PRATIQUES DÉFENSIVES
ET
DÉSENCHANTEMENT PROFESSIONNEL

SFNCL

The New York Times Magazine

THE WAY WE LIVE NOW: 3-16-03; Hard Cures

By ABRAHAM VERGHESE and M.D. MARCH 16, 2003

After coming through a long malpractice suit, a physician friend of mine said to me, "Now I think of the patient as the enemy."

These are troubled times. We have seen doctors striking to protest soaring insurance premiums. In some states like Florida and West Virginia, neurosurgeons and others in high-risk, high-liability specialties are closing shop or retiring early. Insurance companies blame rising claims and bigger jury awards for their rate hikes. Personal-injury lawyers deny their responsibility and insist that the insurance companies have invested poorly. Organized medicine and President Bush push for tort reform, including a cap on awards. And while the powerful lobbies jockey to preserve their interests, patients suffer.

« Your medical problem is more complicated that I thought.
I am going to refer you to another doctor, who as more
medical insurance than I have »

Spine

SPINE Volume 42, Number 3, pp 177–185

HEALTH SERVICES RESEARCH

Defensive Medicine in U.S. Spine Neurosurgery

Ryan S. Din, BS, Sandra C. Yan, BS, David J. Cote, BS, Michael A. Acosta, BS,
and Timothy R. Smith, MD, PhD, MPH

The NEW ENGLAND JOURNAL of MEDICINE

HEALTH POLICY REPORT

Medical Malpractice

David M. Studdert, LL.B., Sc.D., M.P.H., Michelle M. Mello, J.D., Ph.D.,
and Troyen A. Brennan, M.D., J.D., M.P.H.

Few issues in health care spark as much ire and angst as medical-malpractice litigation. Physicians revile malpractice claims as random events that visit unwarranted expense and emotional pain on competent, hardworking practitioners. Commentators lament the "lawsuit lottery," which provides windfalls for some patients, but no compensation for the vast majority of patients injured by medical care.[1,2] Within the health care industry, there is a nearly universal belief that malpractice litigation has long since surpassed sensible levels and that major tort reform is overdue.

Yet the drive to litigate continues. Plaintiffs' attorneys and some consumer groups interpret providers' grievances as little more than predictable chafing on the part of a profession that is unaccustomed to external policing. They view litigation as an indispensable form of protection against medical carelessness. The response of trial attorneys to recent research on medical errors illustrates their perception of themselves as champions of patient safety: new knowledge of the burden of medical errors is seen as vindication of the battles fought on behalf of patients, and the imperative such findings announce is clear — more litigation.[3]

With a malpractice crisis spreading across the United States today, it is an opportune time to review the current situation in the light of the goals of the liability system, previous crises, and available evidence on the performance of the system. A survey of the field yields a picture of a system that has internal logic but falls far short of its social goals of promoting safer medicine and compensating wrongfully injured patients.

FRAMEWORK AND GOALS OF THE SYSTEM

Malpractice law is part of tort, or personal-injury, law. To prevail in a tort lawsuit, the plaintiff must prove that the defendant owed a duty of care to the plaintiff, that the defendant breached this duty by failing to adhere to the standard of care expected, and that this breach of duty caused an injury to the plaintiff.[4]

The standard traditionally used to evaluate whether the breach in question rises to the level of negligence is medical custom — the quality of care that would be expected of a reasonable practitioner in similar circumstances. Custom is determined primarily through the testimony of experts in the same field as the defendant, although some encapsulations of expert opinion, such as practice guidelines, may also be used.[5,6] In at least 20 states, there has been a discernible shift in recent years away from custom and toward a more independent determination by the court of whether the defendant deviated from "reasonable" conduct.[7]

There are three social goals of malpractice litigation: to deter unsafe practices, to compensate persons injured through negligence, and to exact corrective justice.[4] Theoretically, lawsuits deter physicians by reminding those who wish to avoid the emotional and financial costs of litigation that they must take care.[8] With respect to compensation, reasons of fairness and efficiency dictate that the party at fault for an injury should bear the associated costs, including lost earnings, medical bills, and "pain and suffering."

Clinicians and health care facilities are well placed to bear the costs of injury because they are able to pool risk and resources through insurance.[9] Nearly all hospitals and physicians carry deep coverage, usually through separate lines of insurance. The cost of insurance coverage for hospitals is typically linked to the history of claims from year to year, an arrangement known as "experience rating." Physicians, on the other hand, generally are not risk rated unless they have been repeatedly sued, in which case they may be forced to obtain coverage from high-cost insurers or may have trouble obtaining any coverage.[10] In recent years, anecdotal evidence suggests that some insurers in states experiencing tort crises are declining to renew policies for physicians with even a single claim.

Judiciarisation

Dérive à l’américaine?

