

MALPRACTICE CLAIMS: REDUCING RISK THROUGH PHYSICIAN HEALTH PROGRAM PARTICIPATION

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INTRODUCTION

Despite knowing that for certain illnesses (addictions, depression) physicians have good clinical outcomes associated with their participation in a PHP, there is a dearth of research data concerning whether PHP participation affects practice and especially safety to practice.

INTRODUCTION

- ▶ In concert with the liability insurer that underwrites most Colorado physicians, we completed a study to determine whether there was any relationship between malpractice claims and monitoring by CPHP.
- ▶ We understand that malpractice claims are not a direct (or inverse) measure of skill or safety, but felt that they are one window on this issue, especially if we examined claims paid rather than suits made.

INTRODUCTION

We felt that such a study could benefit 3 groups

- ▶ Patients: by exploring the conditions of safe and effective care.
- ▶ Insurance carriers: by exploring the question of carrier risk and cost among those who are ill and have been monitored by a PHP.
- ▶ PHPs: further our understanding of the effects of PHP monitoring on actual practice rather than just clinical outcome.

INTRODUCTION

- ▶ Colorado Physicians' Insurance Company (COPIC) has long been a strong supporter of CPHP, with financial contributions, referrals of doctors, and underwriting of physician education.
- ▶ PHP met with COPIC in a series of meetings to explore the mutual benefit of such a study, to consider possible research strategies, and to address confidentiality and proprietary issues.

OBJECTIVE

To examine whether and how medical malpractice claims were associated with monitoring by a PHP.

METHODS

Operational Definitions:

- Malpractice claims defined as suits in which compensation was *paid* to a plaintiff.
- Incident date used as the claim date. In some instances, participants had multiple claims.
- Indemnity costs are all costs, including fees, charges, disbursements, expenses and remuneration, incurred by a party to litigation.

METHODS

Cases

- ▶ Active and formerly active clients of the CPHP
 - Various medical specialties
 - Various presenting problems
 - Voluntarily-referred or mandated
 - 818 clients

METHODS

Analysis – 3 tests

1. Demographic Differences

- ▶ Examined demographic baseline characteristics between CPHP clients with and without a malpractice claim.
- ▶ - Binomial logistic regression looking at: gender, age, marital status, race, medical specialty, and referral status (mandated or voluntary).

METHODS

2. Difference in the annual rate of claims before and after monitoring

- Before monitoring period:
 - July 1, 1982 - enrollment date at CPHP
- After monitoring period:
 - CPHP discharge date through 1/30/2009
- Patients without at least one year of follow-up data were not examined.
- Wilcoxon Signed-Rank test

METHODS

3. **Risk relativity ratings** : business-specific procedure to determine the relative risk of a malpractice claim.
 - Matched to a non-PHP reference group for analysis
 - COPIC insured doctors who had not utilized CPHP (comparable in terms of physician specialty and physician years of coverage).

METHODS

- The combination of **frequency (# of claims) and severity (dollars paid/reserved) while also accounting for a physician's years of coverage and specialty** to derive a relative risk indication.
- ▶ Meaningful differences are determined by each individual malpractice carrier rather than a significance value.

RESULTS: GENERAL DEMOGRAPHICS

RESULTS: DEMOGRAPHIC DIFFERENCES

- ▶ In adjusted logistic regression, males and older physician had an increased odds of malpractice claims.
- ▶ Specialties that had an increased odds of paid claims included family practice physicians, anesthesiologists, OB/GYN, and surgeons.

