Malpractice
Andy Walker, MD FAAEM
Editor, Common Sense
AAEM Board of Directors

“The fault, dear Brutus, is not in our stars,
But in ourselves, that we are underlings.”
— Cassius, in Shakespeare’s Julius Caesar

Does the United States have a malpractice problem? No, absolutely not. True medical malpractice is exceedingly rare in this country. Studies have consistently shown that patients are injured by negligence in less than 1% of hospitalizations. Obviously we would like to drive that number even lower, especially given the large number of hospital admissions that occur every year, but a negligent injury rate of below 1% is a pretty good starting point. Furthermore, I suspect that the rate of physician malpractice is even lower. I graduated from medical school in 1985, and can count on one hand the cases of actual malpractice that I have seen. I trust that your experience is similar: What we have is a lawsuit problem.

In theory, to win a malpractice suit the plaintiff-patient must show that the defendant-doctor committed negligence (violated the standard of care), and that this negligence caused harm. If this theoretical standard applied in the real world, we wouldn’t have a lawsuit problem and physicians wouldn’t be wasting countless hours and dollars on defensive medicine, because medical negligence is defined as something a reasonable physician would not do under similar circumstances. In other words, the standard of care isn’t perfect care or good care, it isn’t even average care. It’s just reasonable care under the circumstances. At most medical decision points there is a range of reasonable options — not just one or even two. Unfortunately, this standard of reasonable behavior is not applied in the real world, the world in which we practice emergency medicine and get sued. The good news is that roughly 70% of malpractice suits end with no payment to the plaintiff. The bad news is that the occurrence of malpractice has surprisingly little influence on the outcome of the lawsuit, or even on whether or not a lawsuit is filed. Only permanent disability is reliably correlated with the outcome of a medical malpractice suit. Worst of all from a physician’s point of view, 16% of malpractice suits involving no injury of any kind to the patient still result in a payment of damages, and 28% of malpractice suits in which there is no error — not just no negligence but no error at all — result in a payment of damages! And in the latter case, the damage award averages over $313,000! That is why we practice defensive medicine and live in fear — because any bad outcome can result in a lawsuit that has a reasonable chance of winning, even if we performed flawlessly.

So why all the lawsuits against physicians, including emergency physicians? Perhaps more importantly, if nearly all these lawsuits are unjustified, why are so many successful? Much of the blame lies with the legal profession. The United States has far more lawyers than it needs, to the point that many law school graduates now cannot find a job that requires them to pass the bar. We need a certain number of attorneys to write contracts and handle wills, estates, trusts, divorces, etc. — and most importantly to help keep the various levels of government honest through litigation and criminal defense — but when there are too many lawyers for the constructive and necessary work available, they create work for themselves by creating mischief for everyone else. Too many lawyers seem to be completely amoral, caring nothing for justice and willing to do anything marginally legal if it’s profitable. Some of the blame also lies with a segment of the American public, whose ignorance of science and probabilistic reasoning, unrealistic expectations, and sometimes just plain greed drives them into the arms of a lawyer whenever anything bad happens to them in a medical setting.

As emergency physicians we cannot control those things. Part of the blame, however, lies with something we can control: ourselves. No medical malpractice suit can proceed without at least one expert witness for the plaintiff, a physician who is willing to say that negligence occurred and that it harmed the patient. Who are these “experts” who testify against emergency physicians? After doing expert witness work for several years myself, I believe I can answer that question.

Many aren’t emergency physicians at all. They are cardiologists, neurologists, radiologists, orthopedists, psychiatrists, etc. who think they know what the standard of care is in emergency medicine. They worked briefly in the ED during medical school or residency, moonlighted in an ED during training, occasionally talk to an emergency physician on the phone, or admit a patient from the ED; and are both ignorant enough and arrogant enough to think that gives them an understanding of our practice.

We’re listening, send us your thoughts!
specialty. I see this in almost every case I participate in: a cardiologist (for example) thinks that because he understands the standard of care for treating acute coronary syndromes, he is qualified to testify on the standard of care in emergency medicine. What he doesn’t understand is that the issue is almost never how to recognize a STEMI on the EKG or treat MIs, it is how to approach a patient with undifferentiated chest pain in the ED, where we see dozens of people every day with chest pain — few of whom turn out to have MIs. Most of the emergency medicine lawsuits I see revolve around the signal to noise issue that all of us wrestle with every day, and that no other specialty understands, because we act as filters for them — they see only the patients we select for them to see. In a patient with a normal EKG and troponin, how high does your suspicion for an acute coronary syndrome have to be to justify a cardiology consult or admission to a hospital where you can’t get an exercise or other stress test immediately? One chance in ten? Absolutely. One chance in 1,000? Absolutely not. One in 100? Probably not. One in 50, one in 20? How much noise are you willing to put up with to catch a signal? No physician in any other specialty understands how emergency physicians act as filters for them and for the hospital, and how we roll the dice every time we send a patient home — and no one from another specialty should ever be allowed to testify on the standard of care in emergency medicine. This is a tort reform we should push vigorously in every state where it isn’t currently the law, including my own.