Modification sociétale

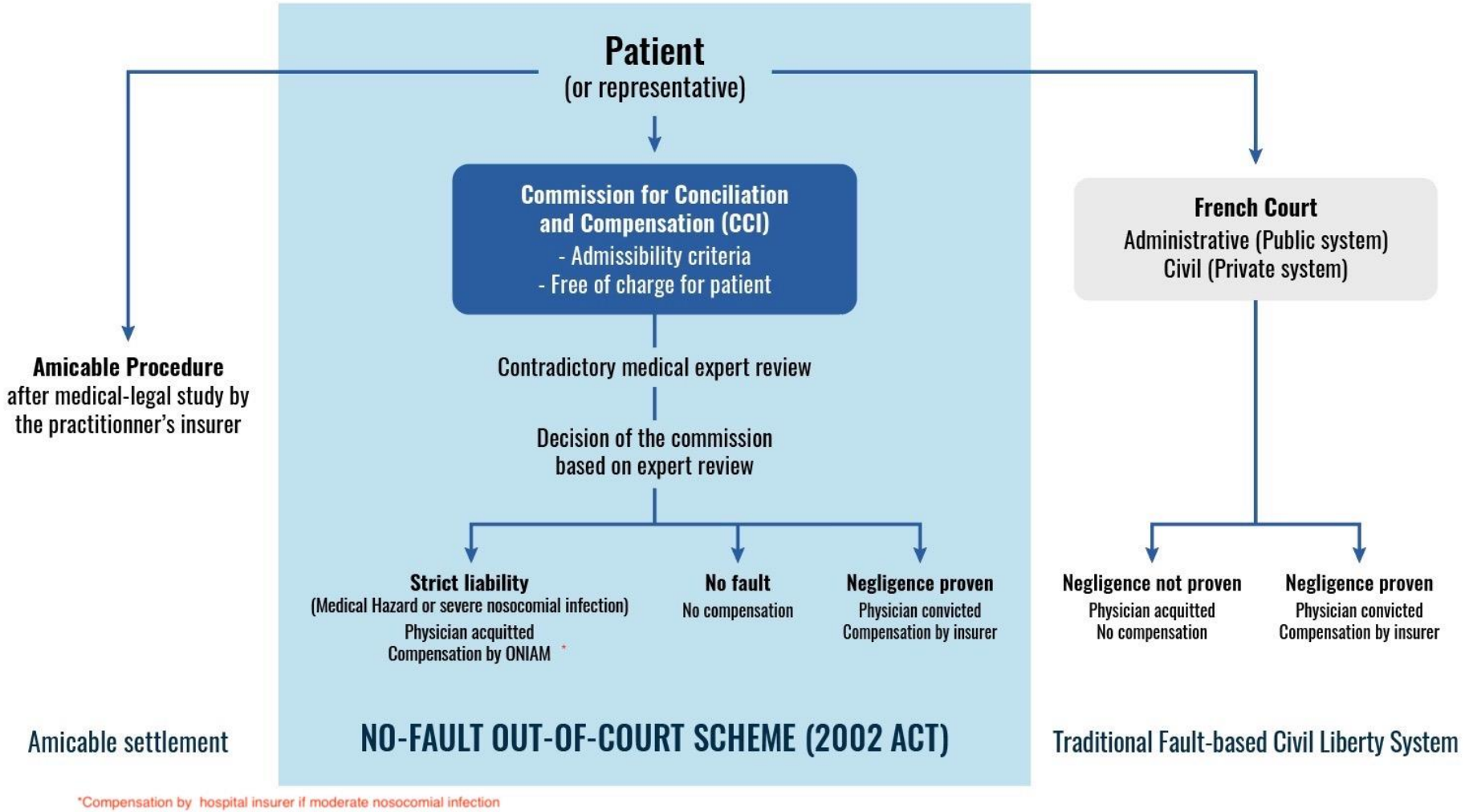
Impact dans notre quotidien

Conséquences assurantielles

Modification dans nos pratiques (médecine défensive?)

