



The Role of Informed Consent in Defensive Medicine

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Studies Track Reasons for Excessive Medical Tests and Procedures; Fear of Lawsuits Is Not the Culprit Some Expected

Those who advocate tort reform often point to the problem of defensive medicine as a justification to limit the right of redress of victims of medical malpractice. The argument is that the "pervasiveness of malpractice litigation" causes health care providers to "order tests or procedures in excess of their actual need to protect themselves from the risk of lawsuits." Tara F. Bishop, MD, Alex D. Federman, MD, MPH & Salomeh Keyhani, MD, MPH, Physicians' Views on Defensive Medicine: A National Survey, 170 *Arch Intern. Med.* 1081 (2010). Accordingly, malpractice litigation is seen as creating a problem of over-deterrence, with lawsuits causing doctors to take more precautions than they otherwise should when they treat their patients.

Physician Perceptions vs. Reality

When attempting to determine why diagnostic tests and procedures are being over-ordered, it is difficult to distinguish a doctor's attempt to stave off liability from other motivations, and relying on doctors to self-report their motivation can be problematic.

Doctors certainly think the threat of malpractice causes them to be excessively cautious. Studies surveying doctors for the last 30 years reveal that anywhere between 21% to 98% admit engaging in defensive medicine. J. William Thomas et al., Low Costs of Defensive Medicine, Small Savings from Tort Reform, 29 *Health Affairs* 1578-1584 (2010). Nevertheless, it is hard to reconcile physicians' perceptions that they are acting in an overly cautious manner with reality. Ten years ago, the Institute of Medicine concluded that the amount of medical errors in the United States was at epidemic proportions. Robert M. Wachter, M.D., The End of the Beginning: Patient Safety Five Years After 'To Err Is Human', W4 *Health Affairs*, Web Exclusive, 534-545 (2004). Similarly, although the last few years have seen an escalation in the discussion about the costs of defensive medicine, over-cautious behavior is not evident in outcomes because medical error rates have held steady. Christopher P. Landrigan, M.D. et al., Temporal Trends in Rates of Patient Harm Resulting from Medical Care, 363 *New Eng. J. Med.* 2124 (2010).

Bias

Bias may be one culprit here, as some commentators have pointed out. "Because many physicians are attuned to defensive medicine as a problem, and their professional organizations agitate prominently against it," studies that attempt to quantify the scope of the problem of defensive medicine by surveying physicians are prone to a "socially-desirable response bias." David M. Studdert, LLB, SeD, MPH, et al., Defensive Medicine and Tort Reform: A Wide View, 25 *J. Gen. Intern. Med.* 380 (2010).

Inherent Defects

In addition to the problem of bias, surveying doctors to attempt to determine whether the threat of a medical malpractice lawsuit causes over-utilization has other inherent defects. First, there are many other causes for profligate testing in medicine, including: 1) the public culture of entitlement; 2) the expectation of immediate and

perfect results; 3) the extraordinary increase in diagnostic and treatment options today; and 4) growing specialization and fragmentation of care. Marcel Frenkel, M.D., M.B.A., Consensual Medicine and the Therapeutic Partnership: Reducing the Costs of Defensive Medicine and Litigation, 25 *J. Med. Prac. Mgmt.* 78 (2009). Additionally, managed care contributes to over-ordering because it requires faster analysis and decisive conclusions. *Id.*

Does Reform Bring Results?

Studies that have attempted to quantify the costs of defensive medicine by looking at the impact that tort reform has had on health care savings have obtained inconsistent results. For example, while some studies have found lower health care costs in states with tort reform, others noted a weak relationship between tort reform and health care savings. Still other studies found no relationship at all. J. William Thomas et al., Low Costs of Defensive Medicine, Small Savings from Tort Reform, 29 *Health Affairs* 1578, 1579 (2010). These varied results have been attributed to the fact that researchers invariably focus on limited sets of clinical conditions or specialties. *Id.* at 1579.

In 2009, a broader and more comprehensive study was undertaken to ascertain the impact of tort reform measures on health care costs by examining Medicare spending in states that adopted tort reform. Frank A. Sloan & John H. Shadle, Is There Empirical Evidence for 'Defensive Medicine'? A Reassessment. 28 *J. Health. Econ.* 481 (2009). The study concluded that its analysis, and those of previous studies, suggested that contrary to statements in the media, caps on damages and the abolition of punitive damages did not have a significant impact on the reduction of payments for the studied Medicare services. The researchers' overall conclusion was that "tort reforms do not significantly affect medical decisions, nor do they have a systematic effect on patient outcomes." Notably, these results meshed with the Congressional Budget Office's estimate that if tort reform were enacted in the form of a \$250,000 cap on non-economic damages, a \$500,000 cap on punitive damages and a decrease in statute of limitations, the savings from a combination of: 1) decreased use of services from less defensive medicine; and 2) lower malpractice insurance premiums would be merely .5% of the annual national expenditure of health care. Cong. Budget Office, Letter to Honorable Orrin G. Hatch, U.S. Senate, Oct. 9, 2009, available at www.cbo.gov/ftpdocs/106xx/doc10641/10-09-Tort_Reform.pdf.

