2024

Is Defensive Medicine Increasing or Decreasing Risk of Lawsuits

Alec Mais

Table of Contents

INTRODUCTION

It is estimated that medical error is the third leading cause of death in the United States.[1] More than one in three physicians, thirty four percent, have reported being involved in a medical malpractice lawsuit at least once in their careers.[2] In order to avoid lawsuits and decrease their potential liability, physicians may practice defensive medicine. Defensive medicine is the act of physicians ordering tests, procedures, or hospitalizations that may be of little value in terms of quality of care for the patient out of fear of liability.[3] Defensive medicine may also include avoiding procedures that are perceived to have a high risk of resulting in a lawsuit.[4] This can create a healthcare access issue because patients are unable to access the procedures and physicians they need so that they can properly care for their illness. The most cited reason physicians give for practicing defensive medicine is "that patients and the litigation process are highly unpredictable."[5] While the rationale for engaging in defensive medicine tactics is to avoid lawsuits, this paper argues that engaging in defensive medicine increases the likelihood of a medical malpractice suit. This is because defensive medicine may increase the risk of injury to patients and thus create further liability for physicians.

In addition to decreasing the risk of liability, some argue the benefits of defensive medicine include improving healthcare quality, especially when ordering additional testing and when referring difficult cases to more specialized physicians or better equipped hospitals.[6]

---

[1] *See* Michael J. Saks & Stephan Landsman, *The Paradoxes of Defensive Medicine*, 30 Health Matrix: J. of Law-Med. 25, 30 (2020).
[2] American Medical Association, *1 In 3 Physicians Has Been Sued; By Age 55, 1 In 2 Hit With Suit* (2018), https://www.ama-assn.org/practice-management/sustainability/1-3-physicians-has-been-sued-age-55-1-2-hit-suit.
[3] *Saks*, *supra* note 1, at 26–27.
[4] *Id.*
[5] *Id.* at 38.
[6] David M Studdert et al., *Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment*, 293 J. of the Am. Med. Ass'n 2609, 2616 (2005).

Another benefit is the cost savings from death and injuries that were prevented by performing defensive medicine.[7] Although some procedures and tests have minimal risks, no medical procedure or test is without risk. The more tests ordered, procedures done, and inpatient hospitalizations, the greater likelihood of an adverse outcome which can result in physician liability. Defensive medicine poses a variety of risks to patients. False-positive results associated with low-yield diagnostic testing can have detrimental effects on healthcare quality, particularly when ambiguous results produce emotional distress and necessitate additional invasive procedures which takes a toll on the patient-physician relationship.[8] The patient-physician relationship is strained because the patient may distrust their physician for improperly diagnosing them, making the patient less likely to receive medical care in the future. Unnecessary radiological testing subjects patients to the risks of radiation exposure and anaphylactic reactions to the contrast dye.[9] The defensive use of testing reduces the overall quality of patient care.[10] The defensive use of antibiotics poses a risk to patients by promoting antibiotic resistance which could cause difficulty in accessing antibiotic treatments in the future.[11] Other harms stemming from defensive medicine actions include infection, falls, and harmful drug interactions, which "increase the potential for a lawsuit—the very thing the doctor was hoping to avoid."[12]

[7] *Saks*, *supra* note 1, at 77.
[8] *Studdert*, *supra* note 6, at 2616.
[9] Massachusetts Medical Society, *Investigation of Defensive Medicine in Massachusetts* at 1 (2008). An anaphylactic reaction is a severe allergic reaction that can be life threatening.
[10] Paul A. Manner, *Practicing Defensive Medicine--Not Good for Patients or Physicians*, AAOS Now, 2007, https://www.aaos.org/aaosnow/2007/janfeb/clinical/clinical2/.
[11] Daniel Chalk, *How does defensive medicine cause harm to patients in the healthcare environment*, 5 Inspire: Student Health Scis. Rsch. J. 1,2 (2021), https://inspirestudentjournal.co.uk/wp-content/uploads/2021/12/Autumn-2021-LOW.pdf.
[12] *Saks*, *supra* note 1, at 43.

It is estimated that defensive medicine costs the United States healthcare system over 100 billion dollars annually, accounting for twelve percent of all yearly healthcare expenditures.[13] These costs are due to additional testing, procedures, referrals, and other resources being used for defensive medicine purposes.[14] It is also estimated that thirty percent of the healthcare spending in the United States is worthless because it offers no benefit to the patient.[15] A 2006 study performed by Price Waterhouse Coopers for America's Health Insurance Plans estimated the costs associated with medical malpractice liability account for seven to eleven percent of health insurance premiums, and the costs of litigation and widespread practice of defensive medicine increase healthcare spending by ten percent.[16] These costs associated with medical malpractice lawsuits are being endured by patients, their families, first party health insurers, and taxpayer funded government insurance programs.[17] This highlights how defensive medicine does not only pose a healthcare access issue but a healthcare cost issue as well.

