic patient expectations?7–11

There is increasing evidence that excellent patient-physician relationships and good communication reduce the risk of malpractice litigation, particularly for primary care physicians.7–11 Physician behaviors associated with reduced malpractice claims include appropriate use of humor, solicitation of patient opinions, checking for patient understanding, and encouraging patients to
talk.\textsuperscript{7} It has also been shown that physicians with high numbers of unsolicited patient complaints get sued more frequently.\textsuperscript{11}

There are many reasons why physicians fail to make the diagnosis of lung cancer. Radiologists may not see a small nodule on a radiograph. They may fail to report an abnormal finding to the patient's doctor. Reports get lost or misplaced. Primary care doctors sometimes read their own films, and make errors. They may fail to receive an abnormal report, or if they see it, fail to act on the information. McLean concludes that physicians—particularly primary physicians and radiologists—need to develop better systems of care (continuous quality improvement\textsuperscript{12}) to track radiograph results and to decrease the error rate of reading radiographs. By doing these things, patient care will improve and malpractice claims will decrease.

McLean’s conclusions are not surprising. After the Institute of Medicine 2000 report on the extent of medical errors,\textsuperscript{2,13} there has been public and professional clamor to improve the safety of our hospitals and physicians’ practices. The patient safety movement, however, with its calls for more transparency regarding medical errors and disclosure of physician mistakes, puts physicians at greater risk in the current tort environment. Tort lawyers potentially use the disclosures to bolster their cases against doctors. As several authors note, “The conflicts between the tort system and error reduction programs are fundamental and severe, and physicians’ concerns about being sued and losing their liability insurance have reached a fever pitch. Appeals to professionalism may ring hollow with physicians operating under a siege mentality.”\textsuperscript{14}

Despite these conflicts, McLean is right: we need to find ways to devise processes of care that decrease the incidence of missed diagnoses and mishandled reports. Patient safety is ultimately in the best interests of everyone, including lawyers. Many of these processes can be improved without putting physicians at undue risk for malpractice litigation. In addition, better patient-physician relationships will improve patient care, increase patient and physician satisfaction, and reduce malpractice risks. However, if the patient safety movement is ultimately to succeed, radical reform of the tort system will be required to eliminate the “siege mentality” of physicians. At a political level, we must find ways to decrease frivolous suits, excessive plaintiff awards, and huge contingent fees. We must also find ways to justly compensate patients who are injured by the healthcare system. Right now, very few patients who are injured by the system seek compensation through litigation.\textsuperscript{2}

Brennan and Mello\textsuperscript{14} offer an appealing solution: a no-fault system, like workers’ compensation, in which blame is not assigned to any particular group or individual. Rather, it would fairly compensate patients injured by “medical management,” and provide incentives to physician groups and hospitals to prevent errors. They rightly point out that “Modern notions of error prevention, emphasizing evidence-based analysis of systems of care and application of technological and structural methods to foster prevention, find little value in assessing individual moral blame.”\textsuperscript{14} Needless to say, tort lawyers will vigorously fight to oppose this solution and will continue to advocate for the merits of the status quo.

What to do while we continue to push legislators for malpractice reform? Develop stronger relationships with patients. Learn to communicate more effectively with patients and peers. Maintain clinical competence.\textsuperscript{15} Document well. Get involved in quality improvement initiatives. None of these things guarantees protection from malpractice claims; nor are they particularly easy to do. They make sense, however, from both a patient safety and defensive medicine perspective.

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