Defensive medicine: Spiraling costs

The editorial pages of this and other medical publications have pointed out with varying degrees of intensity that the practice of defensive medicine has been a major contributing factor to the rising costs of medical care.

A recent study¹ reported in *The Journal of the American Medical Association* estimates that medical professional liability costs in 1984 accounted for 15 percent of total expenditures on physicians' services, with much of the cost paid to defensive practice changes prompted by malpractice risks.

The study, conducted by Roger A. Reynolds, Ph.D., John A. Rizzo, Ph.D., and Martin L. Gonzalez, M.S., of the AMA's Department of Medical Practice Economics, Center for Health Policy Research, reports that the risk for the average physician of incurring a malpractice claim has nearly tripled since 1980, with indications that increases in the severity of losses have accelerated as well. The researchers say that the problem is of growing public and professional concern, but "to date there has been little quantitative evidence on the overall economic impact of the problem."

In the *JAMA* editorial² concerning the Reynolds' report, it is stated that average malpractice insurance premiums rose by an estimated \$1,300 to \$8,400 annually from 1983 to 1984. Concurrently, perceived increases in malpractice risks caused physicians to increase defensive medical procedures, at an additional average cost of \$4,600 per physician per year.

The increase in defensive medicine costs was more than 3.5 times the parallel increase in malpractice insurance premiums. That is, for each \$100 spent on malpractice risk—gauged by insurance premiums—\$3.50 are expended for defensive medicine. "Hence, the average physician who paid \$8,400 in malpractice premiums for 1984 was responsible for a total annual health care expenditure of \$30,000 for defensive medicine."

Whether the practice of defensive medicine will have a major impact on the cost of professional liability insurance or a reduction in claims is problematic. Until the public is made to realize the true nature of the medical professional liability crisis—its bottom-line effect—defensive medicine will con-

tinue to be practiced to greater and greater degrees. Logical, rational controls of the situation will somehow be achieved. At the present time, unfortunately, it's a runaway problem.

GEORGE W. NORTHUP, D.O., FAAO

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1. Reynolds, R.A., Rizzo, J.A., and Gonzales, M.L.: The cost of medical professional liability. *JAMA* 257:2776-81, 22/29 May 87
 2. Harris, J.E.: Defensive medicine. It costs, but does it work? (editorial). *JAMA* 257:2801-2, 22/29 May 87

We need you!

A colleague of mine once raised two questions in quick succession: "Who cares whether I am an AOA member or not? So who misses me?"

The 24,443 members of the American Osteopathic Association, that's who! We care, and we need you!

We need you because your presence strengthens the organization and your absence weakens it.

We need you because your ideas, your needs, and your help are important. And because we need each other. The American Osteopathic Association can be a protector, a supporter, and an advisor. Although the AOA is the sole representative of the entire profession in the United States, its greater service is through its membership, not nonmembership.

We need you in order to serve the public better.

As a member of the osteopathic profession, you are represented by the American Osteopathic Association. In making policy, it helps to create the environment in which you live your professional life. You practice under acts that your state and national organizations help to develop. Hospitals, general practitioners, and specialists maintain standards of service that are spelled out by your national association. It is *your* organization, yet some of you are not a part of it.

It would be naive to believe that every member and nonmember agrees with all that the AOA does and has done. Many of us have not always agreed, and that is one reason why we belong. Individuals are guilty of errors of commission and omission, and organizations are collections of individuals that are capable of making the same errors. The

great advantage of a group over an individual, however, lies in characteristics that are just as human—an organization represents the collective strength, vitality, and talent of its individual members, united in a common purpose.

The profession's role in the health care of the public is our common purpose. In it lies our professional life of yesterday, today, and tomorrow. Participate in the direction of your own professional future. Be one of the building blocks in a worthwhile institution, not just a sole building block.

AOA past-president Eugene L. Sikorski, D.O., has been traveling the country from North to South, and from East to West proclaiming the very fact that "Osteopathic medicine is on the move."

A recent survey¹ conducted by *Medical Economics* revealed many interesting statistics. The group with the largest amount of predicted change in numbers of primary care physicians between 1985 and 1995 is the osteopathic profession, with a predicted increase of 76.1 percent. Those with the next highest percentage of increase are the pediatricians, with a predicted growth of 47.5 percent by 1995. Thus, supporting Dr. Sikorski's addresses, the AOA is on the move, and to those who are not members, the invitation stands open for you to join.

We need you. We want you to be part of the surging movement in osteopathic medicine.

GEORGE W. NORTHUP, D.O.

1. Kirschner, M.: 1995. Which specialties will prosper? *Medical Economics Review Series: The Competitive Challenge*, vol. 1, no. 2, pp. 5-11, 1987

The manipulators

There has been a good deal of discussion both pro and con concerning the teaching of structural diagnosis and manipulative therapeutics (manual medicine) to others than comprehensively trained physicians, D.O. or M.D. It has long been a policy of the osteopathic profession that diagnostic measures and therapeutic techniques be taught on a doctorate or postdoctorate level and that they be integrated into the broad base of medical diagnosis and treatment.

The AOA and all other organizations affiliated with the profession desire to share appropriate scientific information with those seeking it. Knowledge should have no boundaries. However, when that knowledge is being used for political or legislative advantage, it becomes a matter having little or nothing to do with educational freedom, and, in some instances, it is quite the opposite.

A case in point occurred recently in one of the western states. A D.O. was informed by a duly li-

censed state board of physical therapy that he could not use ultrasound on his patient because he was not licensed as a physical therapist. Hopefully, this was an isolated incident. However, it is one that should not go unnoticed.

At the same time, in a monthly journal published by the physical therapy association, there is an advertisement for "manual therapy courses," including the following subjects: introduction to extremity evaluation manipulation; introduction to spinal evaluation and manipulation; advanced evaluation and manipulation of the pelvic, lumbar, and thoracic spines; advanced evaluation and manipulation of the craniofacial, cervical, and upper thoracic spines; manual therapy review, soft-tissue (myofascial) manipulation; and evaluation and treatment of the craniomandibular system (TMJ). These courses are advertised as being given in some 78 locations in various cities coast to coast beginning in January.

As it is generally known, several states have passed legislation permitting physical therapists to accept patients for treatment with physical therapeutic methods without prior referral from a physician. In other words, a physical therapist is now given the legislative right to directly accept patients, make their own diagnoses, and prescribe their own treatments.

To say the least, these are interesting developments.

GEORGE W. NORTHUP, D.O., FAAO

editorial comment

The American Association of Colleges of Osteopathic Medicine (AACOM) has published its *Annual Statistical Report* for 1986. Don C. Zobell, Director of Information Services, has compiled many interesting and useful statistics, which are accented in numerous charts and graphs.

The report shows that more women are becoming osteopathic physicians. Ten years ago, women comprised only 14 percent of all applicants and 6 percent of all graduates. But today, 29 percent of the applicants and 23 percent of our graduates are women. Equally interesting is the fact that the numbers of ethnic minorities seeking careers in osteopathic medicine are increasing. The largest minority group in the colleges included Asian Americans and Pacific Islanders, whose representation has quadrupled since 1976, to 166 students enrolled. The number of Hispanic freshmen has increased by a factor of 4.7 in the last decade, to 126