This paper's main argument, perhaps counter-intuitively, is that defensive medicine increases the likelihood of a physician being sued based on the exact medical malpractice principles driving the physician to practice defensive medicine. "Perhaps the greatest irony is that defensive medicine may be counterproductive and actually might increase malpractice risk."[18] The rise of defensive medicine began in the 1970s when there was an increase in medical malpractice suits for a physician's failure to perform an act.[19] The trend of physicians practicing

[13] *Massachusetts Medical Society, supra* note 9, at 1.
[14] *See id.*
[15] *Saks*, *supra* note 1, at 32.
[16] *Manner, supra* note 10, at 4.
[17] *Id.* at 34.
[18] Peter P. Budetti, *Tort Reform and the Patient Safety Movement: Seeking Common Ground*, 293 J. of the Am. Med. Ass'n. 2660–2662 (2005), https://jamanetwork.com/journals/jama/fullarticle/200974 (last visited Apr 26, 2023).
[19] Leonard Berlin, *Medical Errors, Malpractice, and Defensive Medicine: an Ill-fated Triad*, 4 Diagnosis 133–139 (2017), https://www.degruyter.com/document/doi/10.1515/dx-2017-0007/html.

defensive medicine continues today despite lower rates of medical malpractice suits because physicians fear lawsuits and medical students are being taught defensive medicine by older physicians.[20] There are numerous ways defensive medicine actions can result in liability for physicians. All defensive medicine actions can implicate the physician's duty to follow the standard of care. The defensive medicine action of ordering additional tests can result in liability based on the physician's duty to advise of test results and from misdiagnosis. Additionally, the defensive medicine action of ordering additional procedures can result in liability based on proximate causation. Finally, the defensive medicine action of avoiding risky patients or procedures can result in liability based on the principles of patient abandonment and delay of treatment or diagnosis. Part I of the paper defines defensive medicine and categorizes the two types of defensive medicine behaviors. Part I also discusses the history of medical malpractice lawsuits in the United States that gave rise to defensive medicine. Part II discusses three studies that show the existence of defensive medicine in the United States as well its scope and impact. Part III applies the standards of medical malpractice and tort law to show how defensive medicine actions potentially open the door to more lawsuits. The conclusion includes recommendations on how to combat defensive medicine to improve healthcare quality and ease physicians' fears of being sued.

I. DEFENSIVE MEDICINE OVERVIEW

Defensive medicine is a complex phenomenon that lies at the intersection of law and medicine. This section gives an overview of defensive medicine from its definition to its history. Part A defines defensive medicine and Part B discusses the two types of defensive medicine

[20] *Id.* at 137.

actions. Part C discusses how the history of medical malpractice litigation in the United States gave rise to defensive medicine and how defensive medicine remains an issue today despite a decrease in medical malpractice suits.

A. Definition

In general terms, defensive medicine is defined as the practice of ordering medically unnecessary tests and procedures for the purpose of averting a possible lawsuit rather than benefitting the patient.[21] An essential aspect of defensive medicine is that "it helps the doctor while doing little or no good for the patient."[22] Defensive medicine is a deviation from established medical practice that is induced by the threat of liability.[23] "[A]ctions may be defensive medicine even if they are performed for reasons such as belief in a procedure's effectiveness, a desire to reduce medical uncertainty, or a financial incentive, provided that the primary motive is to avoid malpractice risk. Also, the motive need not be conscious."[24] There is little or no empirical evidence as to which defensive medicine tactics will reduce the risk of a malpractice claim being filed.[25] The evidence that "defensive practices reduce lawsuits is quite scarce, belief that defensive practices fend off lawsuits is said to be common" amongst physicians.[26]

[21] *Saks, supra* note 1, at 26–27.
[22] *Id.* at 42. *See also*, Manish Sethi, *Defensive Medicine: "Glowing" With Pain*, Patient Safety Network (2010), https://psnet.ahrq.gov/web-mm/defensive-medicine-glowing-pain#references (defining defensive medicine as "as medical practices that may exonerate physicians from liability without significant benefit to patients").
[23] *Studdert*, *supra* note 6, at 2609.
[24] *Manner*, *supra* note 10, at 1.
[25] *Saks*, *supra* note 1, at 38.
[26] *Id.* at 40.

B. Types of Defensive Medicine Actions

There are two types of defensive medicine actions. The first is assurance behavior (also referred to as "positive defensive medicine") which involves supplying additional services of no medical value with the purpose of reducing adverse outcomes, deterring patients from filing malpractice claims, or persuading the legal system that the standard of care was met.[27] Forms of assurance behavior include: (1) ordering more tests than medically indicated, (2) prescribing more medications than medically indicated, (3) referring patients to specialists in unnecessary circumstances, and (4) suggesting invasive procedures against professional judgement.[28] The second type of defensive medicine action is avoidance behavior (also referred to as "negative defensive medicine") which is a physician's efforts to distance themselves from the sources of liability.[29] Forms of avoidance behavior include: (1) avoiding conducting certain procedures or interventions, and (2) avoiding caring for high-risk patients.[30]

C. Litigious History of Medical Malpractice

The litigious history of the United States—particularly in medical malpractice cases—gave rise to defensive medicine practices. In the nineteenth and early twentieth centuries, physicians were occasionally sued for medical malpractice.[31] These suits were based primarily on errors of commission.[32] Errors of commission occur when the physician did something wrong like mistreating a condition, complications from surgical procedures, or prescribing the wrong medication.[33] In the 1970s, the nature of medical malpractice claims underwent a

[27] *Studdert*, *supra* note 6, at 2609.
[28] *Id.* at 2610.
[29] *Id.* at 2609.
[30] *Id.* at 2610.
[31] *Berlin, supra* note 19, at 134.
[32] *Id.*
[33] *Id.*

transformation.[34] Instead of being sued for doing something wrong (errors of commission) physicians were being sued for failing to do something right (error of omission).[35] This resulted in a three hundred percent increase in medical malpractice lawsuits in the United States between 1965 and 1970.[36] The experience of having been sued in the past and the fear of being sued in the future was a powerful motivation for physicians to practice defensive medicine.[37] Physician's "motivation to keep ordering more was further strengthened by the public's almost insatiable appetite in demanding radiologic and non-radiologic tests for screening, minor symptoms, and all varieties of medical illness. The threat of liability began to strongly influence the day-to-day practice of virtually all physicians."[38] Physicians began to practice defensive medicine out of fear of liability so that their care would not be perceived by their patients and malpractice lawyers as careless or substandard.[39]

