Publication of Medical Mutual / Professionals Advocate®

DOCTORS Rx

Volume 23 No. 1 Spring 2015

A Letter from the Chair of the Board

Dear Colleague:

Recent studies have focused on the effects of "defensive medicine" as it relates to Physicians and patient outcomes. This important issue of Doctors RX *will look at how you can remain on the offensive in an increasingly defensive world.*

George S. Malouf, Jr., M.D.
Chair of the Board
Medical Mutual Liability Insurance Society of Maryland
Professionals Advocate Insurance Company

Playing Defense

Consider the following scenario: A man in his late 50s goes to the emergency room complaining of chest pain. Upon examination, the Physician considers the patient's age and reported family history of heart disease. The patient also reports that he ate two bacon cheeseburgers, an order of fries, and a chocolate milkshake for dinner approximately one hour earlier. Although the emergency room Physician believes the patient is most likely experiencing indigestion, the patient becomes aggressive and insists he is having a heart attack. The Physician, taking all of the factors into consideration, and based on her clinical training, judgment, and experience, admits the patient to rule out a cardiac episode. After an electrocardiogram, blood tests, echocardiogram, and a stress test are returned as normal, the patient is released and ordered to follow up with his family Physician. This is not an infrequent scenario in hospitals across the country, but do you consider the Doctor's decision to admit the patient appropriate medical care, or do you believe that the Doctor was practicing defensive medicine?

Depending on who you speak to, the answer may vary. Those looking to find savings in the health care system will point a finger at the Physician and claim that fear of a medical negligence action drove her to order arguably unnecessary tests and procedures. Others will opine that

Continued on next page

Jamie Lynn Meier, Esquire
Legal Associate – Medical Mutual/Professionals Advocate

the Physician is a highly educated and trained professional who made a decision based on the best interests of the patient. So what's the answer?

What is Defensive Medicine?

To understand the implications of defensive medicine, we must first seek to understand how the term has been defined in the context of health care delivery. The Congressional Office of Technology Assessment provides a commonly referenced definition of defensive medicine, stating that it occurs when "Doctors order tests, procedures, or visits, or avoid high-risk patients or procedures, primarily (but not necessarily or solely) to reduce their exposure to malpractice liability." These forms of practice conduct are frequently divided into two groups: *avoidance behavior* and *assurance behavior.*

Avoidance behavior occurs when providers refuse to participate in high-risk procedures or circumstances in an effort to distance themselves from sources of legal risk. This behavior includes restricting areas of practice, eliminating high-risk procedures and procedures prone to complications, and avoiding patients with complex problems or those presumed to be litigious.[1]

Assurance behavior, sometimes called "positive" defensive medicine, involves supplying additional services of minimal or no medical value for the purpose of deterring patients from filing malpractice claims, reducing adverse outcomes, or to have additional proof that the legal standard of care was met if a claim is, in fact, filed. This issue of *Doctors RX* will focus on assurance behavior, which includes ordering tests, performing diagnostic procedures, referring patients for consultation, and prescribing medications. Regardless of the type of behavior identified, it is considered to be motivated primarily by a threat of liability and, to date, nearly impossible to quantify.

Is Defensive Medicine Real?

Some in the medical community acknowledge that a level of defensive medicine may exist. In fact, a 2014 study commissioned by the Advancing Medical Professionalism to Improve Health Care (ABIM) Foundation found that three out of four Physicians believe that fellow Physicians prescribe an unnecessary test or procedure at least once a week, and some Physicians feel practicing defensive medicine has become the new "standard of care." Specifically, Physicians reported that when others in the same specialty are consistently ordering additional tests, this promotes feelings of deficiency in those not following the new norm. More importantly, such activity may impact how the patient feels about the level of care provided.

Patient pressure is another major factor that has been identified as a component of defensive medicine. In the mid-twentieth century, the Doctor-Patient relationship shifted from a paternalistic relationship to one that is patient-driven. Society recognized the right of patients to determine what will be done with their bodies, culminating in the doctrine of informed consent. This relationship shift, combined with the increasing availability of diagnostic information on the internet and the loosening of restrictions on direct-to-consumer marketing by pharmaceutical companies, has produced an era in which patients frequently attempt to diagnose themselves and decide on a specific course of treatment before they even step into their Physician's waiting room. As soon as the Physician enters the examination room, he or she may be met with demands regarding the tests that should be administered or the medications that should be prescribed. After examination, the patient's initial self-diagnosis and treatment plan may differ from that of the Physician, but in some cases may cause the Physician to second-guess themselves, asking "what if?"