		Odds Ratio	(95% CI)		P Value
Gender	Female (ref)	--			
	Male	2.27	1.08	4.78	0.03
Age at Evaluation		1.06	1.03	1.09	0.00
Marital Status	Unmarried (ref)				
	Married	1.40	0.76	2.58	0.29
Race	Caucasian (ref)				
	African American	1.66	0.27	10.20	0.58
	Asian	1.28	0.38	4.31	0.69
	Hispanic	0.46	0.06	3.64	0.46
	Other	1.81	0.31	10.40	0.51
Specialty	Various				
	Family Practice	3.55	1.20	10.50	0.02
	Anesthesiology	4.52	1.21	16.96	0.03
	Emergency				
	Medicine	2.57	0.64	10.22	0.18
	Internal Medicine	2.02	0.61	6.69	0.25
	OB/GYN	17.19	5.47	54.01	0.00
	Pediatrics	2.70	0.59	12.32	0.20
	Surgery	15.12	5.37	42.53	0.00
Substance Use Disorder	No (ref)				
	Yes	0.87	0.45	1.68	0.68
Mandated to Physician Health Program	Not Mandated (ref)				
	Mandated	0.76	0.45	1.29	0.31

RESULTS: ANNUAL RATE OF CLAIMS

Average Number of Claims Before and After PHP Monitoring						
	N	# of Claims	Annual Rate of Claims	SD	P Value	z
Claims Before Monitoring	560	56	0.10	0.38	0.00	-4.66
Claims After Monitoring	560	12	0.02	0.15		

RESULTS: RISK RELATIVITY RATINGS

► Prior to monitoring:

- CPHP clients **111% worse** than the physician cohort. In other words, for every \$1 spent, this group would require \$2.12 more than their peers.
- Relative risk fell dramatically during the monitoring period although still **28% worse** than the physician cohort.
- After monitoring, this pattern reverses. CPHP clients' **20% better** than cohort. In other words, for every \$1 spent on the physician cohort, the CPHP group would require \$.20 less than their peers.

DISCUSSION - POSSIBLE EXPLANATIONS

1. Participants' primary **health problem was treated effectively** and their health problem did not impact their work
2. Participants learned skills during their treatment/recovery which **improved their ability to practice effectively**
 - a study of addicted nurses found that the subjects considered themselves more **patient, tolerant and compassionate**

POSSIBLE EXPLANATIONS

3. Participants learned skills in their treatment/recovery that enabled them to **communicate better** with colleagues, staff, and patients
 - **malpractice claims are known to be partially a function of doctor-patient communication** problems; however, claims *paid* more likely represents other practice issues.

POSSIBLE EXPLANATIONS

4. Positive experience with CPHP may have led participants **to make use of other professional supports**, e.g.. seek consultation earlier.
5. After treatment/during recovery and CPHP involvement and observing adverse consequences (practice, licensing, other institutions), participants may **be more motivated** to practice more conservatively and adhere to standards of practice.

LIMITATIONS

- ▶ **Preliminary study**
- ▶ Risk-relativity is a business-specific procedure and **may differ among insurers** – how generalizable?
- ▶ Insufficient numbers to analyze by **type of health condition or clinical problem**
- ▶ Retrospective – unable to establish **causation**
- ▶ Technical difficulty of comparing **unequal periods of time** (here addressed through post hoc analysis of annual claim rates)

CONCLUSIONS

1. This preliminary study found that PHP **involvement reduced the risk of malpractice claims** (defined as claims paid), **both for the individual physicians and when the CPHP physicians were compared to a reference cohort of those not involved with CPHP.**
2. The inverse of the #1: **Ill physicians were at considerably greater risk before CPHP involvement**, and at slightly greater risk when participating in CPHP.

CONCLUSIONS

The study strongly supports the need for/to:

- ▶ **Early CPHP involvement** for ill physicians, which implies
- ▶ Create conditions that **encourage self-referral** and voluntary CPHP involvement
- ▶ Confidentiality regarding CPHP participation

CONCLUSIONS

4. It is **essential to educate** regarding the practice and malpractice risks of untreated/unmonitored illness among physicians
 - ▶ Physicians and students/trainees
 - ▶ Employers
 - ▶ Insurers
 - ▶ Hospitals
 - ▶ Licensing boards

FURTHER RESEARCH

- ▶ Need for larger sample
- ▶ Examining other indicators of quality (patient satisfaction, adverse actions, CME activity, examination of practice or records)

Questions??