Defensive Medicine and Informed Consent

There is another reason to question whether defensive medicine causes doctors to over-order tests. At face value, the defensive medicine argument is premised on an outdated and paternalistic view of the physician/patient relationship that is contrary to law. In most circumstances, the law compels physicians to empower their patients to make consequential medical decisions. Thus, it is a mistake to assume that reduced exposure to liability will allow doctors to be less cautious.

The doctrine of informed consent has been in existence since the early 20th Century. In *Schloendorff v. Soc'y of the N.Y. Hosp.*, 211 N.Y. 125 (1914), Justice Benjamin Cardozo concluded that "every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which is he liable in damages."

It is settled in New Jersey that a physician has a legal duty to disclose to the patient all medical information that a reasonably prudent patient would find "material" before deciding whether to undergo a medical procedure. *Largey v. Rothman*, 110 N.J. 204 (1988). The test of materiality is simply whether a reasonably prudent patient, "in what the physician knows or should know to be the patient's position, would be likely to attach significance to the risk or cluster of risks in deciding whether to forgo the proposed therapy or to submit to it." *Caputa v. Antiles*, 296 N.J. Super. 123 (App. Div. 1996) (citing to *Largey, supra*, 110 N.J. at 211-212 (quoting *Canterbury v. Spence*, 464 F.2d 772, 787 (D.C. Cir.), cert. den., 409 U.S. 1064 (1972)). "A physician who fails to disclose alternative treatments that a reasonably prudent patient, in what the physician knows or should know to be the patient's position, would consider significant in making one's own treatment decision, violates the standard for disclosure." *Caputa, supra*, 296 N.J. Super. at 134.

The standard governing the disclosure focuses on what a reasonable patient needs to know — that is what a reasonable patient would likely find significant given the risks — to make an informed decision in foregoing or consenting to a medical procedure. *Howard v. Univ. of Med & Dentistry of N.J.*, 172 N.J. 537, 547 (2002). Notably, the foundation for this duty to disclose is found in the idea that "it is the prerogative of the patient, not the physician, to determine for herself the direction in which her interest seems to lie." *Largey, supra*, 110 N.J. at 214

(citing *Canterbury, supra*, 464 F.2d at 781). It is an objective standard; "it relates to the patient's needs, not the physician's judgment." *Blazoski v. Cook*, 346 N.J. Super. 256, 267-268 (App. Div. 2002).

While informed consent does not require doctors to "recite all the risks and benefits of each potential appropriate antibiotic," for example, when they write a prescription for treatment of an upper respiratory infection, doctors do have an obligation to "disclose all courses of treatment that are medically reasonable under the circumstances." *Matthies v. Mastromonaco*, 160 N.J. 26, 36 (1999). Doctors can and are expected to make recommendations about care, but "the ultimate decision is for the patient." *Id.* at 34.

Conclusion

There are many reasons to question the scope of the problem of defensive medicine. First, initial steps to quantify it were based solely on surveys of physicians. An examination of the health care landscape revealed that there were many forces that would motivate doctors to over-order diagnostic tests and procedures. Second, although some states have now enacted tort reform, data from studies suggest that limiting a medical malpractice victim's right of redress does not significantly impact physician behavior. This is not very surprising given the absence of progress in the patient safety movement. Moreover, since tort reform does not impact physician behavior, it is not surprising that government projections conclude that drastic steps to limit a medical malpractice victim's right of redress will result in negligible health care savings.

It is a mistake to think that granting doctors immunity for consequential decisions will result in less diagnostic tests and procedures because most consequential medical decisions are being made by doctors and patients. It may very well be that bringing patients into the process has resulted in more decisions that err on the side of caution. Courts decided long ago that patients had this prerogative. It does not seem fair to shift the burden of the costs of informed consent to a smaller group of people simply because they have been harmed by medical malpractice. Fairness aside, enacting tort reform to combat defensive medicine is a public policy decision based on a loosely defined and overstated problem and studies already show that it will not impact physician behavior. Of course, it will not impact the medical decisions of patients either.

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