The threat of a medical malpractice suit has decreased over the past decade.[40] To some extent this is due to better medical diagnosis and treatment, but to a greater extent this is due to the high cost of undertaking and litigating a medical malpractice case.[41] Despite the decrease in medical malpractice lawsuits, particularly frivolous lawsuits, the practice of defensive medicine has not decreased.[42] According to Leonard Berlin:

> Although it was the malpractice crisis of the 1970s that gave birth to defensive medicine, defensive medicine seems to have perpetuated itself on its own, independent of the

---

[34] *Id.*
[35] *Id.*
[36] *Id.*
[37] *Berlin, supra* note 19, at 134.
[38] *Id*.
[39] *See id*. at 135.
[40] *Id.* at 136.
[41] *Id.* at 136–37. These costs are associated with high litigation expenses that result from court costs and paying expert witness. *Id.* Since plaintiff's attorneys work on a contingency basis many will not accept cases unless the expected damages are at least $250,000. *Id.* For cases where winning is less certain most plaintiff's attorneys require a minimum expected damages of $500,000. *Id.*
[42] *Id.* at 137.

> changes in the malpractice environment. Defensive medicine remains as rampant today as it was [in the 1970s]. It has been passed down from one generation of physicians to another generation to yet another generation. Defensive medicine is introduced early in the education of young physicians. A survey of 4th year medical students and 3rd year residents at a prominent university academic medical center found that 94% of students and 96% of residents have seen or experienced examples of defensive medicine in their clinical training. The survey found that physicians' provision of additional services that are of little clinical value to the patient are particularly common.[43]

Thus, despite a decrease in medical malpractice suits as a result of medical advancements and apprehension by lawyers to bring cases due to high costs associated with litigating a medical malpractice case, defensive medicine actions have not decreased.[44] Defensive medicine remains an issue today because physicians' fear of lawsuits is being passed down from one generation of physicians to the next.[45]

II. SCOPE AND IMPACT OF DEFENSIVE MEDICINE

There have been debates within the medical and legal communities over whether defensive medicine exists and if it does exist what is the scope of the phenomenon. Some have argued that most physicians are not practicing defensive medicine but rather they are using good clinical practice and that physicians are following the standard of care.[46] Multiple studies have been conducted to evaluate the existence and scope, if any, of defensive medicine. Studies have been conducted in specific states, like Pennsylvania and Massachusetts, which are known for their high rates of medical malpractice lawsuits. Studies have also been conducted nationally across all fifty states. These studies have proven the existence of defensive medicine in the

[43] *Berlin, supra* note 19, at 137.
[44] *Id.* at 136-137.
[45] *See id.* at 137. Some may argue that defensive medicine being taught in schools shows that defensive medicine is actually a part of the standard of care. However, as this paper shows it is not a part of the standard of care because it does not have any benefit to the patient and the primary motivation for defensive medicine is not medical but legal. See part III section A for a more in-depth discussion of the standard of care.
[46] *See Saks*, *supra* note 1, at 38.

United States. The studies highlight the scope and impact of defensive medicine on the way physicians treat patients.

A. Pennsylvania Study

A 2003 study conducted in Pennsylvania, which is a state known for its volatile malpractice climate, surveyed 824 physicians from six specialties with a high risk of malpractice litigation on their defensive medicine behaviors.[47] These specialties included emergency medicine, general surgery, obstetrics/gynecology, orthopedic surgery, and radiology.[48] Ninety three percent of the physicians surveyed reported practicing defensive medicine.[49] Ninety two percent of respondent physicians reported engaging in assurance behavior.[50] Regarding assurance behaviors, one third of respondents reported prescribing more medications than medically indicated.[51] One third of respondent physicians also reported suggesting invasive procedures which in their professional judgement was unwarranted.[52] Regarding diagnostic procedures, more than ninety percent of respondents reported ordering tests unnecessarily and sixty percent (not including neurosurgery) reported requesting invasive diagnostic procedures.[53] Additionally, fifty two percent of respondent physicians reported they often transferred patients to other specialists in unnecessary circumstances.[54] Regarding avoidance behaviors, forty-two percent of respondents reported restricting their practices in the previous three years which included eliminating procedures prone to complications and avoiding patients who had complex

[47] *Studdert*, *supra* note 6, at 2609.
[48] *Id.* at 2610.
[49] *Id.* at 2612.
[50] *Id.*
[51] *Id.*
[52] *Id.*
[53] *Studdert*, *supra* note 6, at 2616.
[54] *Id.* at 2612.

medical problems or who were perceived at litigious.[55] Additionally, thirty nine percent of respondents reported they "definitely will/already decided to" avoid caring for high-risk patients.[56] Finally, one third of respondent physicians reported avoiding certain procedures or interventions.[57]