According to a survey commissioned for *Choosing Wisely*, a campaign created by the ABIM Foundation to identify and reduce overused tests and procedures, approximately 47 percent of Physicians have at least one patient per week request something unnecessary. While most Doctors in the survey believed they were responsible for interceding, 48 percent said that when facing an adamant patient, they will advise against it but still order the test. Another five percent said they generally just order the test. If a Physician orders tests or procedures against his or her medical judgment because of an insistent patient, then defensive medicine is identified as the underlying cause.

Is Defensive Medicine a Problem?

If a Physician practices defensive medicine, then the critical thinking that is so highly valued in the practice of medicine is effectively defeated and assurance behaviors become the standard of care. Patients become accustomed to these standards, subsequently impacting and usually increasing their expectations and adding additional pressure to meet the heightened expectations. This is a cycle of potential increased risk to the patient, with little or no benefit.

Many patients believe that more care is equivalent to better care, but that is not always the case. Every additional test or procedure comes with its own risks that generally outweigh the benefits if performed purely for defensive reasons. On the therapeutic side, defensive measures such as cesarean deliveries scheduled for the patient's convenience or invasive procedures like breast biopsies for cysts come with significant risks to the patient in addition to increased health care expenditures. The fact that tests are never 100 percent accurate is ancillary but still worth mentioning, as false positive test results lead to more unnecessary treatment.

In addition to patient risk from unnecessary procedures, the cost of defensive medicine has been estimated at anywhere from $54 billion to $650 billion per year, equaling between five percent and 34 percent of annual health care expenditures, respectively. This is a massive range, and studies have shown this lack of pecuniary clarity is a point of confusion for patients as well as Physicians.

The potential consequences of defensive medicine practices go beyond increasing the overall cost of health care. It also reduces access to care for high-risk patients and, especially in tests where treatments like radiation are involved, can cause harm to the patient.

The good news? There are several things Physicians can do to reduce the risk of practicing defensive medicine, and to support challenges to your care plans that, retrospectively, are called out as unnecessary. And whether or not you believe it to be a good thing, the evolving reimbursement systems create another variable that may inevitably cause a shift in the focus of possible defensive medicine practiced.

An Interesting Twist

The massive health care overhaul, beginning in 2010 with the implementation of the federal Patient Protection and Affordable Care Act[2] (ACA), has brought a number of challenges and questions that have yet to be fully realized by the health care industry. The ACA includes provisions intended to expand access to insurance, increase consumer protections, emphasize prevention and wellness, improve quality and system performance, expand the health workforce, and curb rising health care costs. The change from a volume-based to a value-based model creates a unique challenge, as it seeks to reduce the rate of growth in health care spending, but does so while also requiring an improvement in patient care and overall population health. The U.S. Centers for Medicare and Medicaid Services (CMS) estimate that 7-8 million people have purchased insurance via the Healthcare Insurance Marketplace over the past year, and the majority of new enrollees are believed to have had little access to routine health coverage prior to enrollment, creating additional concerns of its own.[3]

On January 10, 2014, the State of Maryland and the CMS jointly announced the launch of a state-wide model that will transform Maryland's health care delivery system. Shared savings programs and Physician coordination encourage efficiency and cost savings, and directly conflicts with the use of what some might consider unnecessary interventions. The system will change the fee-for-service model into a capitated model focused on coordination, efficiency, and cost savings. This creates an interesting paradox with the current system where providing extra services, even when unnecessary, is economically supported. And, from a liability perspective, it is much easier to defend the fact that a Doctor ordered a test, as opposed to **not** ordering a test. However, the application of fee-for-service reimbursement is diminishing and capitated payment models are being employed. Instead of a per-admission payment, the new model focuses on overall per capita expenditures for hospital services, population health outcomes and improving quality of care. The goal is increased coordinated care, a greater emphasis on care transitions, and a focus on prevention.

Lack of clarity and the desire to better understand defensive medicine was an issue recognized by the State of Maryland in making this payment shift. During the 2014 Maryland legislative session, the General Assembly passed legislation which clarified the Health Services Cost Review Commission's (HSCRC) authority to implement global budgets and manage costs and quality on a per capita basis.[4] As part of that legislation, workgroups were created to provide advice on implementation of the new payment model and were required to consider the impact of defensive medicine on costs.

A report on defensive medicine was submitted to the HSCRC on January 7, 2015, which relied heavily on a 1994 report from the Office of Technology, *Defensive Medicine and Medical Malpractice.* The first page of the 1994 report states that it is impossible to accurately measure the overall level and national cost of defensive medicine, explaining that it's largely due to methodological limitations of studies. When reviewing more recent studies, the 2015 report notes that the issues of the 1994 report are largely the same today.