Modification dans notre plaisir à exercer notre métier

Loi 2002

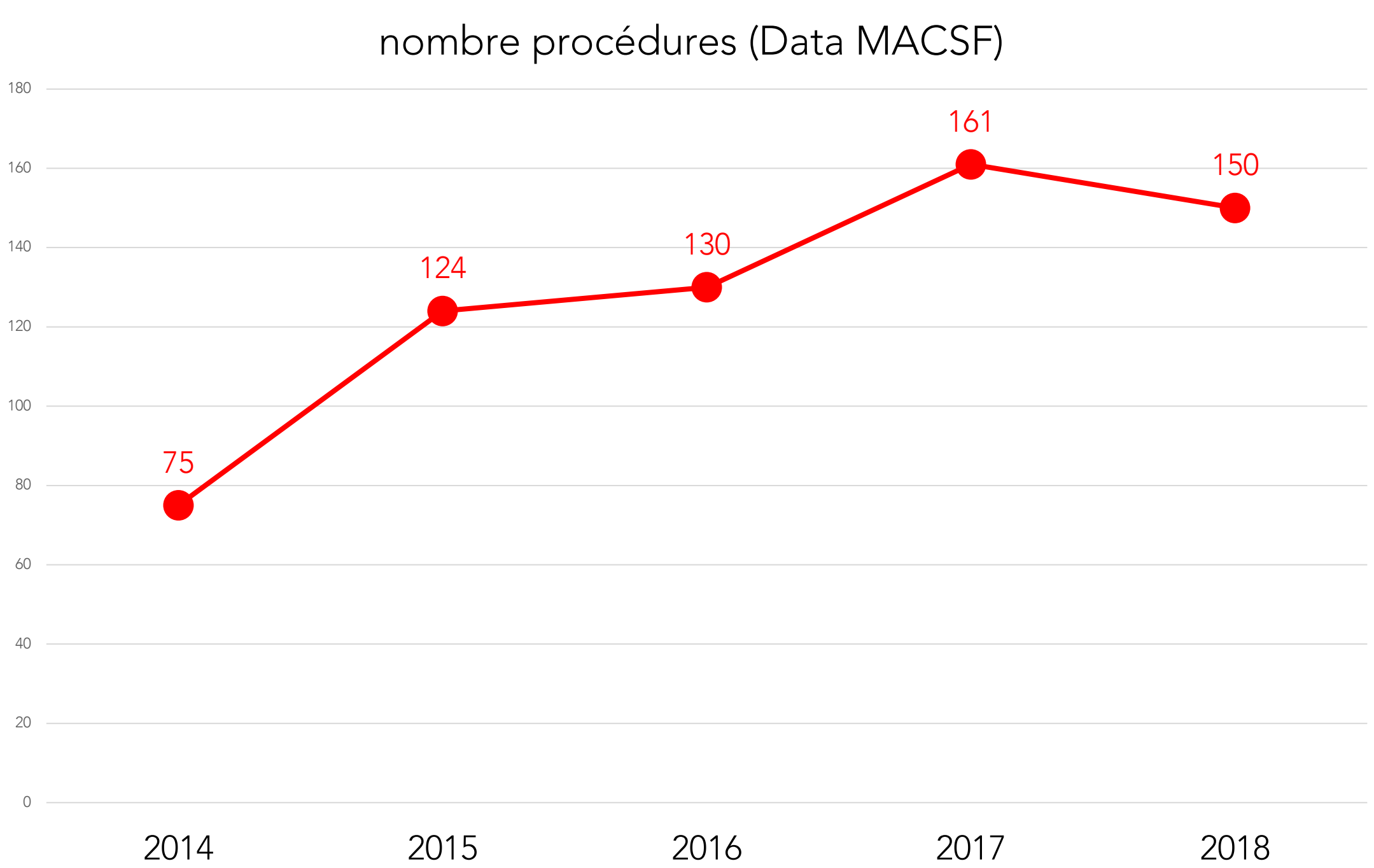

Patient
(or representative)
Commission for Conciliation and Compensation (CCI)
- Admissibility criteria
- Free of charge for patient
Contradictory medical expert review
Decision of the commission based on expert review
Amicable Procedure
after medical-legal study by the practitionner's insurer
Strict liability
(Medical Hazard or severe nosocomial infection)
Physician acquitted
Compensation by ONIAM *
No fault
No compensation
Negligence proven
Physician convicted
Compensation by insurer
French Court
Administrative (Public system)
Civil (Private system)
Negligence not proven
Physician acquitted
No compensation
Negligence proven
Physician convicted
Compensation by insurer
Amicable settlement
NO-FAULT OUT-OF-COURT SCHEME (2002 ACT)
Traditional Fault-based Civil Liberty System
*Compensation by hospital insurer if moderate nosocomial infection

D’un point de vue assurantiel

- **Sinistres fréquents**
- **Sinistres coûteux**

- (séquelles neurologiques, aménagements, retentissements professionnels…)

- Contexte particulier de la chirurgie rachidienne
  - AT prolongés avant la chirurgie
  - Contexte d’accident du travail ou de maladie professionnelle
  - Persistance des douleurs après la chirurgie (FBSS)


nombre procédures (Data MACSF)
180
160
140
120
100
80
60
40
20
0
75
124
130
161
150
2014
2015
2016
2017
2018

Voie choisie

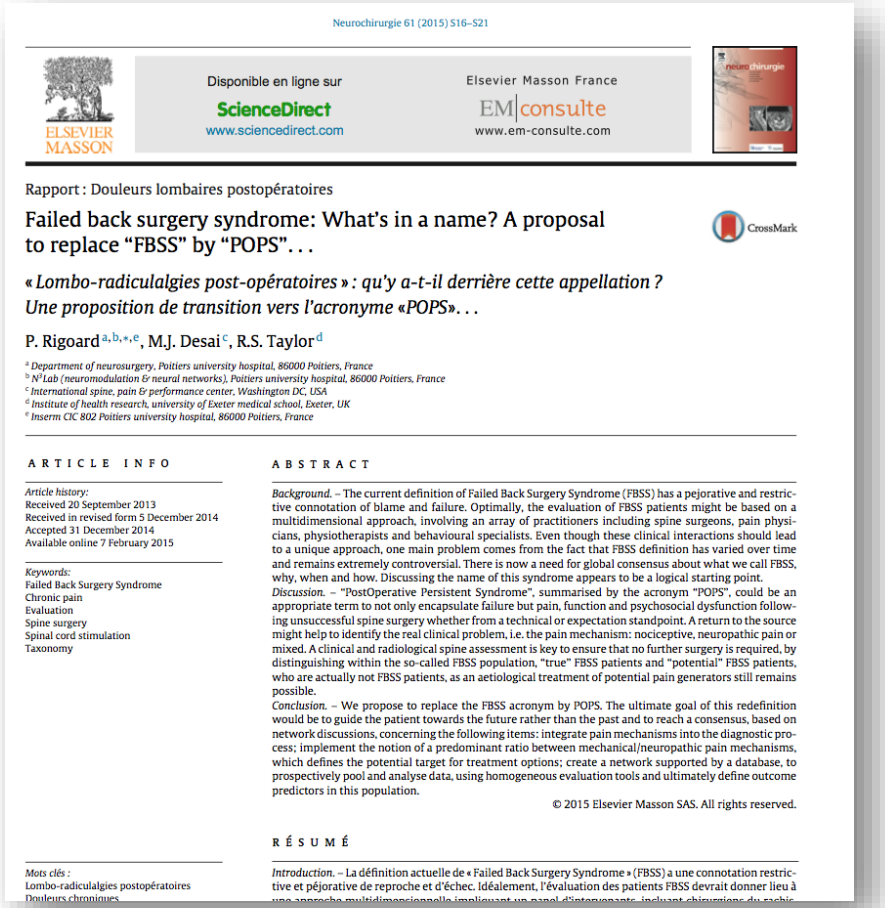
- CCI : 55%
  (aléas thérapeutique, gratuité, critères de recevabilité)
- Amiable : 15%
  (50% toutes spécialités confondues)

- Pénal : 1 cas / 650

Typologie des plaintes

- Rachis dorso-lombaire : 80%
- Arthrodèses : 40%

- Griefs des plaignants
  - Résultats insuffisants
  - Séquelles neurologiques
  - Infections



Neurochirurgie 61 (2015) S16–S21

Disponible en ligne sur ScienceDirect www.sciencedirect.com

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Rapport : Douleurs lombaires postopératoires

Failed back surgery syndrome: What's in a name? A proposal to replace "FBSS" by "POPS"...

« Lombo-radiculalgies post-opératoires » : qu'y a-t-il derrière cette appellation ? Une proposition de transition vers l'acronyme «POPS»...

