How to Not Get Sued

[Editor’s Note: I’m trying something new next week that I haven’t done before, a webinar. I’m partnering up with one of our insurance partners and we’re going to try answering your questions on student loans, investing, and insurance live. It’ll be Tuesday evening at 9 pm EST (6 pm PST). Sign-up here!]

I wanted to highlight a paper that came out this year in the Annals of Emergency Medicine. The paper and its accompanying editorial (behind a paywall if you’re not a subscriber) are pretty revolutionary and a good opportunity to discuss both risk management and asset protection.

The paper was entitled “Provider and Practice Factors Associated With Emergency Physicians’ Being Named in a Malpractice Claim.” It looked at a bunch of physician (and one location) characteristics that one might think would be associated with a higher risk of being sued, using data obtained over 5 years from 87 EDs in 15 states. There were 98 claims involving 90 docs. The study looked only at the risk of being named in the suit, not the actual outcome of that suit. The 9 factors included were:

1. Total Years in Practice
2. Whether they were board-certified in EM (remember some docs who work in EDs are not)
3. Whether they are primarily nocturnists
4. Total number of visits
5. Patient Satisfaction scores
6. RVUs/hour
7. Admission percentage rate
8. Whether they work at multiple facilities
9. ACEP Malpractice Environment Score

Guess which ones mattered? Here’s the table:

<table>
<thead>
<tr>
<th>Variable</th>
<th>Physicians With No Malpractice Claims (N=539)</th>
<th>Physicians With 1 or More Malpractice Claims (N=50)</th>
<th>Odds Ratio (95% CI)*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physician characteristics</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total years in practice (SD)</td>
<td>11.8 (9.4)</td>
<td>15.7 (9.2)</td>
<td>1.04 (1.02-1.06)</td>
</tr>
<tr>
<td>Board certification in EM (N, % yes)</td>
<td>758 (80.72)</td>
<td>81 (80)</td>
<td>1.14 (0.49-2.69)</td>
</tr>
<tr>
<td>Predominantly night practice (N, % yes)</td>
<td>63 (5.6)</td>
<td>8 (6.7)</td>
<td>1.31 (0.50-3.44)</td>
</tr>
<tr>
<td><strong>Operational characteristics</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Total number of visits (IQR)</td>
<td>7,572 (3,401-13,501)</td>
<td>13,797 (10,282-17,352)</td>
<td>1.09 (1.05-1.12)</td>
</tr>
<tr>
<td>Median monthly physician Press Ganey percentile (QR)</td>
<td>60 (25-90)</td>
<td>60 (30-90)</td>
<td>1.00 (0.99-1.01)</td>
</tr>
<tr>
<td>Median monthly RVUs/h (QR)</td>
<td>9.6 (8.6-10.6)</td>
<td>9.76 (8.8-10.7)</td>
<td>1.00 (0.87-1.15)</td>
</tr>
<tr>
<td>Median monthly admission rate (IQR)</td>
<td>20 (13.5-26.5)</td>
<td>18.5 (13.4-23.8)</td>
<td>2.92 (0.32-32.8)</td>
</tr>
<tr>
<td>Work at multiple facilities (N, % yes)</td>
<td>217 (23.1)</td>
<td>20 (28.9)</td>
<td>1.34 (0.63-2.87)</td>
</tr>
<tr>
<td><strong>Jurisdictional characteristic: ACEP report card</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grades A and B</td>
<td>States: 2/15 (13.3%)</td>
<td>States: 2/15 (13.3%)</td>
<td>[Reference]</td>
</tr>
<tr>
<td></td>
<td>Physicians: 138/939 (20%)</td>
<td>Physicians: 27/90 (30%)</td>
<td></td>
</tr>
<tr>
<td>Grades C, D, and F</td>
<td>States: 13/15 (86.7%)</td>
<td>States: 13/15 (86.7%)</td>
<td>0.65 (0.27-1.54)</td>
</tr>
<tr>
<td></td>
<td>Physicians: 751/939 (80%)</td>
<td>Physicians: 63/90 (70%)</td>
<td></td>
</tr>
</tbody>
</table>

CI: Confidence interval; IQR: interquartile range. ACEP, American College of Emergency Physicians.