As it stands, the lack of consensus on the true definition, severity, and costs stems from the fact that there is a very fine line between being thorough and practicing defensive medicine, and the difference is difficult to clearly identify. The only person who will know the **true** reason behind a Physician's decision is the Physician. While tort reform

could possibly impact this ubiquitous part of medical practice, there are several things a Physician can do in his or her own practice to ensure purely clinical decision-making is evidenced. Let's review some fundamentals that will defend against accusations of defensive behavior.

The Solution? Get on the Offensive!

1. Time is of the Essence

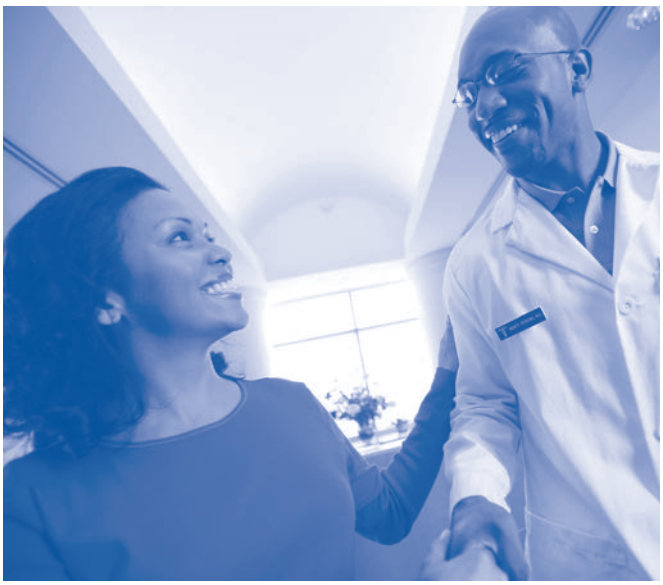
Time is one of the more surprising factors that contribute to the likelihood that a Physician may order unnecessary treatments. Three in four Physicians say having more time with patients to discuss alternatives would be effective in reducing the practice of defensive medicine. Time also has an effect on the patient and the likelihood that the patient will file a malpractice lawsuit in the event of an adverse outcome. If a patient frequently waits well beyond the scheduled appointment time before being seen, or is made to feel you're rushing through the appointment without listening to his or her concerns, it promotes a sense of less than optimal care and could be the tipping factor in the decision to go see a lawyer instead of you in the event of an adverse outcome.

The number one reason given for longer waiting periods is failing to start the day on time. This is something preventable that puts stress on everyone in the office. There will always be factors outside of one's control that make it impossible to eliminate wait times, but that can be mitigated by providing a comfortable waiting room with things to keep the patient occupied, rather than focused on the fact they are waiting. Additionally, a warm greeting upon entering the examination room will go a long way in making the patient feel at ease. These things may appear insignificant; however they can largely impact the patient's opinion towards your quality of care.

2. Create a Team Relationship

Communication is crucial to managing a patient's expectations. A strong Doctor-Patient relationship allows you to feel comfortable speaking honestly with your patients. Almost one-fifth of Physicians reportedly struggle with feeling uncomfortable when speaking to patients about why they should avoid an unnecessary test or procedure. This struggle is compounded by the fact that now more than ever, patients want to be involved in their own care.

As discussed, time is important, but equally as important are your verbal tone and nonverbal body language. When you see the patient, it is vital to be calm and focused, even if you're feeling rushed. Maintaining eye contact and listening while letting the patient talk for one minute – *without interruption* – followed by asking open-ended questions, is crucial to the relationship and to letting the patient know he or she has been heard. Everyone faces time pressures, but tone and demeanor have been shown to make a major difference, and managing patients' expectations in the process will go a long way in reducing the defensive medicine trigger.



3. Focus on Decision-Making and Documentation

The decision-making process for determining subsequent treatment is one that must be shared between the patient and Physician, as emphasized in *McQuitty v. Spangler*, where it was alleged that the Physician did not discuss the option for an immediate procedure thereby removing the plaintiff's ability to make an informed decision.[5] The Maryland Court of Appeals stated that "it is the duty of a health care provider to inform a patient of material information, or information that a practitioner 'knows or ought to know would be significant to a reasonable person in the patient's position in deciding whether or not to submit to a particular medical treatment or procedure.'" A thorough discussion of the patient's health issue, including all of the pros and cons of available treatments as well as all material risks, is critical. And the patient's medical record should be as comprehensive as possible regarding every discussion and change in the treatment plan.