B. Massachusetts Study

From November 2007 to April 2008, the Massachusetts Medical Society conducted a statewide survey of physicians on their defensive medicine actions because Massachusetts ranked sixth in the United States for mean medical malpractice payments.[58] The study's sample included 3,650 physicians from the specialties of anesthesiology, emergency medicine, obstetrics/gynecology, family medicine, general surgery, internal medicine, and orthopedic surgery.[59] The study found that for assurance behaviors, physicians ordered the following diagnostic testing for defensive reasons: twenty percent of x-rays, twenty eight percent of CT scans, twenty seven percent of MRI scans, and twenty four percent of ultrasound studies.[60] Liability concerns also played a role for twenty eight percent of referrals to specialists, thirteen percent of hospital admissions, and eighteen percent of laboratory tests.[61] Regarding avoidance behaviors, thirty eight percent of respondent physicians reported they reduced the number of

---

[55] *Id.*
[56] *Id.* at 2613.
[57] *Id.*
[58] *Massachusetts Medical Society*, *supra* note 9, at 2. According to their website, the Massachusetts Medical Society is a statewide professional association of over 25,000 physicians and medical students dedicated to advocating for physicians and patients both locally and nationally.
[59] *Id.*
[60] *Id.* at 3-4.
[61] *Id.* at 4.

high risk services or procedures they provided and twenty eight percent of respondents reported reducing the number of high-risk patients they saw.[62]

C. National Study

In December 2009, Jackson Health System conducted a nationwide online survey to quantify the cost and impact of defensive medicine.[63] Over 3000 physicians spanning across all fifty states and across all medical specialties completed the survey.[64] The study found that ninety two percent of physicians reported practicing defensive medicine.[65] Respondent physicians attributed thirty four percent of overall healthcare costs to defensive medicine.[66] In terms of assurance behaviors, the study found that to avoid lawsuits: thirty four percent of respondent physicians ordered diagnostic tests, twenty nine percent ordered lab tests, nineteen percent ordered hospitalizations, fourteen percent ordered prescription medications, and eight percent performed surgeries.[67] Additionally, a national study done by the American Medical Association found that ninety one percent of physicians reported that they believe that physicians order more tests and procedures than necessary for their patients in order to protect themselves from medical malpractice suits.[68]

---

[62] *Id.* at 4–5.
[63] *Physician Study: Quantifying The Cost Of Defensive Medicine*, Jackson Healthcare (2019), https://perma.cc/76BJ-2A3N. According to their website, Jackson Health System is a non-profit academic medical system with multiple hospitals throughout Florida.
[64] *Id.*
[65] *Id.*
[66] *Id.*
[67] *Id.*
[68] Tara F. Bishop, Alex D. Federman & Salomeh Keyhani, *Physicians' Views on Defensive Medicine: A National Survey*, 170 Archives of Internal Med.1081-1083 (2010).

III. MEDICAL MALPRACTICE PRINCIPLES THAT SHOW HOW DEFENSIVE MEDCINE COULD LEAD TO AN INCREASED POTENTIAL FOR LAWSUITS

Physicians practice defensive medicine to avoid medical malpractice lawsuits. However, these same medical malpractice liability principles can result in a lawsuit based on the defensive medicine action. The first part of the analysis highlights general issues that apply to all defensive medicine actions, which is the physician's duty to follow the standard of care. The second part of the analysis is issues related to specific defensive medicine actions. These actions include assurance behaviors of ordering additional testing and ordering additional invasive procedures or treatments, and the avoidance behavior of avoiding risky procedures or patients. The analysis is based on New Jersey medical malpractice law.

A. General Issue: Standard of Care

The physician's duty to follow the standard of care is a medical malpractice principle that applies generally to all defensive medicine actions. A medical malpractice case is a type of tort action in which the traditional negligence elements are refined to reflect the professional setting of the physician-patient relationship.[69] Thus, a plaintiff in a medical malpractice action must prove the applicable standard of care and that the deviation from that standard of care proximately caused the injury.[70] When a physician is charged with negligence in the diagnosis or treatment of a patient's condition it must appear that the physician departed from the degree of skill required of them.[71] There are two elements that are needed to prove a deviation from the

[69] *Verdicchio v. Ricca*, 843 A.2d 1042, 1055–56 (N.J. 2004).
[70] *Id.*
[71] *Carbone v. Warburton*, 91 A.2d 518, 520 (Super. Ct. App. Div. 1952), *aff'd* 94 A.2d 680 (1953).

standard of care.[72] The first element is the standards to be established must be generally recognized and accepted by the specialty to which the physician belongs as the customary and proper methods of diagnosis or treatment of the condition.[73] The second element is a "departure from such standards under circumstances justifying the conclusion of want of the requisite degree of care." [74]

A physician's duty and the applicable standard of care comes down to a battle of the experts so that the jury can determine if the physician is liable. The applicable standard of care is judged by the standard that is accepted in the medical community.[75] The court in *Hall v. Hillbun* defined a physician's duty in this manner:

> the physician's non-delegable duty of care is this: given the circumstances of each patient, each physician has a duty to use his or her knowledge and therewith treat through maximum reasonable medical recovery, each patient, with such reasonable diligence, skill, competence, and prudence as are practiced by minimally competent physicians in the same specialty or general field of practice throughout the United States, who have available to them the same general facilities, services, equipment and options.[76]

This is a national standard based on the practices followed by physicians throughout the United States rather than a local standard of practices followed by physicians in a particular state or geographic area.[77] The more physicians engage in defensive medicine actions, '"the more likely such practices are to become the legal standard of care.'…Unnecessary invasive procedures and surgery are themselves potentially serious violations of the standard of care and could be the basis for malpractice litigation."[78]

---

[72] *Id.*
[73] *Id.*
[74] *Id.* (citing *Hull v. Plume*, 37 A.2d 53 (N.J. 1944)).
[75] *Hall v. Hilbun*, 466 So. 2d 856, 873 (Miss. 1985).
[76] *Id.*
[77] *Id.* at 883. *Hall* highlights the trend throughout the United States of a national standard for physicians rather than a local one. This means that experts witnesses do not need to practice medicine in a specific state or area in order to testify as to the standard of care.
[78] *Budetti, supra* note 18, at 2660–61 (quoting *Studdert, supra* note 6, at 2616).