Some expert witnesses are simply prostitutes, and will say anything the attorney wants them to say in return for money. These are easy to spot, not just because their allegations of negligence are ridiculous, but because of the volume of expert witness work they do and how exorbitantly they charge. After all, a soul is an expensive thing to sell. These mercenaries make up a minority of plaintiffs’ experts, however, and are usually defeated by a good defense lawyer and ethical defense expert. If you run into one of these, please report him to AAEM’s “Remarkable Testimony/Due Process” website.

Believe it or not, most plaintiff’s experts are honorable, well-intentioned emergency physicians — and while the first two types discussed above make me angry, these break my heart. Why would a good emergency physician incorrectly claim another emergency physician has committed malpractice? There are three reasons: 1) not understanding what standard of care and negligence mean, 2) hindsight bias, and 3) the ivory tower syndrome.

I encourage you to act as an expert witness if called upon, because it gives you a chance to bring a voice of reason to our horribly unfair and broken tort system. To do that, however, you must remember what negligence means and what the standard of care is. Negligent means unreasonable; not imperfect, mediocre, average, or even below average. The standard of care is not perfection. It is not how you do things or how things were done where you trained. It is most certainly not a good outcome (see hindsight bias) — the vast majority of bad outcomes occur despite proper medical care, not because of bad medical care. Standard of care means within the bounds of reason. And remember, if there is a controversy raging in our specialty, then there is no standard of care on that issue — no matter what your personal opinion of the evidence is (IPA for stroke, for instance).

You must also be aware of your own unavoidable hindsight bias and strive to overcome it. When you know in advance the patient died of a PE, everything about the case screams the diagnosis at you. You must put yourself in the shoes of the emergency physician who was seeing the patient in real time, and then decide if his behavior was within the bounds of reason. Sure, the patient had pleuritic pain, hypoxia, and shortness of breath. He also had sinus congestion, rhinorrhea, a cough with purulent sputum, and the radiologist called pneumonia on a chest X-ray. Are you going to say that every patient with a URI and pneumonia should have a D-dimer or CTA of the chest? That’s what you’re saying when you say that defendant emergency physician was negligent. Always consider where your opinion will take our specialty when your line of reasoning reaches its conclusion.

Finally, for those of you in academia, if the lawsuit involves a community hospital ED and you haven’t recently worked extensively in one — you have no idea what you are talking about and are not qualified to offer an opinion on the standard of care in such an ED. Try to get over your hubris. When you are not only the only physician in the ED, but the only physician in the building, the situation is completely different than when you have half a dozen EM residents around you and getting a consult means having another doctor come down the elevator, rather than transferring the patient to a completely different hospital. Just as no doctor from another specialty should ever be allowed to testify on the standard of care in emergency medicine, no academic from a tertiary care center should ever testify on the standard of care in a small community hospital.

There is little we can do about unethical medical experts, absolutely nothing we can do about bad lawyers, and reforming our dysfunctional tort system is difficult and will take years of effort, one state at a time. We can, however, change our own flawed behavior. When you are the medical expert — be humble, be fair, and be honest. Understand exactly what you are doing and think carefully about everything you say. A bad outcome is not proof of malpractice — it usually isn’t even evidence of malpractice.

References
Call for Assistant Editor —
Join the Common Sense Team

Common Sense needs an assistant editor. I am looking for someone who enjoys reading and writing, who is passionate about AAEM’s values, and who is dedicated to fighting for individual emergency physicians, our specialty, and our patients by spreading news of the Academy and growing its membership. Responsibilities include editing articles for accuracy, grammar, and to some degree, for style. Our goal in editing is to make every article an easy and interesting read while leaving the author’s original voice and intent intact.

The assistant editor will always edit the “Resident Journal Review,” as well as anything else I need help on, and write an occasional “From the Editor’s Desk” column when I need a break. An important part of the job will be to recruit authors and solicit interesting material to publish. I hope the assistant editor will also contribute ideas on how to make Common Sense more interesting, useful, and popular to AAEM members.

If you are interested, please contact either me (cseeditor@aaem.org) or Laura Burns (lburns@aaem.org) and explain why you want the job and think you would be right for it. A sample of your writing would be appreciated. Note that this is a volunteer job, just like all AAEM leadership positions — including my own.

Thank you for being part of the AAEM family.
Have you renewed with AAEM for 2014?
Visit www.aaem.org/renew today!

Protection You Can Count On...