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Chronic pain
Evaluation
Spine surgery
Spinal cord stimulation
Taxonomy

ABSTRACT

Background. – The current definition of Failed Back Surgery Syndrome (FBSS) has a pejorative and restrictive connotation of blame and failure. Optimally, the evaluation of FBSS patients might be based on a multidimensional approach, involving an array of practitioners including spine surgeons, pain physicians, physiotherapists and behavioural specialists. Even though these clinical interactions should lead to a unique approach, one main problem comes from the fact that FBSS definition has varied over time and remains extremely controversial. There is now a need for global consensus about what we call FBSS, why, when and how. Discussing the name of this syndrome appears to be a logical starting point.
Discussion. – "PostOperative Persistent Syndrome", summarised by the acronym "POPS", could be an appropriate term to not only encapsulate failure but pain, function and psychosocial dysfunction following unsuccessful spine surgery whether from a technical or expectation standpoint. A return to the source might help to identify the real clinical problem, i.e. the pain mechanism: nociceptive, neuropathic pain or mixed. A clinical and radiological spine assessment is key to ensure that no further surgery is required, by distinguishing within the so-called FBSS population, "true" FBSS patients and "potential" FBSS patients, who are actually not FBSS patients, as an aetiological treatment of potential pain generators still remains possible.
Conclusion. – We propose to replace the FBSS acronym by POPS. The ultimate goal of this redefinition would be to guide the patient towards the future rather than the past and to reach a consensus, based on network discussions, concerning the following items: integrate pain mechanisms into the diagnostic process; implement the notion of a predominant ratio between mechanical/neuropathic pain mechanisms, which defines the potential target for treatment options; create a network supported by a database, to prospectively pool and analyse data, using homogeneous evaluation tools and ultimately define outcome predictors in this population.

Mots clés :
Lombo-radiculalgies postopératoires
Douleurs chroniques

RÉSUMÉ

Introduction. – La définition actuelle de « Failed Back Surgery Syndrome » (FBSS) a une connotation restrictive et péjorative de reproche et d'échec. Idéalement, l'évaluation des patients FBSS devrait donner lieu à

% de mise en cause

- 72% des rapports des experts favorables

- 15 % défavorables ou « à risques »
  - Insuffisance de suivi
  - Retard à la prise en charge
  - Anomalie technique
  - PEC infection

NEUROSURGICAL FOCUS

Neurosurg Focus 49 (5):E11, 2020

Litigations following spinal neurosurgery in France: "out-of-court system," therapeutic hazard, and welfare state

Bertrand Debono, MD,[1,2] Carole Gerson, MD,[3] Thierry Houselstein, MD,[3] Lynda Lettat-Ouatah,[4] Renaud Bougeard, MD,[5] and Nicolas Lonjon, MD, PhD[6]

[1]Centre Francilien du Dos, Neurosurgery Department, Paris; [2]Neurosurgery Department, Private Hospital of Versailles–Ramsay Santé, Versailles; [3]Compensation and Medical Communication Department, Mutuelle d'Assurance du Corps de Santé Français (MACSF), Paris; [4]Cabinet Clapot-Lettat, Lyon; [5]Department of Neurosurgery, Clinique du Val d'Ouest, Ecully; and [6]Department of Neurosurgery, Hôpital Gui de Chauliac, Montpellier University Medical Center, Montpellier, France

OBJECTIVE Spinal surgeries carry risks of malpractice litigation due to the random nature of their functional results, which may not meet patient expectations, and the hazards associated with these complex procedures. Claims are frequent and costly. In France, since 2002, a new law, the Patients' Rights Law of March 4, 2002, has created an alternative, out-of-court scheme, which established a simplified, rapid, free-of-charge procedure (Commission for Conciliation and Compensation [CCI]). Moreover, this law has optimized the compensation provided to patients for therapeutic hazards by use of a national solidarity fund. The authors analyzed the consequences of this alternative route in the case of claims against private neurosurgeons in France.

METHODS From the data bank of the insurer Mutuelle d'Assurance du Corps de Santé Français (MACSF), the main insurance company for private neurosurgeons in France, the authors retrospectively analyzed 193 files covering the period 2015–2019. These computerized files comprised the anonymized medical records of the patients, the reports of the independent experts, and the final judgments of the CCI and the entities supporting the compensation, if any.

RESULTS During the 5-year study period (2015–2019), the insurance company recorded 494 complaints involving private neurosurgeons for spinal surgery procedures, of which 126 (25.5%) were in civil court, 123 (24.9%) were under amicable procedure, and 245 (49.6%) were in the out-of-court scheme administered by the CCI. Out of these 245 cases, only 193 were closed due to delays. The conclusions of the commission were rejection/incompetence decisions in 47.2% of the cases, therapeutic hazards in 21.2%, nosocomial infections in 17.6%, and practitioner fault in 13.5%. National solidarity compensated for 48 complaints (24.8%). The final decision of the CCI is not always consistent with the conclusions of the experts mandated by it, illustrating the difficulty in defining the concept of hazards. The authors found that the therapeutic hazards retained and compensated by the national solidarity included decompensated spondylotic myelopathies (15% of the 40 cases) and cauda equina syndromes (30%). As allowed by law, 11.5% of the patients who were not satisfied triggered a classical procedure in a court.

CONCLUSIONS In the French out-of-court system, trial decisions resulting in rulings of proven medical malpractice are rare, but patients can start a new procedure in the classical courts. The therapeutic hazard remains a subtle definition, which may be problematic and require further discussion between experts and magistrates. In spite of the imperfections, this out-of-court system proposes a major evolution to move patients and medical providers from legal battles to reconciliations.