A physician can incur liability if an expert can prove to the jury that the defensive action was not accepted in the medical community and as a result of the physician's negligent action harm was done to the patient. An expert for the defense could argue that some defensive actions are standard actions in the medical community. To counter this assertion a plaintiff's expert could show how the action was not standard in the medical community and was of no medical benefit to the patient. Experts can use medical literature to bolster their claims regarding the appropriate standard of care.[79] The jury, as fact finders, make the ultimate decision as to whether the physician deviated from the standard of care based on expert testimony.

B. Specific Issues

There are medical malpractice principles that are implicated for specific defensive medicine actions. Part one discusses the assurance behavior of ordering additional testing implicating the principles of the physician's duty to advise their patients of test results and misdiagnosis. Part two discusses the avoidance behavior of ordering additional procedures implicating the principle of proximate causation. Finally, part three discusses the avoidance behavior of avoiding risky patients or procedures implicating the principles of patient abandonment and delay in treatment or diagnosis.

1. Ordering additional testing

Physicians have a duty to advise their patients of test results. A consulting physician who is interpreting test results owes the patient a duty of care even if the physician never treats or

[79] *See Jacober v. St. Peter's Med. Ctr.*, 608 A.2d 304 (N.J. 1992). Medical literature can include textbooks, journal articles, and guidelines. This is referred to as The Learned Treatise Rule/ Jacober Rule. However, the Physician's Desk Reference cannot be used to establish the standard of care. *See Morlino v. Med. Ctr.*, 706 A.2d 721, 728 (N.J. 1998). The Physician's Desk Reference is a compilation of drug manufacturer's prescribing information (package inserts) for prescription medications.

examines the patient.[80] In *Jenoff v. Gleason*, the plaintiff was hospitalized for a wrist surgery and the hospital's policy was to perform a routine chest x-ray prior to any surgery.[81] A consulting radiologist interpreting the chest x-ray noted a possible lung tumor but did not notify the treating physician other than by preparing a written report after the patient was discharged.[82] The patient was never informed of the lung tumor until two months later when a nurse reviewing the patient's workman's compensation claim discovered the findings of the lung tumor in the patient's medical records.[83] The patient was then diagnosed with lung cancer and he died as a result of the cancer.[84] The court of appeals laid out the framework for the jury to evaluate the physician's duty to advise patients of test results:

> [C]ommunication of an unusual finding in an X-ray, so that it may be beneficially utilized, is as important as the finding itself. The fact that a physician may only be an indirect provider of medical care is but one relevant circumstance. In some situations, indirect service may provide justification for the absence of direct communication with the patient, but that does not in any way justify failure of communication with the primary care physician . . . Modes of communication are not so peculiarly within the expertise and knowledge of the medical profession as to necessitate expert testimony. The manner of communication is not so complex and technical that it should escape the comprehension of a lay jury. The trier of fact should be permitted to pass on the issue of the adequacy of the radiologist's communication" [85]

This case highlights the use of the common knowledge doctrine for communicating test results, rather than expert testimony, for a failure to communicate a test result.[86] Use of the common knowledge doctrine is more desirable for plaintiffs because it is less expensive since they do not need to hire an expert. Liability can also arise from a misdiagnosis when additional tests are

---

[80] *Jenoff v. Gleason*, 521 A.2d 1323 (Super. Ct. App. Div. 1987).
[81] *Id.* at 353. This case is meant to illustrate the physician's duty to inform patients of test results. The line that is drawn is when an additional test is ordered there is a duty to inform the patient of the results. This case is not meant to demonstrate that preventive tests should never be ordered because if the test is not ordered then there would not be any liability for not informing of the results.
[82] *Id.*
[83] *Id.* at 354.
[84] *Id.*
[85] *Id.* at 357.
[86] *Id*.

ordered. An actionable injury arises when the physician's misdiagnosis causes a greater harm than the harm that existed at the time of the misdiagnosis.[87] The injury is not based on the original condition that the patient visited the physician for but rather the injury that occurs later because of the misdiagnosis.[88]

When a physician orders a test, they have a duty to inform the patient of the test results. Failure to inform the patient of test results can result in liability for both the physician treating the patient and the consulting physician who is interpreting the test. The more tests that are ordered the more likely a physician may overlook test results or forget to inform the patient of the test results. The physician could also face liability if there is a delay in informing the patient of test results that leads to an adverse outcome for the patient. For example, if a patient received a chest x-ray showing a possible lung tumor but the physician waited two months to inform the patient of the results the plaintiff has two options. First, the plaintiff could use the common knowledge doctrine, like in *Jenoff,* and show the jury how this delay in providing test results was a deviation from the normal manner of communication between a physician and patient. The second option is use of an expert to show the standard of care for communicating test results in order to show how the doctor deviated from the standard of care.[89] Regardless of the option used, the physician could face liability for failing to communicate test results or delaying communication of test results. Liability from misdiagnosis can arise if the physician misreads

[87] *Liability of Physician or Health Care Facility for False Positive Diagnosis of Cancer*, 98 A.L.R.6th 1.
[88] *Id.* at 2.
[89] This is the less risky but more expensive option. The *Jenoff* case applied to a failure to communicate the test results. I have been unable to find cases applying the common knowledge doctrine to delayed test results. Therefore, it could be viewed by the courts as a standard of care issue which would require expert testimony. Since an expert is required, it is the more expensive option and less desirable option for a plaintiff because the expert needs to be paid.

any of the results from the tests they ordered.[90] This particularly comes into play with tests that may result in a false positive or false negative. Ordering additional testing can lead to liability for physicians if the physician fails to communicate the test results, delays in communicating the test results, or makes a misdiagnosis based on the test results.

