HEALTH CARE REFORM

RESEARCH LETTERS

Physicians' Views on Defensive Medicine: A National Survey

Overuse of health care services, which is frequently cited as a major driver of uncontrolled health care spending, has received considerable attention by policy makers as they debate health care reform.[1] There is a variety of causes for overuse of health care services, but few appear to inspire as much contention as the issue of malpractice. The pervasiveness of malpractice litigation is believed to lead to defensive medical practices, whereby physicians order tests or procedures in excess of their actual need to protect themselves from the risk of lawsuits.[2] Malpractice concerns could have an impact on health care reform efforts to improve efficiency and quality in health care, such as the promotion of the use of comparative effectiveness data, if physicians believe that following comparative effectiveness-based guidelines leaves them vulnerable to malpractice suits. We conducted a national survey of physicians to better gauge the potential impact of malpractice concerns on clinical practice in the context of health care reform.

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Methods. Data for this analysis were from a national survey of physicians on health care reform.[3] From the American Medical Association (AMA) Physician Masterfile, we randomly sampled 1500 physicians from each of 4 specialty groups: primary care, nonsurgical (medical) specialists, surgical specialists, and other specialists. Half of this sample was then randomly selected to receive questions about malpractice (n=3000). Physicians were asked to rate their level of agreement with 2 statements: "Doctors order more tests and procedures than patients need to protect themselves against malpractice suits" and "Unnecessary use of diagnostic tests will not decrease without protections for physicians against unwarranted malpractice suits." Response options on a 5-point Likert scale ranged from strongly agree to strongly disagree. Additional questions assessed the amount of time spent in clinical activities, practice ownership (or potential for ownership), salary structure, and professional society affiliation. The survey was mailed to physicians in 3 waves beginning on June 25, 2009, and data collection was completed on October 31, 2009.

For our analytic sample, we excluded physicians in training and physicians from the US territories. We calculated the response rate using standard methods[4] and compared the characteristics of respondents and nonrespondents using data in the AMA master file. Weights were used to adjust for the stratified sampling design, and all analyses were performed using the complex survey sampling procedures in Stata version 9 statistical software (StataCorp, College Station, Texas).

Results. Of the 2416 eligible physicians who received the survey with malpractice questions, 1231 returned completed surveys, for a response rate of 50.9%. Survey respondents were slightly older than nonrespondents (52.0 vs 50.2 years; $P<.001$), but there were no significant differences by sex, geographic location (census region or division, or urban or rural setting), specialty category, or type of practice.

An overwhelming majority of respondents (91.0%) reported believing that physicians order more tests and procedures than needed to protect themselves from malpractice suits (**Table**). These views were consistent across a range of physician characteristics, most notably across specialty groups, where 91.2% of generalists, 88.6% of medical specialists, 92.5% of surgeons, and 93.8% of other specialists agreed with the statement ($P=.35$). No significant differences were seen by geographic location, type of practice, or professional society affiliation. A statistically significant difference in responses to the question was only observed for sex: male physicians were more likely to agree than female physicians (92.6% vs 86.5%; $P=.01$). The majority of physicians also agreed that protections against unwarranted malpractice suits are needed to decrease the unnecessary use of diagnostic tests (90.7%). There were no significant differences across any of the physician characteristics for this question (data not shown).

Comment. We found that most physicians in this study believe that malpractice concerns result in unnecessary testing and procedures. They also believe that reforms should be instituted to protect physicians from medical liability. Physicians in typically lower liability-risk specialties, such as primary care, expressed as much concern about malpractice as physicians in high-risk surgical specialties. Our findings are consistent with research conducted in more limited geographic areas and among a narrower scope of physicians.[5]

This nearly universal fear may stem from the pervasiveness of malpractice suits. On average, 2 to 3 malpractice claims are paid for every 100 physicians annually.[6] Physicians may also feel vulnerable to malpractice suits because malpractice claims often do not involve medical error or negligence[7] and physicians have been sued despite practicing within the standard of care.[8] Our findings indicate that physicians want protection from liability risk. Further, they suggest that proposals to promote cost-effective care, such as the promulgation of guidelines from a national comparative effectiveness cen-

Table. Do Physicians Order More Tests and Procedures Than Patients Need to Protect Themselves From Malpractice Suits?

	Agree, %	Unsure, %	Disagree, %	*P* Value
Overall	91.0	2.5	6.6	
Sex				
Male	92.6	2.1	5.3	.01
Female	86.5	3.6	9.9	
Specialty[a]				
Primary care	91.2	1.8	7.0	.35
Nonsurgical specialists	88.6	3.5	7.9	
Surgical specialists	92.5	2.5	5.0	
Other specialists	93.8	1.7	4.5	
Census division				
Pacific	88.8	3.5	7.7	.97
Mountain	92.3	1.0	6.7	
West North Central	90.6	2.2	7.2	
West South Central	90.0	2.1	8.0	
East North Central	94.0	1.2	4.8	
East South Central	94.1	2.1	3.8	
South Atlantic	91.5	2.7	5.9	
Middle Atlantic	88.5	3.8	7.7	
New England	91.2	1.8	7.1	
Practice location				
Rural	95.0	2.6	2.4	.19
Urban	90.5	2.5	7.0	
Practice type				
Office	91.0	2.7	6.3	.61
Other	90.7	1.8	7.5	
Patient care, h				
>20	91.1	2.4	6.5	.99
≤20	91.3	2.4	6.4	
Practice owner				
Yes	89.7	3.2	7.1	.17
No	92.6	1.6	5.8	
Source of income				
Salary only	87.4	3.5	9.1	.28
Salary plus bonus	93.3	2.2	4.4	
Billing only	90.6	2.4	7.0	
Shift work or hourly wages	96.0	0.0	4.0	
Other	89.4	2.8	7.8	
AMA member				
Yes	91.5	2.2	6.4	.90
No	90.9	2.7	6.5	