https://thejns.org/doi/abs/10.3171/2020.8.FOCUS20582

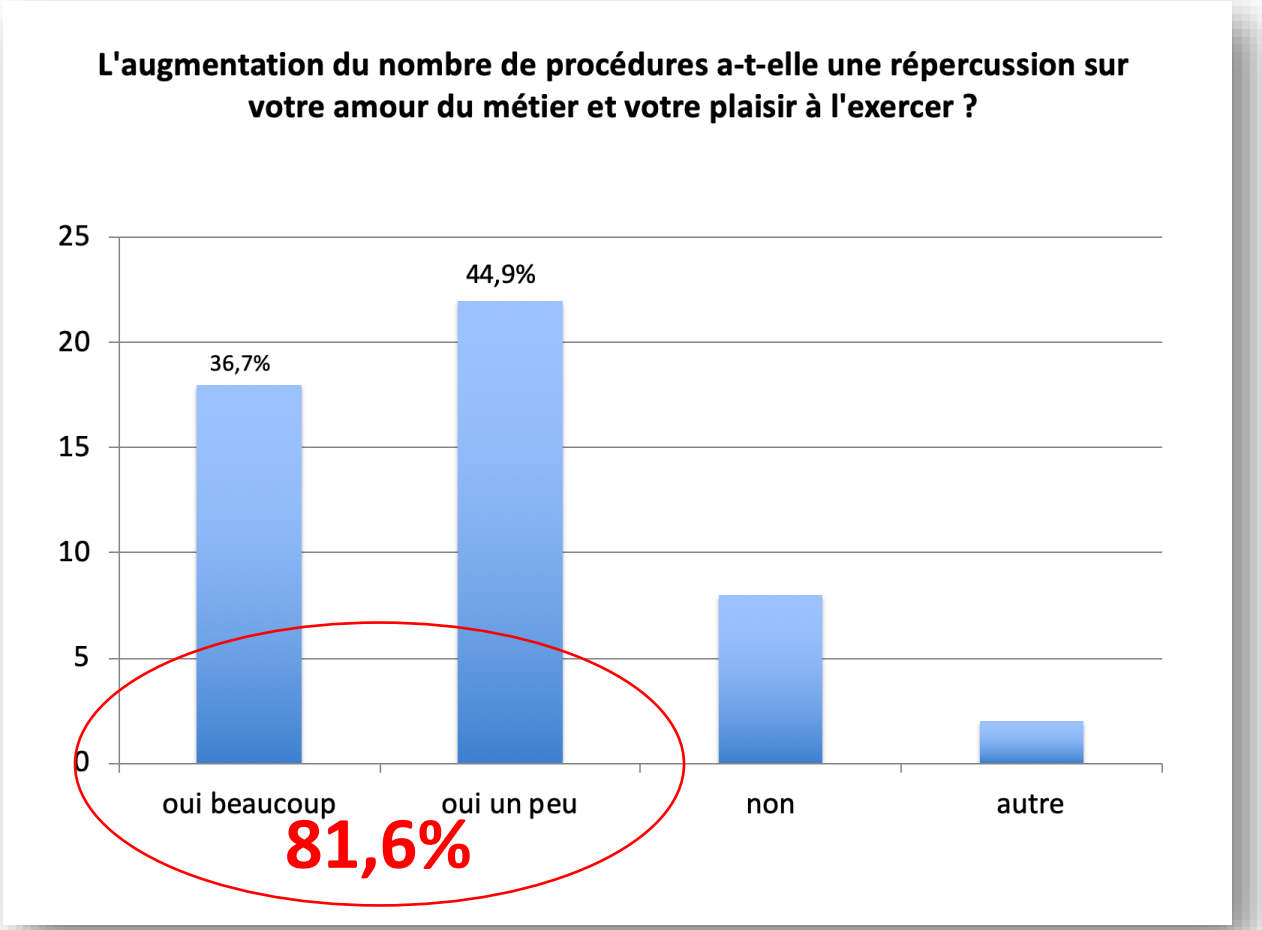
KEYWORDS malpractice; litigation; no-fault system; out-of-court system; therapeutic hazard; spine surgery

Spine surgery, particularly for procedures involving degenerative conditions, has the dual characteristic of experiencing quasi-exponential development in its indications,[1] particularly for fusions,[2] and representing a major source of litigation between patients and surgeons.[3] The functional context of the conditions treated, the impact of complications in one's personal and professional life, and the potential severity of the associated neurological lesions explain why complaints are frequent and compensation is potentially high.[4,5]

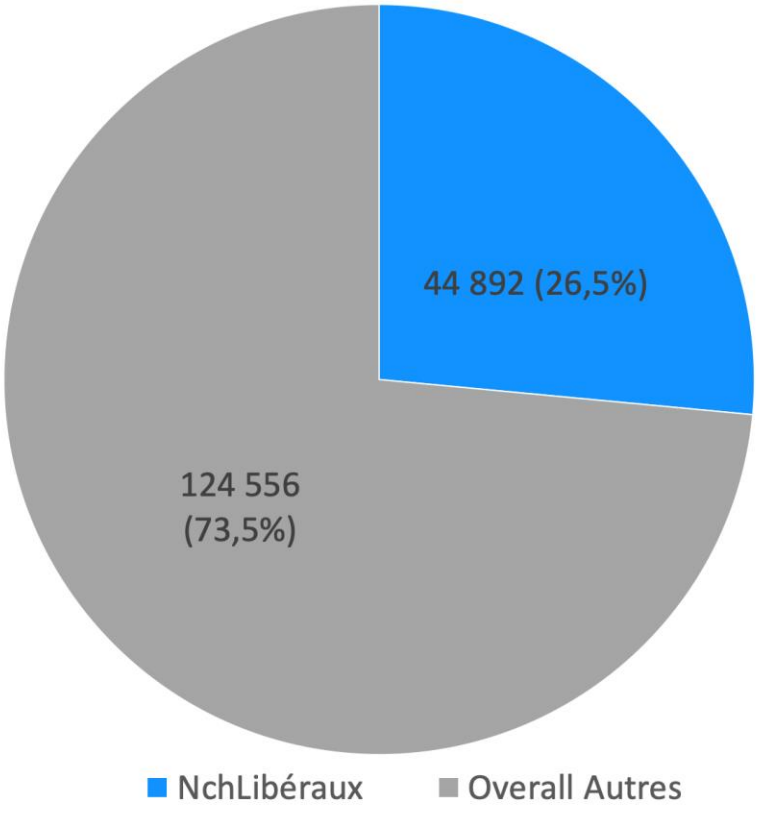
ABBREVIATIONS ACDF = anterior cervical discectomy and fusion; ALIF = anterior lumbar interbody fusion; CCI = Commission for Conciliation and Compensation; MACSF = Mutuelle d'Assurance du Corps de Santé Français; NI = nosocomial infection; ONIAM = National Compensation Office for Medical Accidents; PDR = permanent disability rate; PRL = Patients' Rights Law.