*Odds ratios represent the results of multivariable analysis for physician-level risks of being named in one or more malpractice claims during the study period.

†Odds ratio per 1,000 visits. Hosmer-Lemeshow statistic for logistic regression model: 8.305.

The key results are the odds ratio on the right. An odds ratio of 1 means it doesn’t make a difference, so if the 95% confidence interval of the odds ratio includes 1.00 then, statistically speaking, the factor doesn’t affect your likelihood of being sued. Only two of the 95% confidence intervals did not include 1.00 — Total Years in Practice and Total Number of Visits. Your board certification status didn’t seem to matter (although there was a trend), which shift you worked didn’t matter, your patient satisfaction score didn’t matter, your patient acuity (RVUs/hr and admission rate) didn’t matter, working at multiple facilities didn’t increase your risk, and the ACEP Malpractice Environment score didn’t seem to matter either.
What does that mean? It means whether or not you get sued is basically a crapshoot. As the accompanying editorial (Malpractice Claims: It’s a Crapshoot—Time to Stop the Self-Blame and Ask Different Questions) explains:

Other authors, using less robust methodology, have suggested physician behavior may be associated with lawsuits. Venkat et al have given us a gift with their careful study. Only exposure matters. Of course, there are limitations here. Venkat et al could not study all practice elements potentially associated with malpractice risk. Supervision, handoffs, and volume of tests ordered are all missing. Does this, then, provide impetus for yet more research exploring other variables with larger data sets? Perhaps not. Perhaps we are now free to explore different questions.

Why does this matter? It matters because we blame ourselves and each other for lawsuits when in reality, it may have nothing to do with us. When I posted this on Twitter a few months ago, people chimed in with comments like “just smile, if you smile you get sued less.” What this study shows is that it doesn’t matter if you smile. We’ve been told for years that you need to treat people nicely, smile, sit down, spend time with them, and communicate well. Those are all the factors that we’re told cause high patient satisfaction scores. But what does this study say? It doesn’t matter. All that matters is exposure- How long you practice and how many patients you see.
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While this information invokes a certain sense of fatalism, it also provides freedom. It’s just like the freedom an investor gets when he realizes that none of those talking head on CNBC have any idea what the future holds and he should just buy index funds. You no longer have to pay attention to all that useless stuff. You can now focus on what really matters. If you want to be named in fewer lawsuits, do the following:

1. Work part-time
2. Work in a lower volume practice
3. Don’t supervise residents/mid-levels (increases the volume of charts your name is on)
4. Retire early

That’s it. Easy peasy. Forget all that other crap.

Of course, there may be other factors that contribute. As the editorial suggests:

"Variables such as the amount of a medical bill for which the patient is responsible, patient insurance type, and the number and experience of local attorneys specializing in plaintiff malpractice may turn out to be the best predictors of claims. Should researchers turn efforts instead toward investigation of patient and attorney factors? If we knew that certain patient insurance status, race, sex, or chief complaint conferred an increased risk of lawsuits, would we change our encounter dynamics? If so, how would this bias affect our work and our concern for our patients? Likely this would create animosity, negatively affecting our patient relationships and work well-being. In the end, it might prove to be even more damaging to the practice of emergency medicine than exploring provider factors. Yet we must not underestimate the damage done by the way in which our own society currently channels patient remediation for adverse outcomes and our own responses to claims."

The most important part of the article and the editorial is at the end of the editorial:

The most important information learned from the [article] is
that it’s a crapshoot. Physicians who treat more patients are slightly more likely to be sued than colleagues who consistently treat fewer patients over the years. If you practice long enough, you will be sued—and this does not mean you are a bad physician. You have plenty of company. When your colleagues are sued, it does not mean they are bad physicians. They have plenty of company. Furthermore, continued exploration into provider factors associated with lawsuits merely reinforces our own extreme self-blame and perfectionist ideals. Exploring patient factors is equally challenged because it can damage our relationships with patients before we even meet them.

For our own well-being, we need to practice good medicine, work ethically, treat every patient with equal kindness, and uphold our Hippocratic oath. Short of sweeping reform in the way we compensate patients for events currently handled by malpractice lawsuits, there appears to be little specific we as individuals can do to prevent the majority of malpractice claims. It is time that we teach the truth about this to our students, residents, and fellow emergency physicians. We need to cease pretending that a specific course, degree, or charting tip will prevent lawsuits. It is also time that we provide collegial and mental health support before, during, and after allegations.