2. Ordering and performing additional procedures

Ordering and performing additional procedures is a form of defensive medicine that can lead to liability based on the proximate cause element of causation in addition to the negligence elements of duty and breach discussed previously. Specifically, it is an error of commission increasing the risk of harm. An error of commission is a medical error resulting in an inappropriate increased risk from a medical intervention.[91] New Jersey does not use the traditional "but for" causation negligence test in medical malpractice cases because this test has limitations "in situations where two or more forces operate to bring about a certain result and 'any one of them operating alone would be sufficient.'" [92] As a result, New Jersey uses the substantial factor test for medical malpractice cases. The substantial factor test is "whether the defendant's deviation from standard medical practice increased a patient's risk of harm or diminished a patient's chance of survival and whether such increased risk was a substantial factor in producing the ultimate harm."[93] A physician's deviation does not need to be the primary cause of the plaintiff's injury to be a substantial factor, a "defendant's negligent conduct

[90] The more tests a physician orders, the more tests they have to review. This can increase the chances the physician misreads the test results because of the volume of test results they have to go through leading to a misdiagnosis.
[91] Rodney A Hayward et al., 20 *Sins of Omission Getting Too Little Medical Care May be the Greatest Threat to Patient Safety* 687 (2005).
[92] *Verdicchio v. Ricca*, 843 A.2d 1042, 1056 (N.J. 2004). The "but for" causation test allows for recovery when the injury is one that would not have occurred "but for" the wrongful act. *Verdicchio* refers to the "but for" causation as a test for proximate causation however it is a test for actual/factual causation.
[93] *Id.* (citing *Gardner v. Pawliw,* 696 A.2d 599, 609 (N.J. 1997)).

cannot be a remote or an inconsequential contributing factor. It must play a role that is both relevant and significant in bringing about the ultimate injury." [94] Once the plaintiff demonstrates that the defendant physician's negligent act increased the risk of an injury that later occurred, that conduct is deemed to be a cause "in fact" of the injury and the jury must determine whether the increased risk was a substantial factor in bringing about the harm that occurred.[95] Both the plaintiff and defendant will need to use expert witnesses to determine if there was a deviation from the standard of care caused by the alleged negligent act and how the risk of harm from the act was a substantial factor in the plaintiff's injury.[96]

Ordering and performing additional procedures increases the likelihood of liability for the physician performing the defensive act. If the procedure causes harm to the patient it can result in liability if it is shown that the action was a substantial factor in bringing about the patient's injury. Even if the physician's action is not the primary cause of the patient's injury, the physician could still be found liable as long as it is not remote or inconsequential. There is broad discretion given to the jury as to what may constitute a substantial factor which increases the likelihood the physician can be found liable. If the jury, as fact finders, determines that the procedure proximately caused the patient's injury the physician can incur liability.

3. Avoiding risky patients or procedures

Two issues can arise related to a physician's defensive action of avoiding risky patients or procedures. The first issue is patient abandonment, which includes the termination of the

[94] *Id.* at 1060 (quoting *Reynolds v. Gonzalez*,798 A.2d 67 (N.J. 2002)). For analysis regarding proximate causation related to a preexisting condition in a medical malpractice case see *Scafidi v. Seiler*, 574 A.2d 398 (N.J. 1990).
[95] *Id. See also Evers v. Dollinger*, 471 A.2d 405, 413 (N.J. 1984) (quoting *Hamil v. Bashline*, 392 A.2d 1280, 1286 (Pa. 1978)) (finding that when there is evidence that the defendant's negligent act increased the risk of harm to someone in the plaintiff's position and the harm was in fact sustained, it becomes a question for the jury as to whether or not the increased risk was a substantial factor in producing the harm).
[96] *See id*. at 1062.

physician-patient relationship and proximate causation. The second issue is delay in treatment or diagnosis which can result in emotional damages in addition to other physical compensatory damages.

i. Abandonment

Abandonment is "a failure by the physician to continue to provide service to the patient when it is still needed in a case for which the physician has assumed responsibility and from which he has not been properly relieved."[97] A physician replacing themselves with another physician without any notice to, or agreement from, the patient involved constitutes patient abandonment.[98] A physician can avoid liability for abandonment if they properly terminate the doctor-patient relationship.[99] A physician has a right to withdraw from care, but if they withdraw before the need for their services ends, the physician must give proper notice to the patient and allow the patient the opportunity to find a new physician of the *patient's* choosing.[100] If a physician withdraws from treating a patient they *must* obtain reasonable assurances that the treatment and care will continue.[101] When care has been transferred to another physician the duty of the initial doctor is usually terminated.[102]

---

[97] *Clark v. Wichman*, 179 A.2d 38, 41 (Super. Ct. App. Div. 1962). *See also*, *Liability of physician who abandons case*, 57 A.L.R.2d 432, 1d (defining abandonment as "the unilateral severance by the physician of the professional relationship between himself and the patient without reasonable notice at a time when there is still the necessity of continuing attention").

