Identify, Counsel EPs Frequently Targeted in Med/Mal Suits

Very small number of EPs account for vast majority of litigation

How many times has someone said, “He’s a great EP, but ... ,” wonders Gerald B. Hickson, MD, senior vice president of quality, safety, and risk prevention at Vanderbilt University School of Medicine in Nashville, TN. What’s usually said next — that the EP is notoriously difficult to deal with — probably means he or she is no stranger to a courtroom. “We are gaining empirical knowledge of the ‘whys’ of suing for malpractice,” Hickson says. “We can’t just learn from people’s anecdotes and war stories.”

Why families choose to sue for malpractice, why certain physicians attract a disproportionate share of claims, and how to identify and intervene with high-risk physicians has been the focus of Hickson’s research for the past 25 years.1,2

Some busy EPs come off as disrespectful without even realizing it. “Sometimes, it’s because we’re in a hurry. Or, it may be the way we behave all the time,” Hickson says. “Ultimately, it’s about the importance of modeling respect and building trust.” About 1% of physicians accounted for 32% of paid malpractice claims, according to a recent analysis of 66,426 claims paid against 54,099 physicians from 2005 through 2014.3 Only 6% had a paid claim. The researchers expected to see a skewed distribution of claims. “But the extent to which claims were concentrated among a small group of physicians was really surprising,” says Michelle M. Mello, JD, PhD, one of the study’s authors. Mello is a professor of law at the Stanford Law School and professor of health research and policy at Stanford University School of Medicine. The researchers suggested that liability insurers and hospitals monitor how claims accumulate among their insured physicians. “Intervene when the predictive factors for more claims, that our analysis identified, start to emerge,” Mello recommends. Risk varied widely according to specialty. The risk of recurrent paid malpractice claims for emergency medicine was greater than for cardiology, anesthesiology, family medicine, and pediatrics, but less than for neurosurgery, orthopedic surgery, and obstetrics/gynecology. “The types of interventions that
could be helpful include peer-to-peer counseling, additional training, and enhanced supervision,” Mello says.

Early in his career, Derek S. Davis, RPh, JD, now a defense attorney in the Dallas office of Cooper & Scully, fielded calls for a plaintiff’s medical malpractice firm. Few of the calls involved actual malpractice. The precipitating factor for most was that a healthcare provider was rude or unapologetic about a mistake. “Bad bedside manner can motivate patients to make the call, even when there has been little or no harm,” Davis warns.

**EPs Can and Do Change**

At the Vanderbilt University School of Medicine, patient complaints are reviewed and aggregated using the Patient Advocacy Reporting System. The program uses unsolicited patient complaint data as the basis for tiered interventions on high-risk peer colleagues. “The complaints are not randomly distributed,” Hickson explains. “A small subset of our emergency medicine colleagues receive more than their fair share of complaints.”

About 40% of EPs in any four- to six-year audit period don’t receive a single complaint. A small subset of EPs — about 4% — receive about one-third of complaints, most often related to perceived disrespect. “Those are the EPs most at risk for medical malpractice claims,” Hickson explains. Hickson’s organization developed an approach, now used at 144 hospitals nationally. “We train physician messengers to deliver the aggregated data, to show the EPs where they stand in relation to other EPs in their own ED, and also to EPs in the national database,” Hickson says. The EP has an opportunity to reflect on what it is about their practice that appears to create dissatisfaction. “We tell them that the dissatisfaction they are associated with increases their malpractice risk,” Hickson notes, adding that it’s clear from previous research that dissatisfaction drives malpractice claims. “That’s why we don’t take a lot of stock in standardized satisfaction measures that focus on ‘top box’ scores. That isn’t what predicts risk.”

After receiving the peer intervention, about 75% of all physicians make changes in the way they practice. “We’ve been doing this work since 2000, now with over 1,500 high-risk physician interventions. These numbers apply for all practices,” Hickson says. “The effect is profound and long term.”

A very small minority of the EPs — less than 1% — are unable or unwilling to respond to the intervention. This is a far cry from what some colleagues warned when Hickson began developing the program in the 1990s, that he’d never get physicians to change their practice behaviors. “What our process does is put a mirror in front of people, and they often don’t like what they see,” Hickson says. “Once they see their data, most pause and reflect. Then they change.” Most of the EPs receiving the intervention simply have gotten used to a status quo. They don’t even realize they are creating dissatisfaction. “In any ED, if you ask, ‘Who are your two or three most difficult people to work with,’ people know right away who they are,” Hickson says. However, if one then asks, “Have you ever talked directly to them about their practice behavior,” Hickson says the answer is almost always “no.” “Medical professionals are hesitant to have those conversations,” he adds.
During the intervention, which another EP usually conducts, the Eps first receive a chance to figure out how to change on their own. “We don’t tell them a thing, except ‘This is your data, you’re a bright person, I trust you are going to figure it out,’” Hickson says.

Patient engagement training often falls on deaf ears until someone tells a high-risk physician that he or she has a problem. “Once they understand they have needs, and that education is available if they choose, it’s a very different phenomenon,” Hickson explains. For about 25% of EPs, no improvement occurs after the first intervention. A second intervention occurs within six to 12 months. If at that point no improvement occurs, the next step is a “guided intervention under authority.” The EP is linked with a hospital leader who can apply consequences if the EP does not improve. Of this group, about half improve with additional training.

Outcomes Are at Stake
A recent study of 66 surgeons and 10,000 surgical procedures found that surgeons perceived as rude experienced more surgical complications. The findings have been replicated in a follow-up study conducted at eight hospitals employing 900 surgeons who conduct 32,000 procedures. “It isn’t that being nice makes patients happy so they won’t sue you,” Hickson says. “We now know that when physicians are disrespectful to other members of the surgical team, trust is reduced. That impacts team performance.”

The same is true of EPs who are known to be disrespectful. Hickson offers one compelling reason: “Other team members are less likely to share observed concerns and ask for help.” Hickson believes rudeness actually can harm ED patients clinically, and conversely, “we know there are certain attributes that, if modelled, not only reduce the risk of claims, but also [increase] the probability of good outcomes.”

REFERENCES

SOURCES
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