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The Impact of Defensive Medicine on Patient Access: The United States

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The United States (U.S.) healthcare agenda is the major domestic debate of President Obama's presidency. He had made revamping of the U.S.' pluralistic medical delivery system a cornerstone of his campaign and at his inauguration he prompted both the House of Representatives and the Senate to design legislation to fix it by focusing simultaneously on its deficiencies in access, its high cost and its less than optimal quality.

And well he should. American healthcare is a mosaic of initiatives and regulations tied predominantly to private practitioners and non-governmental reimbursers (save for Medicare for the aged and Medicaid for the poor). It excludes nearly a sixth of the population who lack insurance or are not eligible for public assistance. Moreover, it consumes one sixth of the economy and nearly every year its share of all expenditures rises faster than the rate of inflation.

It is by far the most expensive system in the world, about 50% higher in percentage of GNP than in most other developed countries. Much of the added costs go to meet the anticipated rewards sought by stockholders of private insurance companies and to meet the expectations of procedurally- oriented medical specialists whose compensation depends on the volume of work they generate. At this juncture, a comprehensive health bill is still under debate. A plan to offer a public health insurance option to compete with private insurance in order to enroll those presently uninsured was initially a minor component of a sweeping array of proposals. But it has galvanised opinion not only among legislators but also in the populace itself.

Political Battle Lines are Drawn

While the Democrats favour enhancing access, the Republicans by and large object to any innovation that limits choice and adds cost. Any compromise legislation that accommodates itself to a resolution of these competing claims might represent a victory for Obama's desire to make social change. Yet it will fail, nonetheless, because the matter of quality will not be addressed in a meaningful way. That is because the various legislative initiatives fail to relate to the fact that utilisation is controlled by doctors. Their impetus to do more outflanks the insurance companies objective to reimburse less.

The incorporation into practice of outstanding advances in techniques, procedures and pharmaceuticals is an attraction in itself, made more compelling as a generator of activity by the spectre of malpractice risk. Technologic improvements have caused a sea change in medical education. Now the older techniques of the art of medicine including history and physical exam have been bypassed in favour of the objective measures afforded by imaging tests among other innovations. The notion that failing to obtain such tests constitutes a susceptibility to an eventual malpractice suit has established defensive medicine as a protective sensibility. The looming threat of malpractice and the altered physician behaviour it promotes have aligned patients and doctors together against the political allies of plaintiff lawyers, many of whom are prominent Democrats, who fret about changing a system that would lessen the contributions to their re-election campaigns from their benefactors.

Defensive Medicine Hikes up Costs

It is reckoned that the costs of care engendered by defensive medicine may approach a trillion dollars. But the costs to physicians of defensive medicine in no way counterbalance the benefits they receive, because they are paid by the "piece work" they do. The cost of all judgments per annum of settlements both out of court and court verdicts nationally for all physicians is only four billion dollars and the total cost of their collective malpractice premium is less than 50 billion dollars each year.

Convenient misconceptions about malpractice serve to legitimate defensive medicine. Yet, less than one third of physicians will ever be sued, and less than one third of those sued will lose the case. Among radiologists many, many more will be sued for a complication or a misdiagnosis of a test or procedure that was not indicated clinically than for not doing a test that was indicated. And the leading cause of malpractice suits for all specialists, not just radiologists, is a failure to diagnose breast cancer in a woman under fifty years of age, a group for which the limitations of mammography are well known among physicians but not generally appreciated by patients. Thus healthcare in the U.S. will continue to be expensive and wasteful, an aberrant manifestation of a social policy of misdirected aims and assumptions until quality incentives are redesigned in a meaningful way to serve common rather than selective interests.

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