[98] *Liability of physician who abandons case*, 57 A.L.R.2d 432, 23.

[99] *See id.* at 3b.

[100] *Id.* (citing *Capps v. Valk*, 369 P.2d 238 (Kan 1962)). Emphasis was added to highlight that it is the patient's decision to choose who their new doctor will be. It is not the choice initial physician who is terminating care. The patient-doctor relationship ends when the physician that the patient chooses takes over care.

[101] *Couch v. Visiting Home Care Serv. of Ocean Cty*., 746 A.2d 1029, 1033 (Super. Ct. App. Div. 2000). Emphasis added to the word "must" to highlight the importance of the physician receiving reasonable assurances for the treatment and care of the patient from the new physician. If the physician does not obtain these assurances, they can incur liability.

[102] *See Brandt v. Grubin*, 329 A.2d 82, 86 (N.J. Super. Ct. 1974)

If it is found that the patient-doctor relationship was not properly terminated, and that the physician abandoned the patient, the next inquiry is whether the abandonment is the proximate cause of the patient's injury.[103] The plaintiff must show that the physician's abandonment was the proximate cause of their injury.[104] A mere showing of negligence on the part of the physician is not sufficient to sustain the action, there has to be a causal connection that exists between the physician's abandonment and the patient's injury.[105] In addition to the showing of negligence by the physician, it must be shown that if the patient was not abandoned by the physician there would have been a more satisfactory outcome.[106] This type of proximate causation is categorized as an act of omission which is defined as an inappropriate increased risk of a disease related adverse event from little to no treatment.[107]

When a physician avoids risky patients or procedures, they could incur liability under the theory of abandonment. The physician must give proper notice to the patient and receive proper consent from the patient to terminate the patient-physician relationship. The physician also must give the patient the opportunity to find a new physician of the patient's choosing and must receive reasonable assurances that the patient's care will be continued. If a physician misses just one of these requirements, they can open themselves up to potential malpractice liability. Multiple issues could arise with the transfer of patient care even if the physician receives the proper consent from the patient and assurances from the new physician. The transfer is a double-edged sword, while it may shield the physician from liability it encourages the physician to

[103] *See Liability of physician who abandons case,* 57 A.L.R.2d 432, 2.
[104] *Id.*
[105] *See id.* To determine proximate causation expert testimony is usually considered necessary to support liability. However, under some circumstances where the negligence and harm are so obvious that it would be common knowledge, expert testimony may not be necessary.
[106] *Id.* at 5a.
[107] *See Hayward*, *supra* note 91, at 2.

practice defensive medicine because the liability is transferred to another physician. This could lead to a slippery slope because what if the physician who the patient is supposed to be transferred to is also afraid of liability and refuses to take the patient or that physician transfers the patient to another physician. This is specifically a concern for patients with complicated health needs. This also raises concerns over patients receiving access to proper care and causing unnecessary delays in treating patients. When physicians avoid risky patients or procedures, they can incur liability based on the patient abandonment principle.

ii. Delay in treatment or diagnosis

Avoiding risky patients or procedures can result in a delay of treatment or diagnosis which can lead to malpractice liability for the physician. Delay in treatment constitutes damage, and uncertainty as to the amount of damage caused by the delay does not preclude the right to recovery as long as its certain some damage has occurred.[108] The patient is entitled to be compensated not only for their physical suffering for the period of delay caused by the physician's negligence but also for the mental anguish caused by the delayed diagnosis.[109] In *Evers v. Dollinger*, the New Jersey Supreme Court held that the plaintiff was entitled to recover damages for the "anxiety, emotional anguish and emotional distress" caused not solely by her cancer but rather by "the growth of the tumor during the time period proper treatment was withheld" and from the plaintiff's realization that the defendant's negligence increased the risk she would die from cancer.[110] Furthermore, the court found that where there is a negligent delay in the diagnosis of cancer, even where the plaintiff cannot prove the delay was a substantial

[108] *Betenbaugh v. Princeton Hosp*., 235 A.2d 889, 891 (N.J. 1967).
[109] *See, e.g*., *Friel v. Vineland Obstetrical & Gynecological Prof'l Asso., 579*, 400 A.2d 147 (N.J. Super. Ct. 1979), *Evers v. Dollinger*, 471 A.2d 405 (N.J. 1984).
[110] *Evers*, 471 A.2d at 409.

factor in the recurrence of the tumor, the plaintiff is entitled to have the case submitted to the jury for determination of damages relating to emotional distress and tissue destruction.[111]

A physician is not only liable to the patient for damages but can also be liable to the patient's parents or the patient's spouse for damages resulting from delayed diagnosis or treatment. In *Friel v. Vineland Obstetrical and Gynecological Professional Association*, the plaintiffs (a mother, father, and daughter) brought a malpractice claim for a delay in diagnosing the mothers abruptio placenta and failing to treat the mother and daughter because no one was present in the mother's hospital room when she gave birth resulting in the daughter suffering from multiple complications.[112] The court held that the mother was entitled to damages related to her pain and suffering resulting from the delivery, the father was entitled to damages he incurred related to the injury to his wife, and the daughter was entitled to damages if her injuries were found to be connected to the defendant's negligent acts towards the mother. [113] In addition to physical damages, the court also held that the parents were entitled to emotional damages.[114] The parents were entitled to compensation for pain and suffering during the delay in treatment and diagnosis if it was causally connected to the defendant's acts and omissions.[115] The parents