Abbreviation: AMA, American Medical Association.
[a]Specialty groups: primary care (internal medicine, pediatrics, and family medicine), nonsurgical specialists (medical specialists, neurologists, and psychiatrists), surgical specialists (including obstetrics-gynecology), other specialists (eg, radiologists, anesthesiologists, pathologists).

ter, could be limited by physicians' fears of malpractice unless such protections are ensured. Malpractice reform should focus on ways of offering assurance to physicians that they will have protection against malpractice if they competently practice the standard of care.

Some limitations to our study warrant discussion. First, the survey had a modest response rate, 50.9%, and nonresponse could have biased our findings. However, respondents and nonrespondents in our study only differed significantly by age. Second, we did not measure actual practice patterns to corroborate physicians' perceptions of practicing defensive medicine, and our findings may overstate the role of defensive medicine in practice.

The potential for malpractice reform to save health care dollars is unclear. Direct malpractice expenditures such as insurance premiums and awards account for a small fraction of health care spending.[9] However, it is estimated that as much as $60 billion are spent annually on defensive medicine.[10] Even if the true cost of defensive practices was only a fraction of this amount, it would still represent a significant source of cost savings. Policy makers should consider reforms that curb defensive medical practice as they work to identify strategies to reduce health care spending and promote efficient, high-quality health care.

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HEALTH CARE REFORM

INVITED COMMENTARY

It Is Time to Address the Costs of Defensive Medicine

The common themes running through most of the recent debate over national health care policy, sadly, have been division and partisanship. Though Democrats and Republicans alike agree that our nation's health care system is in dire need of reform, consensus on Capitol Hill has been an elusive commodity. Among the many issues contributing to the seemingly constant division has been what to do about the costs imposed by medical malpractice lawsuits. This is unfortunate because, as studies like the one by Bishop et al have shown, the problems associated with health care litigation are real and widespread, and potential solutions are well within reach.

Over the last several years, as Congress has debated this issue, I have had an opportunity to meet with many physicians, most of whom have told me the same thing: That the constant threat of litigation leads them to perform extraneous and often inappropriate procedures, the costs of which they have no choice but to pass on to their patients. To stay in business, physicians must do everything they can to avoid being sued and to keep the costs of their malpractice insurance premiums from going through the roof. Unfortunately, the best way for them to do this is to perform extra and unnecessary tests and procedures and prescribe needless medications. In each case, this means more costs charged to patients and insurers as a result of fear of lawsuits instead of medical necessity.

The evidence for this trend is not merely anecdotal. The results of the survey Bishop et al published in this issue of the *Archives* indicate that physicians nationwide readily admit that these practices—typically referred to as "defensive medicine"—are commonplace. Other studies have given us a picture of the costs of these practices. For example, a 2008 study by PricewaterhouseCoopers found that as much as one-half of our nation's health care spending can be attributed to waste and that the single largest source of wasteful spending is defensive medicine.[1]

Because of these trends, I and a number of my colleagues have, over the years, supported reasonable, commonsensical reforms that would discourage frivolous claims and encourage the settlement of legitimate claims. These reforms would reduce the need for the practice of defensive medicine and result in significant savings for patients. These proposals have taken a variety of forms, including caps on noneconomic damages (ie, those not associated with actual, calculable losses), limitations on joint and several liability, and heightened evidentiary standards for punitive damages. Efforts have been made to enact these ideas systemwide or even to limit them only to certain high-risk specialties, such as obstetrics. Unfortunately, trial lawyers associations have successfully blocked tort reform, arguing that people with low incomes will not be able to find lawyers to take their cases on contingency if settlements are capped. However, that has not been the case in states like California that have enacted meaningful tort reform.

In the midst of the most recent health care debate, I received a letter from the Congressional Budget Office (CBO) regarding this issue.[2] That letter was remarkable in that, for the first time, the CBO took into account the costs associated with defensive medicine when evaluating the budgetary impact of proposed reforms. In their letter, the CBO indicated that, by enacting a number of commonly proposed tort reform measures, Congress could reduce the deficit by $54 billion over 10 years. In addition, according to the CBO's numbers, the private sector would see a roughly $125 billion reduction in private sector health spending over that same 10-year period. These are hardly insignificant numbers. Yet, even with this evidence in place, this issue was not significantly addressed in any of the recent health care bills debated in Congress, despite several attempts on the part of the minority to introduce amendments toward this end.