Documentation of the treatment plan and patient discussion is essential. Additionally, for procedures, a procedure-specific informed consent form, signed by the patient, provides a necessary safety net that explains the details of your discussions, acknowledging that the patient understands the risks and benefits of all possible options, and that the patient was the one who ultimately chose the next steps in his or her treatment. Likewise, documenting informed refusal – when a patient decides to forgo your recommended treatment – is equally important.

The Only Thing We Have to Fear is... Fear Itself

While the threat of lawsuits has been identified as a driver of defensive medicine, an analysis published in the August 2013 issue of *Health Affairs* suggests that Physicians' fear of a lawsuit may, in fact, overshadow their actual risk of being sued. When researchers tried to find a correlation between Physicians' propensity to order tests with the actual risk of a malpractice claim – they didn't find one. In other words, Physicians may base a decision to practice defensively on their fears rather than the actual relative threat of being sued.

The introductory hypothetical provides an example of a situation where the Physician could arguably have practiced defensive medicine. Only the Physician can make the determination of whether the care provided was done for defensive reasons. To avoid that characterization, remember that you control the patient's care, and that building a relationship with the patient will promote trust and confidence, get the patient fully involved in his or her care, and keep you on the offensive.

Reset Patient Expectations

- Manage unreasonable and unrealistic expectations by redefining your own role, making it a point to understand the patients' perspectives and acknowledging the legitimacy of basic wishes; then you can more readily describe what is realistic, stating the reasons and benefits of alternative courses of action, and conclude with a caring, positive message.
- Improve on explanations by narrating during the exam, use analogies or examples to simplify complex concepts, and provide supplemental information such as handouts to enforce what you've already told them.
- Patient satisfaction surveys and complaint logs are good tools for identifying patient expectations of you and your practice, but the most direct approach is to ask open-ended questions, and then you can shape the conversation to make sure you temper those expectations.

Treatment Tips

- **Do** discuss with your patient the reasons for ordering or not ordering a test, procedure, referral, etc.
- **Do** discuss your differential diagnosis and the reasons for choosing the most likely diagnosis
- **Do** tell the patient what symptoms to look for and when to return for reevaluation
- **Do** discuss the potential complications of tests and procedures
- **Do** make the patient part of the treatment decision
- **Do** listen and respond to your patients' questions and allow them time to express their thoughts
- **Do** let patients know you have heard and understand their symptoms and concerns
- **Do** document the treatment plan and discussion in detail

[1] In settings such as an emergency department, avoidance behaviors can lead to larger consequences because of laws that require patients presenting to the ER to be stabilized and treated.

[2] P.L. 111-148, signed March 23, 2010, as amended by the Health Care and Education Reconciliation Act, signed March 31, 2010.

[3] Elke Kirsten-Brauer & Molly Farrell, Double Jeopardy, Best's Review, August 2014 Issue, www.bestreview.com

[4] MD. House Bill 298/Chapter 263 (2014)

[5] McQuitty v. Spangler, 410 Md. 1, 976 A.2d 1020 (2008)

Doctors RX

Elizabeth A. Svoysky, J.D., *Editor*
Vice President - Risk Management

Dr. George S. Malouf, Jr., M.D., *Chair of the Board*
Medical Mutual Liability Insurance Society of Maryland
Professionals Advocate® Insurance Company

Numbers you should know!

Home Office Switchboard	410-785-0050
Toll Free	800-492-0193
Incident/Claim/ Lawsuit Reporting	800-492-0193
Risk Management Seminar Info	ext. 215 or 204
Risk Management Questions	ext. 224 or 269
Main Fax	410-785-2631
Claims Department Fax	410-785-1670
Web Site	mmlis.com proad.com

CME Test Questions

Instructions for CME Participation

CME Accreditation Statement – MEDICAL MUTUAL Liability Insurance Society of Maryland, which is affiliated with Professionals Advocate® Insurance Company, is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for Physicians.

CME Designation Statement – MEDICAL MUTUAL Liability Insurance Society of Maryland designates this enduring material for a maximum of one (1) *AMA PRA Category 1 Credit.*™ Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Instructions – to receive credit, please follow these steps:

1. Read the articles contained in the newsletter and then answer the test questions.
2. Mail or fax your completed answers for grading:

   Med•Lantic Management Services, Inc.
   225 International Circle
   P.O. Box 8016
   Hunt Valley, Maryland 21030
   Attention: Risk Management Services Dept.

   Fax: 410-785-2631

3. One of our goals is to assess the continuing educational needs of our readers so we may enhance the educational effectiveness of the *Doctors RX*. To achieve this goal, we need your help. You must complete the CME evaluation form to receive credit.
4. Completion Deadline: August 31, 2015
5. Upon completion of the test and evaluation form, a certificate of credit will be mailed to you.