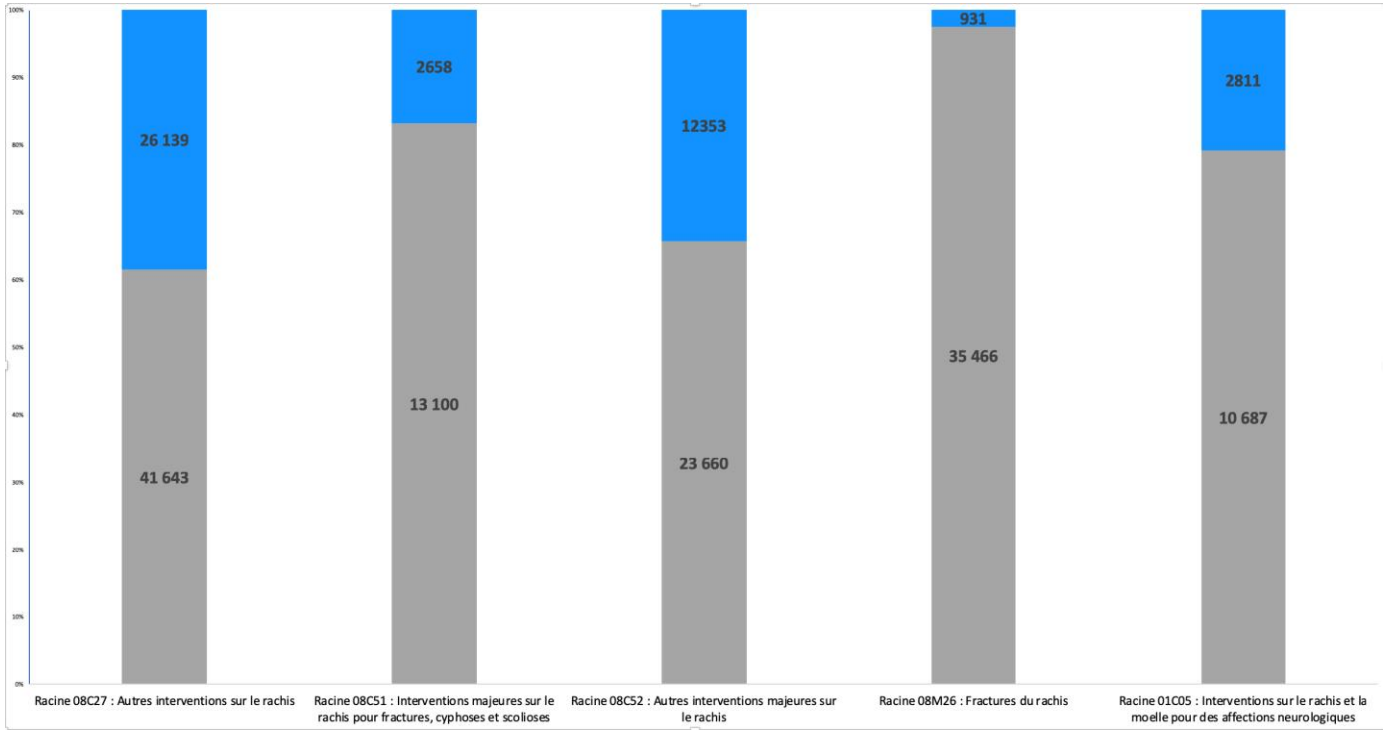
ACCOMPANYING EDITORIAL DOI: 10.3171/2020.8.FOCUS20764.
SUBMITTED June 29, 2020. **ACCEPTED** August 13, 2020.
INCLUDE WHEN CITING DOI: 10.3171/2020.8.FOCUS20582.

Enquête de Grégory Dran (SFNCL Bordeaux 2017)