So quit blaming your colleagues when they get sued and certainly quit blaming yourself. It’s not your fault. There’s no reason to lie awake at night or the next five years worrying about it. I think docs would worry less about malpractice if they realized two things:

1. It’s just money and
2. It’s not even your money
It’s Just Money

Let me explain. Malpractice is a civil tort, not a criminal case. You don’t go to jail for civil torts. All you can be liable for is monetary damages. Money. It’s about money. Remember the four legal elements of malpractice:

1. Professional duty owed to the patient
2. Breach of such duty
3. Injury caused by the breach
4. Resulting damages

You have to have all four for it to be malpractice. # 1 is usually pretty easy, and the battle of the experts in the courtroom typically comes down to proving # 2 (did you breach the standard of care) and # 3 (was that breach responsible for the injury.) A lot of people forget about lowly # 4 – if there are no financial damages, there is no malpractice. Remember, it’s about money. (This is also why there is less liability in killing the patient than maiming them!) So you could do all kinds of crazy stuff to a patient and hurt them, but if there is no financial damage, there is no malpractice. Key lesson? Malpractice is about money, not you. Now if you ask patients why they sue, they’ll give these reasons:

- Concern with standards of care—both patients and relatives wanted to prevent similar incidents in the future
- An explanation—to know how the injury happened and why
- Compensation—for actual losses, pain and suffering or to provide care in the future for an injured person
- Accountability—a belief that the staff or organization should have to account for their actions.
But what do they get out of the lawsuit if they win? They get compensation. That’s what it is about. The attorneys view a malpractice lawsuit as “just business.” The more you are able to view it similarly, the fewer nights of sleep you’ll lose when (not if) you’re sued. Do they prevent similar incidents in the future? Probably not. Do they get accountability? Not really. They might not even get an explanation.

It’s Not Your Money

So, in the event that you lose a lawsuit, whose money does the patient get? He or she gets the insurance company’s money. They don’t get your money. Your money is already gone. It was used to pay the insurance premiums for the previous decade or two. Whether you get sued or not and whether you win the lawsuit or not, that doesn’t affect your money. It’s already been spent. You’re basically a defense witness for the insurance company in their lawsuit. Thinking of it that way might also help you get a little more sleep.

But what about getting sued above policy limits? I’m amazed at how much time doctors spend worrying about this and how much time, effort, and money they spend trying to protect themselves against it. Think of all the things that have to happen for you to lose your personal assets in a malpractice case:
1. You have to make a mistake
2. That mistake has to hurt the patient
3. The patient has to realize it
4. The patient has to want to sue you
5. The patient has to find an attorney
6. The attorney has to think the case is going to be worth enough to spend $50-100K of her money gambling on it
7. The case has to go to court (nobody settles for more than policy limits)
8. You have to lose in court
9. The judgment has to be over policy limits
10. The judgment isn’t reduced on appeal to policy limits

What are the odds that all ten of these occur? In my field of EM, I calculate them at about 1/10,000 per year. Since I’m now halftime, perhaps 1/20,000 per year. Probably even lower since I’m not in Cook or Dade County. Definitely lower for about half the specialties out there as EM is about mid-way up the risk list.

So what would happen in the exceedingly unlikely event that you had a judgment above policy limits against you? Well, most likely it would be for less than a quarter million dollars if you look at the statistics. So you might lose a chunk of your
taxable account once in your career. Big Whoop. But even if it were for some crazy $10 Million dollar amount, what happens? Well, you declare bankruptcy. What do you get to keep? It depends on your state, but almost surely your retirement accounts, anything owned by your spouse or as tenants by the entirety, and maybe some or all of your home equity, life insurance cash value, and annuity value.

Maybe I sound a little Pollyannaish, but when I think about all the risks in my life, this isn’t one that I’m going to spend much time worrying about. After reading this paper, I’m going to worry even less.

What do you think? Do you believe the paper? Do you think there is something you can do personally that will keep you from being named in a suit? Why or why not? Does this make you more likely to go part-time or retire early? Comment below!