1. Examples of avoidance behavior include all EXCEPT the following:

   A. Restricting areas of practice
   B. Eliminating high-risk procedures
   C. Supplying additional services of minimal medical value
   D. Avoiding patients who are presumed to be litigious

2. Over time, the Doctor-Patient relationship has become less paternalistic and more patient-driven.

   A. True B. False

3. What percentage of Physicians has at least one patient per week request an unnecessary test or procedure?

   A. 22 percent
   B. 38 percent
   C. 47 percent
   D. 62 percent

4. Defensive medicine has been estimated to cost up to $650 billion per year.

   A. True B. False

5. The number one reason given for longer waiting periods for an appointment is:

   A. Overscheduling
   B. Emergencies
   C. Not starting the day on time
   D. Patients arriving late

6. There is a direct correlation between a Physician's propensity to order tests and the actual risk of a malpractice lawsuit.

   A. True B. False

7. All of the following may contribute to patient pressure to order unnecessary tests or procedures EXCEPT:

   A. Direct-to-consumer marketing by pharmaceutical companies
   B. Informed consent
   C. Diagnostic information available on the internet
   D. A paternalistic relationship between the Doctor and patient

8. Which of the following are strategies to defend against accusations of defensive medicine?

   A. Spending adequate time with a patient
   B. Creating a team relationship with your patient
   C. Documenting the decision-making process
   D. All of the above

9. It is easy to differentiate between being thorough and practicing defensive medicine.

   A. True B. False

10. Unnecessary tests or procedures have their own risks that can outweigh any benefits if performed as a result of defensive medicine.

    A. True B. False

CME Evaluation Form

Statement of Educational Purpose

Doctors RX is a newsletter sent twice each year to the insured Physicians of MEDICAL MUTUAL/Professionals Advocate.® Its mission and educational purpose is to identify current health care related risk management issues and provide Physicians with educational information that will enable them to reduce their malpractice liability risk.

Readers of the newsletter should be able to obtain the following educational objectives:
1) Gain information on topics of particular importance to them as Physicians,
2) Assess the newsletter's value to them as practicing Physicians, and
3) Assess how this information may influence their own practices.

CME Objectives for "Playing Defense"

Educational Objectives: Upon completion of this enduring material, participants will be better able to:
1) Identify the various forms defensive medicine can take,
2) Understand the ramifications of practicing "defensively," and
3) Learn strategies to stay on the offensive.

	Strongly Agree				**Strongly Disagree**
Part 1. Educational Value:	5	4	3	2	1
I learned something new that was important.	❑	❑	❑	❑	❑
I verified some important information.	❑	❑	❑	❑	❑
I plan to seek more information on this topic.	❑	❑	❑	❑	❑
This information is likely to have an impact on my practice.	❑	❑	❑	❑	❑

Part 2. Commitment to Change: What change(s) (if any) do you plan to make in your practice as a result of reading this newsletter?

_____

_____

_____

Part 3. Statement of Completion: I attest to having completed the CME activity.

Signature: _____ Date: _____

Part 4. Identifying Information: Please PRINT legibly or type the following:

Name: _____ Telephone Number: _____

Address: _____

_____

_____

_____

Attention MEDICAL MUTUAL Insureds:

Practice Management Web Site Now Available!

Have you visited the Practice Management section of the MEDICAL MUTUAL web site? This new online resource for practice management professionals offers a place to interact with other practice managers and access resources to support your day-to-day activities in practice management. The site features an interactive forum to share information and participate in discussions, or send questions to the MEDICAL MUTUAL risk management team. Additional materials on compliance and employment issues, HIPAA, EMRs and other timely topics are also available.

Share this site with your Practice Manager!

Visit **mmlis.com** and log in to the "My Account" area. If they are not already registered to log in, they can select "Login Assistance" in the bottom right. Then, select "I am a Practice Manager" and follow the steps to register. Once logged-in to the web site, open the "Risk Management" tab on the left and select "Practice Management."

Publication of MEDICAL MUTUAL / Professionals Advocate®

DOCTORS Rx

Volume 23 No. 1 Spring 2015

MEDICAL MUTUAL Liability Insurance Society of Maryland
Professionals Advocate® Insurance Company
Home Office: Box 8016, 225 International Circle
Hunt Valley, MD 21030 • 410-785-0050 • 800-492-0193

PRST STD
U.S. POSTAGE
PAID
PERMIT NO. 5415
BALTIMORE, MD