---

[111] *Id.*
[112] *See Friel*, 400 A.2d at 148. The court states that "[i]t must be remembered that this is not simply a prenatal injury case. A combination of the delay in treatment for the abruptio placenta, medication given during labor, unattended delivery and failure to perform an epesiotomy could have coalesced to cause the child's injuries or poor condition that caused her mother anxiety leading up to the birth, shock and distress at the baby's condition at birth, and continuing anxiety and distress over her hospitalization and potential brain damage. Thus, the instant case fits no defined category." *Id.* at 152. Therefore, the holdings in this case can be applicable to other types of medical malpractice and defensive medicine actions that the case touches upon. Abruptio placenta is a serious condition in which the placenta separates from the wall of the uterus resulting in a lack of oxygen and nutrients for the baby.
[113] *See id.* at 150. The damages the father could collect related to expenses he incurred for caring for his wife, his wife's treatment, and loss of his wife's services, society, and comfort. *Id.* If he proves proximate causation these damages can also include future anticipated loss. *Id.* The daughter's damages include expenses related to treatment and care. *Id.*
[114] *Id.*
[115] *Id.*

were also entitled to compensation for their mental anguish during the time period while they were waiting for a definitive answer as to their daughter's neurological status.[116]

The delay in treatment or diagnosis as a result of physician avoiding risky procedures or patients can result in liability for the physician. The patient is entitled to physical damages related to costs associated with the injury and emotional damages as a result of the anguish caused by the delay and awaiting results. Family members are entitled to damages associated with the cost of caring for their loved one who was injured. Family members are also entitled to compensation for emotional damages related to waiting for their loved one's diagnosis in addition to pain and suffering. When a physician avoids risky procedures or patients they can incur liability because of the delay in treatment and be liable to the patient and their family for physical and emotional damages.

CONCLUSION

Defensive medicine increases the chance of liability for physicians. Defensive medicine is a complicated issue facing our country. Some people see defensive medicine as beneficial for patients and good medical practice. Others, like the author, see it as causing more harm than good. Defensive medicine creates both healthcare access issues and payment issues. Healthcare access issues arise when defensive medicine actions involve avoiding certain procedures or patients and transferring care to another physician or facility. Additionally, access issues can arise when defensive medicine puts a strain on the patient-doctor relationship causing the patient to mistrust the doctor and not want to receive care in the future. Defensive medicine also creates a healthcare cost issue because defensive medicine results in additional unnecessary costs for the

[116] *Id.* at 148.

patient. This additional financial burden that is placed on the patient may result in the patient delaying or skipping future care due to an inability to pay which creates another healthcare access issue. When physicians practice defensive medicine it takes away time and resources from patients who may need those services. This is especially true in the case of physicians ordering additional tests or procedures. Patients who may need to access a specific test or procedure may not be able access it because a physician unnecessarily ordered it for another patient for defensive medicine purposes.

Numerous studies have shown the existence of defensive medicine even though some people deny its existence. A physician practices defensive medicine as an attempt to avoid liability in a medical malpractice suit. However, the medical malpractice principles that the physician is trying to avoid can result in liability for the physician based on these same malpractice principles. Generally, all defensive medicine actions can implicate the principle of the standard of care. Additionally, specific defensive medicine actions can implicate specific medical malpractice principles. The assurance behavior of ordering additional testing can result in liability based on the physician's duty to advise of test results and if the physician makes a misdiagnosis based on the test results. The assurance behavior of ordering additional procedures can result in liability for the physician based on proximate causation. Finally, the avoidance behavior of avoiding risky patients or procedures can result in liability based on patient abandonment and delayed treatment or diagnosis.

This paper has shown how defensive medicine increases the risk of liability for the physician rather than decrease it. Physicians take the Hippocratic oath to "do no harm" but defensive medicine harms patients. Physicians should be putting their patients first and not serving their own self-interest of potentially protecting themselves from liability by practicing

defensive medicine. There are multiple ways that lawyers and physicians can work together to improve patient outcomes. The first recommendation is to use resources that are available to both physicians and patients who wish to combat defensive medicine like the Choosing Wisely Campaign. The Choosing Wisely Campaign promotes using evidence-based medicine to avoid unnecessary testing and procedures.[117] Physicians and patients are able to look up a variety of medical conditions on the Choosing Wisely website and see the recommended testing and treatments. The next recommendation is to educate medical students by having lawyers come to their classes to explain and demystify medical malpractice liability so that when the medical students become physicians, they are less likely to practice defensive medicine. Additionally, medical school professors should teach their students about the risks defensive medicine poses to patients. This is to guide medical students' decisions, when they become physicians, to be focused on what is best for the patient and not fear of liability. The final recommendation is for physicians to educate their patients so that patients do not request additional testing and prescriptions unnecessarily.[118] This is to combat physicians practicing defensive medicine out of fear that patients will view their care as substandard since patients themselves may request unnecessary testing, procedures, and medications from their physician. By working together, physicians and lawyers can improve care for patients and make the world a healthier and safer place.

[117] *Choosing Wisely*, https://www.choosingwisely.org/ (last visited Apr 25, 2023). Choosingwisely.org is an initiative of the American Board of Internal Medicine that spans across multiple medical specialty societies.
[118] See footnote 37.