

EDITORIAL

Hospitalists and Liability: Surprising Findings That Point Back to Patient Safety

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In this issue of the *Journal of Hospital Medicine*, Schaffer and colleagues report their analysis of malpractice claims against hospitalists compared to other physician specialties.¹ In contrast to previous work examining medical liability,^{2,3} Schaffer and colleagues have been able to identify hospitalists specifically.^{2,3}

Perhaps surprisingly, their main finding was that the rate of claims against hospitalists was significantly lower than for nonhospitalist internists, emergency medicine physicians, general surgeons, and obstetricians–gynecologists. We say surprisingly, because health systems utilizing hospitalists generally include features that might increase the risk for malpractice claims.

For example, new patients are typically assigned to whichever hospitalist is up for the next admission. Research shows that strained patient–physician relationships increase the risk for malpractice claims.^{4,5} Schaffer's data suggest that lack of a preexisting relationship is a challenge, but one to which most hospitalists have grown accustomed. Hospitalists develop and hone skills that allow them to quickly establish rapport with patients and families. Moreover, though patients seldom choose their hospitalist, they often do select the hospital in which they receive their care. The research group of 1 of the authors was recently surprised to find patients had high levels of trust with their hospital physicians, despite frequently being unable to name them or identify their role.⁶ We suspect patients in the study had high levels of trust with the hospital and transferred this trust to their assigned physicians as representatives of the organization. Certainly, this hypothesis needs to be tested, and in no way does it minimize the importance of a strong patient–physician relationship.

In addition, patient–physician continuity has long been felt to be paramount to safe and effective care; however, it is difficult to achieve in hospitalist systems. Hospitalized patients experience multiple hand-

offs, including those at admission, for night coverage, and at the time of service change (ie, end of rotation/stint). The potential for loss of information is enormous. Though increased attention has been dedicated to handoffs among housestaff, little work has been done to describe issues related to handoffs among practicing physicians. However, some discontinuity may be advantageous. A physician newly taking over patient care from another may not be anchored to the initial diagnosis and treatment plan established by the first. This free “second look” may actually prevent missed/delayed diagnoses and optimize plans of care, further reducing harm from care and risk of malpractice.⁷

Hospital discharge is another highly risky time, due to issues such as tests pending at the time of discharge and the need to manage ongoing workup and treatment of unresolved issues.^{8,9} The responsibility for tying up these loose ends may be unclear as patients are transitioned from the care of hospitalists to outpatient physicians. Prior research has shown that patients are at particularly high risk for preventable adverse events after hospital discharge.^{10,11} More recently, healthcare policy has focused on measuring and incentivizing the reduction of readmissions.¹² Although only a portion of readmissions are truly preventable,¹³ and many patients who suffer adverse events after discharge are not readmitted,¹¹ the efforts resulting from these policy initiatives may have improved the overall safety of transitions of care.

A particularly important contribution of Schaffer and colleagues' study is that it helps us identify patient safety issues related to hospital medicine. Despite intense national efforts over the past 10 to 15 years, progress has been slow in reducing the rate of adverse events among hospitalized patients.^{14–16} Although adverse events and medical liability do not always correlate,^{17,18} the contributing factors identified in Schaffer and colleagues' study help direct our patient safety efforts.

Clinical judgment was the most common factor associated with hospitalist malpractice claims, with examples including failure or delay in ordering a necessary diagnostic test or specialist consultation. These results may be misinterpreted by some to suggest that ordering more tests and services may reduce risk for malpractice claims. However, there is no evidence to support the belief that these defensive medicine

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behaviors actually reduce risk. In fact, the opposite may be true. Research shows that abnormal tests are frequently overlooked,^{9,19} and failure to act on abnormal results is a common cause of diagnostic error.²⁰ Experts have called for the development of diagnosis-related quality measures and better strategies to enhance trainees' clinical reasoning skills.²¹ We suggest that future research also clarify the effect of interruptions, distractions, and workload on cognitive errors in hospital settings.

Communication failures were the second most common contributing factor. As previously mentioned, communication failures may occur between hospitalists during handoffs. We also have major opportunities to improve interprofessional teamwork, especially between physicians and nurses.^{22,23} An increasing number of hospitalist groups are collaborating with other hospital-based professionals to implement novel strategies to improve teamwork,^{24,25} many of which were recently summarized in a review published in this journal.²⁶

Documentation was the third most common contributing factor. Most malpractice claims are filed long after the alleged injury has occurred.¹⁸ Unless the clinicians involved and the hospital in which they work are aware of an event that might result in a malpractice claim, the investigation may be severely delayed. As time goes on, professionals are less able to recall details pertinent to understanding contributing factors to an event. Thus, documentation is critical. As the saying goes, "if it wasn't documented, it didn't happen." The flipside of too little documentation is, of course, too much. The increasing use of electronic health records makes it easy to copy and paste outdated information, the sloppiness of which can only hurt when attempting to defend a malpractice claim.²⁷

In conclusion, despite a model with inherent features that might contribute to medical malpractice risk, hospital medicine has a claim rate lower than many other specialties. Though reassuring, hospitalists should remember that the most productive way to approach malpractice risk is reframe the problem as one that attempts to reduce risk for patients, rather than for physicians. Improving patient safety is a core value for hospital medicine. Schaffer and colleagues' study identifies factors contributing to patient safety risk in hospital medicine, allowing us to renew our efforts in focused areas.

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