Inappropriate prescribing of controlled substances, primarily opiates and benzodiazepines, is the most common complaint brought before the Oregon Board of Medical Examiners. We describe the malpractice claims experience of 120 physicians previously investigated by the Oregon board for inappropriate prescribing. These physicians were matched with a comparison group by age, specialty, and practice location. We found that a mean of one malpractice claim had been filed against each physician in our study, with the specialties of obstetrics and gynecology, neurosurgery, and orthopedics having the most claims. A significantly higher mean number of malpractice claims had been filed against 31 physicians disciplined by the board. Our study suggests a role for state regulatory boards in the malpractice area. We propose that such bodies do practice reviews based on the convergence of two events, a disciplinary action such as those described in this article and the filing of more than one malpractice claim against a physician. Further research is needed on inappropriate prescribing by physicians and its possible association with malpractice. (Bloom JD, Williams MH, Kofoid L, et al: The malpractice claims experience of physicians investigated for inappropriate prescribing. West J Med 1989 Sep; 151:336-338)
keeping current in medicine. These findings point to the need for the investigation of a possible link between physicians who prescribe inappropriately and those who experience malpractice actions.

Methods

From 1981 through 1986 the board investigated 130 physicians for complaints of inappropriate prescription writing. In a section of the Oregon statutes setting out the grounds for suspending, revoking, or refusing to grant a medical license, inappropriate prescribing is defined as "Prescribing controlled substances without a legitimate medical purpose and without following accepted procedures for examination of patients and record keeping." This definition covers three important areas: a legitimate purpose for prescribing, examination of the patient, and record keeping and is used by both the investigative committee and the full board to judge allegations brought against physicians.

We attempted to match each physician in this group with a noninvestigated physician. Physicians were matched for specialty, degree (MD or DO), sex, Oregon county of practice, and year of medical school graduation. An exact match was required for specialty, degree, and sex. If the county of practice could not be matched exactly, a physician from a county of similar size and location was chosen. The year of medical school graduation was matched within three years. A sample of 120 pairs of physicians was generated.

Demographic information was collected for the comparison sample from the computerized data base maintained by the Oregon BME. Malpractice claims records filed with the board were reviewed for each physician in the study. As noted, since 1978 Oregon law has required insurance carriers writing insurance in Oregon to report to the BME any malpractice claims filed against an insured physician. Claims against physicians insured by non-Oregon companies would not appear in our sample. We assumed that underreporting in the sample would apply equally to both study and comparison groups.

Results

The 120 matched pairs of physicians produced a sample in which the mean age was 53, a mean of 26 years had passed since medical school graduation, and a mean of 22 years since Oregon licensure. Table 1 presents a breakdown of the physicians' medical specialties and the percentage of each practicing in Oregon. Of the study group, 64% were involved in primary care specialties of family practice (33%), general practice (18%), and internal medicine (13%), but only 33% of physicians in practice in Oregon are in primary care.

Table 2 shows the malpractice claims data for both study-group and comparison-group physicians accused of inappropriate prescribing. Of the study-group physicians, 53% had at least one previous malpractice claim. Of comparison physicians, 44% had previous malpractice claims. These differences were not significant (paired t test, t = 1.32, df = 119, P = .19).

Table 3 shows the combined malpractice claims data for both the study and comparison groups presented by medical specialty and by number of claims and mean number of claims per practice category. The most frequently sued physicians are those practicing obstetrics and gynecology, followed closely by neurosurgeons and orthopedists, and then by general surgeons and family practitioners.
Of the 120 physicians investigated for inappropriate prescribing, 71 (59%) had their cases closed at the investigative committee level. Of these, 24 (34%) were sent a letter of concern regarding their practices, but their cases were not deemed serious enough for further consideration by the full board. The other 49 cases (41%) were sent on to the full board. We found no significant differences in the number of malpractice claims of the study and comparison groups when we compared physicians whose cases were closed at the investigative committee level with those sent on to the full board (2-factor analysis of variance).

Of the 49 cases sent to the full board, 31 had their prescribing privileges limited. These physicians agreed to give up their privilege to prescribe schedule II, III, and IV drugs. When we compared the malpractice claims experience of this group of 31 disciplined physicians with their matched comparisons, we did find a significant difference in the number of claims. The 31 physicians in the study group had a mean of 1.2 malpractice claims compared with 0.6 for their matched physicians (paired t test, t = 2.21, df = 30, P = .035).

Discussion

Our study is a preliminary investigation of the malpractice claims experience of a group of Oregon physicians who were brought to the attention of the Oregon BME for suspected inappropriate prescribing of controlled substances and a comparison of this group with a matched comparison group.

With 53% of the study group and 44% of the comparison group having at least one malpractice claim, we concluded that all physicians are vulnerable to suit. Because only Oregon underwriters are required by law to report malpractice claims to the BME, malpractice claims for both the study and comparison groups are underreported. For example, most psychiatrists receive their malpractice coverage through nationally sponsored policies. Although psychiatrists are not frequently sued, we did have 12 psychiatrists in the study with no malpractice claims reported to the Oregon BME.

The malpractice findings also mirror national trends in those branches of medicine most vulnerable to lawsuit. Although the study group is heavily dominated by primary care physicians, those practicing obstetrics and gynecology, neurosurgery, and orthopedics have the highest number of malpractice claims filed against them.

We did find a significant difference in the mean number of malpractice claims filed against the 31 physicians disciplined for inappropriate prescribing (1.2 claims per physician) and their matched physician controls (0.6 per physician). These findings are consistent with a view of inappropriate prescribers as a potential group of high-risk physicians worthy of more intensive study and possible remediation.

Our data do not help determine the percentage of malpractice claims that are actually cases of malpractice, representations of incompetence, or both. They do suggest, however, that the Oregon board’s policy of reviewing a physician’s practice after a certain number of malpractice claims could be beneficial and that there is value in doing more comprehensive practice reviews when two events converge, a disciplinary action for inappropriate prescribing coupled with the existence of malpractice claims. Such practice review may allow for an earlier identification of physicians at risk for practice problems and may improve the chances of discovering problems with physicians practicing in specialties at a lower risk for malpractice claims. Simply using the number of claims filed against a physician without a disciplinary action discriminates against the high-risk specialists who are more likely to experience malpractice suits.

Our study results point to a role for a regulatory body such as the Oregon BME in the malpractice arena. Clearly more research is needed in this area. Will our findings hold up after further examination or with more complete malpractice data? Do the same trends exist in relation to impaired physicians? We are currently investigating these questions and urge others to do the same, as these are areas of major importance. With medicine’s house more in order, we will be freer to help bring about other needed reforms in the malpractice area.

REFERENCES

2. Disciplinary actions against physicians on rise but still believed to be on low side. Psychiatric News 1987 Jan, p 12