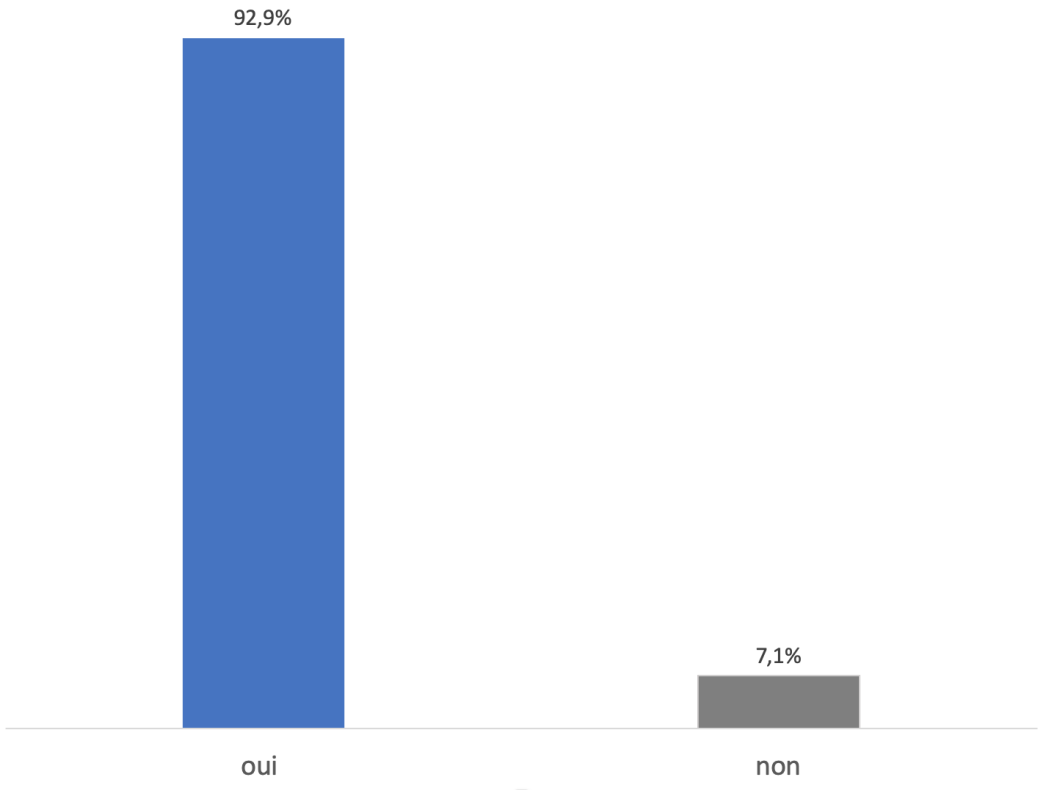
Neurochirurgiens Libéraux



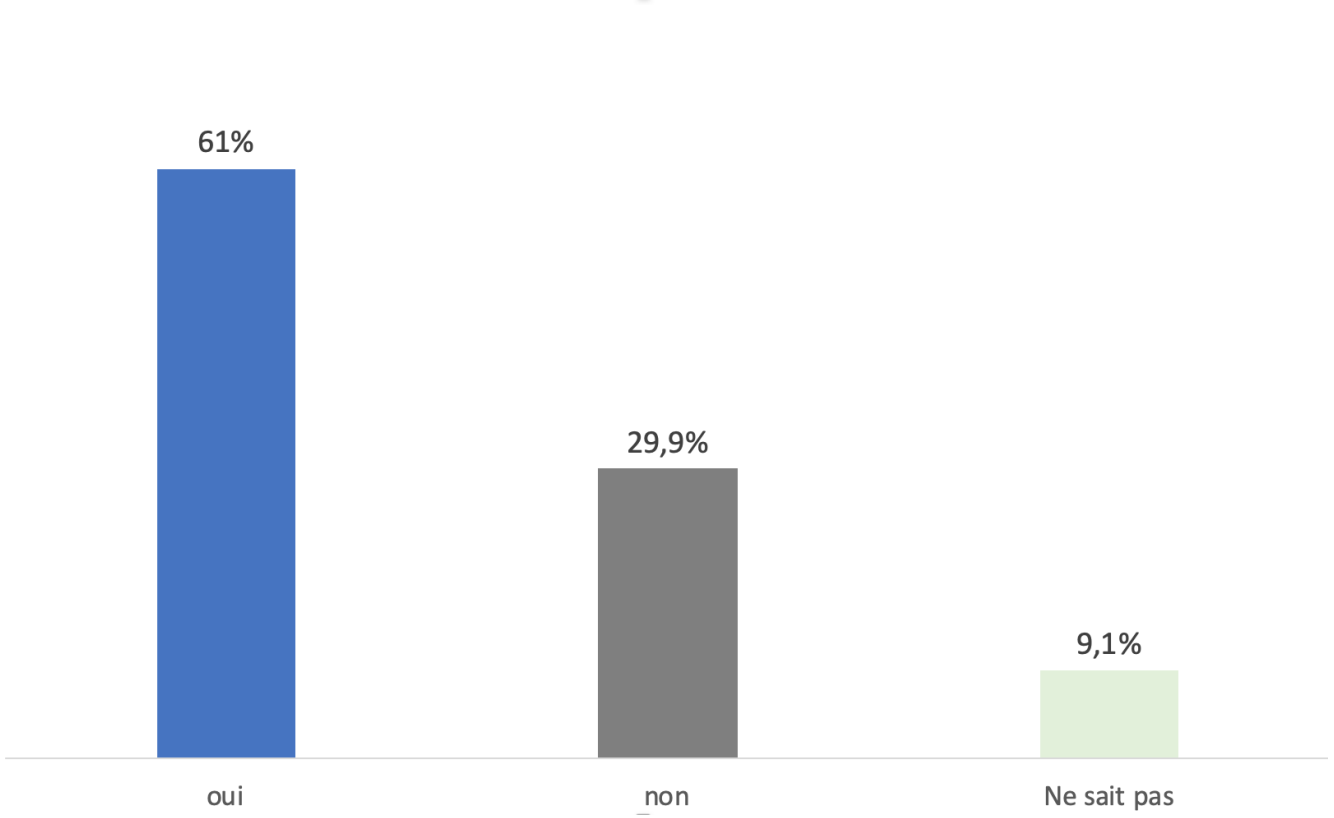


Données ATIH, Livre blanc 2019

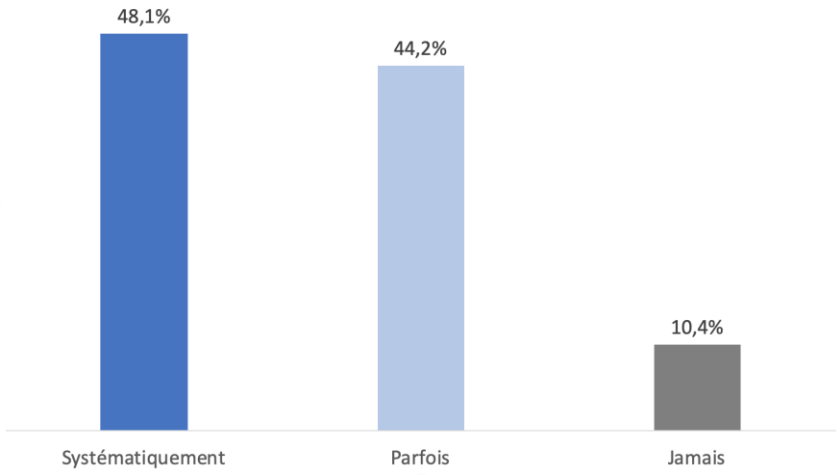
Résultats enquête G Dran SFNCL 2017 (n=77)



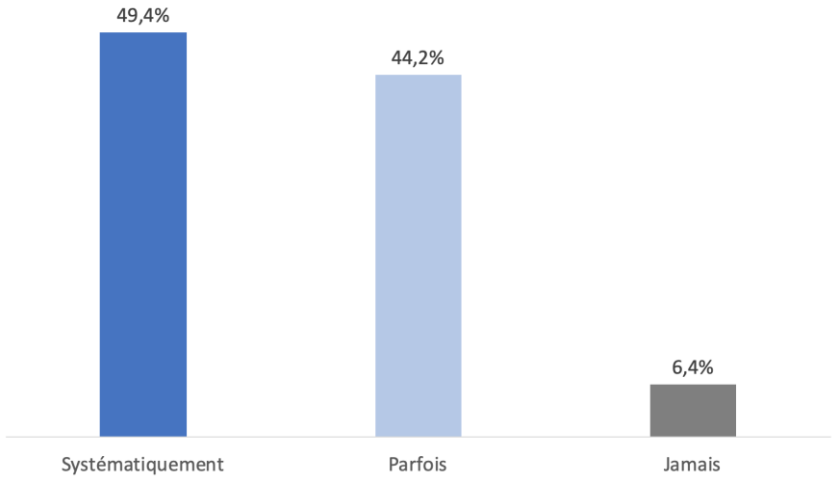
Ressentez vous dans votre pratique quotidienne une modification de votre relation avec le malade liée à la pression médico-légale?