Introducing the AAEM Exclusive Liability Insurance Program

A Professional Liability Policy Specifically Designed for AAEM Members

- Preferred Premium Rates for AAEM Members
- Choices of Distinct Coverage Plans
- Continuing Education Opportunities
- Advocacy for AAEM Members
- Assistance with Application Process
- Reduced Renewal Application Process

Call 202-263-4050 or visit https://AAEM.HaysAffinity.com today!

Call for Assistant Editor —
Join the Common Sense Team

Common Sense needs an assistant editor. I am looking for someone who enjoys reading and writing, who is passionate about AAEM’s values, and who is dedicated to fighting for individual emergency physicians, our specialty, and our patients by spreading news of the Academy and growing its membership. Responsibilities include editing articles for accuracy, grammar, and to some degree, for style. Our goal in editing is to make every article an easy and interesting read while leaving the author’s original voice and intent intact.

The assistant editor will always edit the “Resident Journal Review,” as well as anything else I need help on, and write an occasional “From the Editor’s Desk” column when I need a break. An important part of the job will be to recruit authors and solicit interesting material to publish. I hope the assistant editor will also contribute ideas on how to make Common Sense more interesting, useful, and popular to AAEM members.

If you are interested, please contact either me (cseeditor@aaem.org) or Laura Burns (lburns@aaem.org) and explain why you want the job and think you would be right for it. A sample of your writing would be appreciated. Note that this is a volunteer job, just like all AAEM leadership positions — including my own.

Thank you for being part of the AAEM family.
Have you renewed with AAEM for 2014?
Visit www.aaem.org/renew today!

Protection You Can Count On...

Introducing the AAEM Exclusive Liability Insurance Program

A Professional Liability Policy Specifically Designed for AAEM Members

- Preferred Premium Rates for AAEM Members
- Choices of Distinct Coverage Plans
- Continuing Education Opportunities
- Advocacy for AAEM Members
- Assistance with Application Process
- Reduced Renewal Application Process

Call 202-263-4050 or visit https://AAEM.HaysAffinity.com today!
Letters to the Editor

Andy Walker, MD FAAEM
Editor, Common Sense
AAEM Board of Directors

A “Letters to the Editor” feature is now available on the Common Sense section of the AAEM website. Members must log in with their AAEM username and password to read or post letters, or to comment on letters (www.aaem.org/publications/common-sense). If necessary, you may request that we post your letter anonymously and such requests will be reviewed on a case-by-case basis. The letters that I think are interesting, entertaining, educational, provocative, or of general interest, will be printed in Common Sense.

I hope to hear from many of you, even if you are criticizing me. I need your feedback to make Common Sense an interesting read and a good use of your time. I also want it to attract new members to the Academy. If you like something you see, let me know. If I make you mad, let me know. Especially if I make you mad. I want the “Letters to the Editor” feature to become a forum for civilized but vigorous argument, and the more vigorous the better.

— The Editor

Letter in response to November/December “Medical Student Council President’s Message” titled “‘That’s So Meta’: Cognitive Bias.”

Kudos to MS4 Calderone. It’s encouraging to see someone so early in his/her career realize our “science” is hindered or enhanced by our own personal psychology. I encourage her and other young physicians to continue to delve into this subject as it belies the arguments of medical malpractice. Our profession would be well-served if she, and others like her, took upon themselves, as part of their career, to educate his/her fellow physicians and, more importantly, the general public about the nuances of the clinical decision-making process. It is important for society to understand that medicine is not an algebraic equation. For better or worse, our past experiences play a starring role in our thinking process. Two reasonable physicians can start with the same set of facts and reach different conclusions. Not because one is smarter and the other one is careless. But because our clinical decision-making process cannot be divorced from our humanity.

— Hector Peniston Feliciano, MD FAAEM

Thanks for your letter. I agree. That’s why I encourage all physicians who act as expert witnesses to remember two things above all else. 1) Be aware of your own hindsight bias when you evaluate a case. When you know in advance the pt eventually suffered a posterior circulation stroke, what looked like peripheral vertigo to the original physician was “obviously” a vertebrobasilar TIA. If the pt had no diplopia or other cranial nerve deficits, however, calling that negligent means you are saying that every pt with vertigo must have a CT angiogram or MRA of the head and neck before being sent home. Be fair, and think about where your chain of reasoning will end up. 2) Remember what “standard of care” and “negligent” actually mean. The standard of care is not perfection, what you do in your practice, or what they do where you trained. It is reasonable care. Negligence is something a “reasonable” physician would not have done under similar circumstances. “Reasonable” includes a broad range of medical choices and actions, many of which you might not have chosen. Unfortunately a tiny fraction of physicians will say anything if paid well enough for their testimony. Most plaintiff’s experts, however, are sincere and well-intentioned — but blinded by their own hindsight bias or misunderstanding of what constitutes negligence in emergency medicine.

— Andy Walker, MD FAAEM
Editor