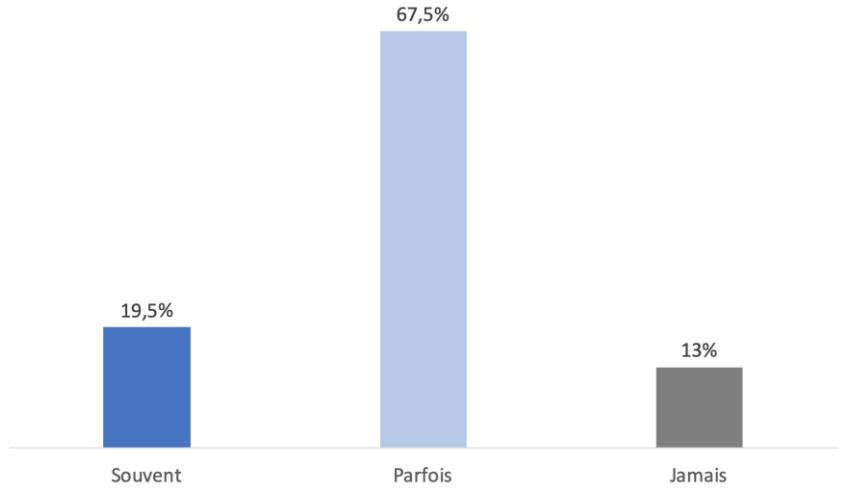
Pensez-vous que votre approche du patient s'est détériorée suite aux différentes plaintes (cci ou autres) que vous avez pu recevoir ces dernières années?



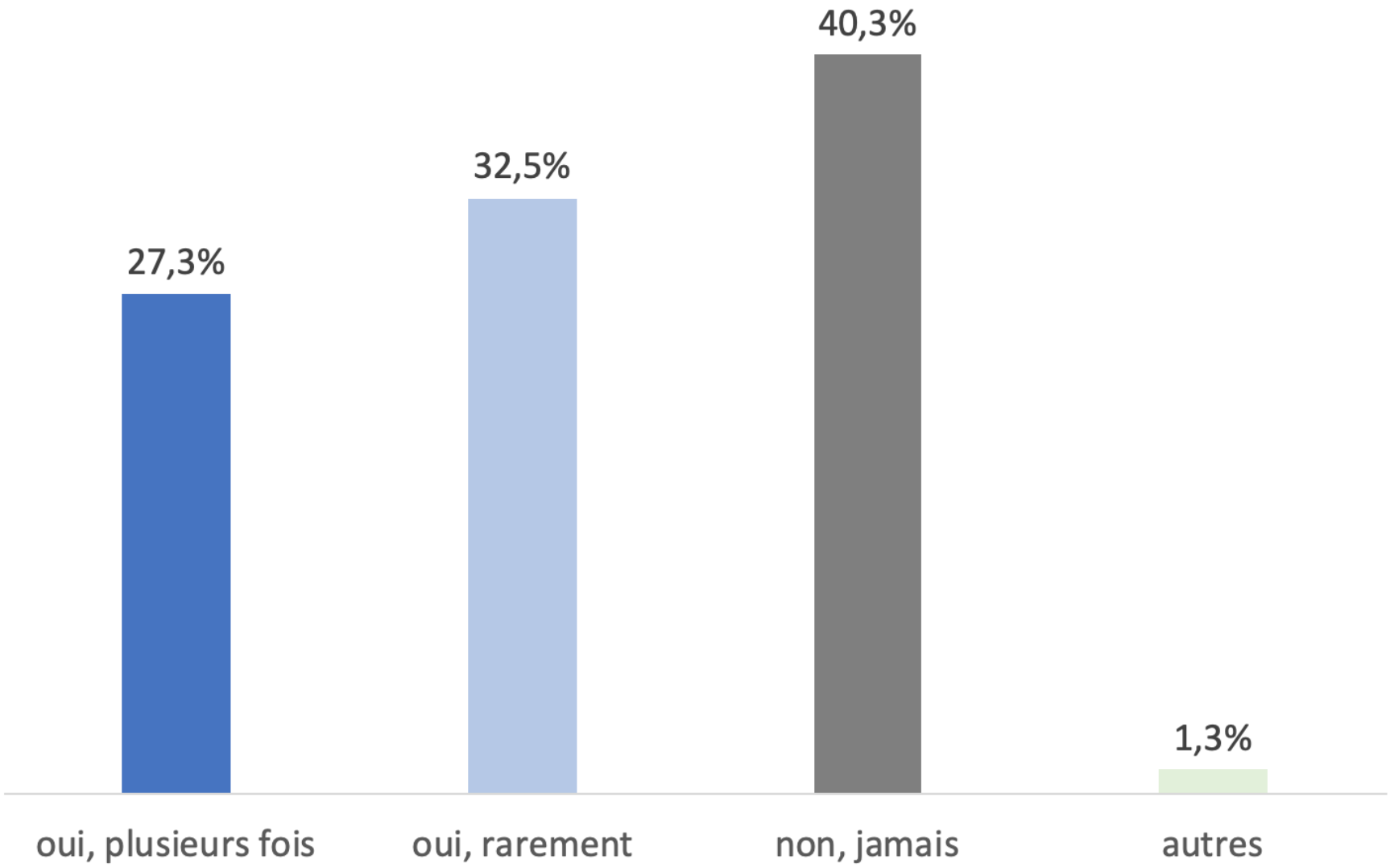
Quand un patient entre dans votre cabinet de consultation, pensez vous à l'éventuel plaignant qu'il pourrait devenir?



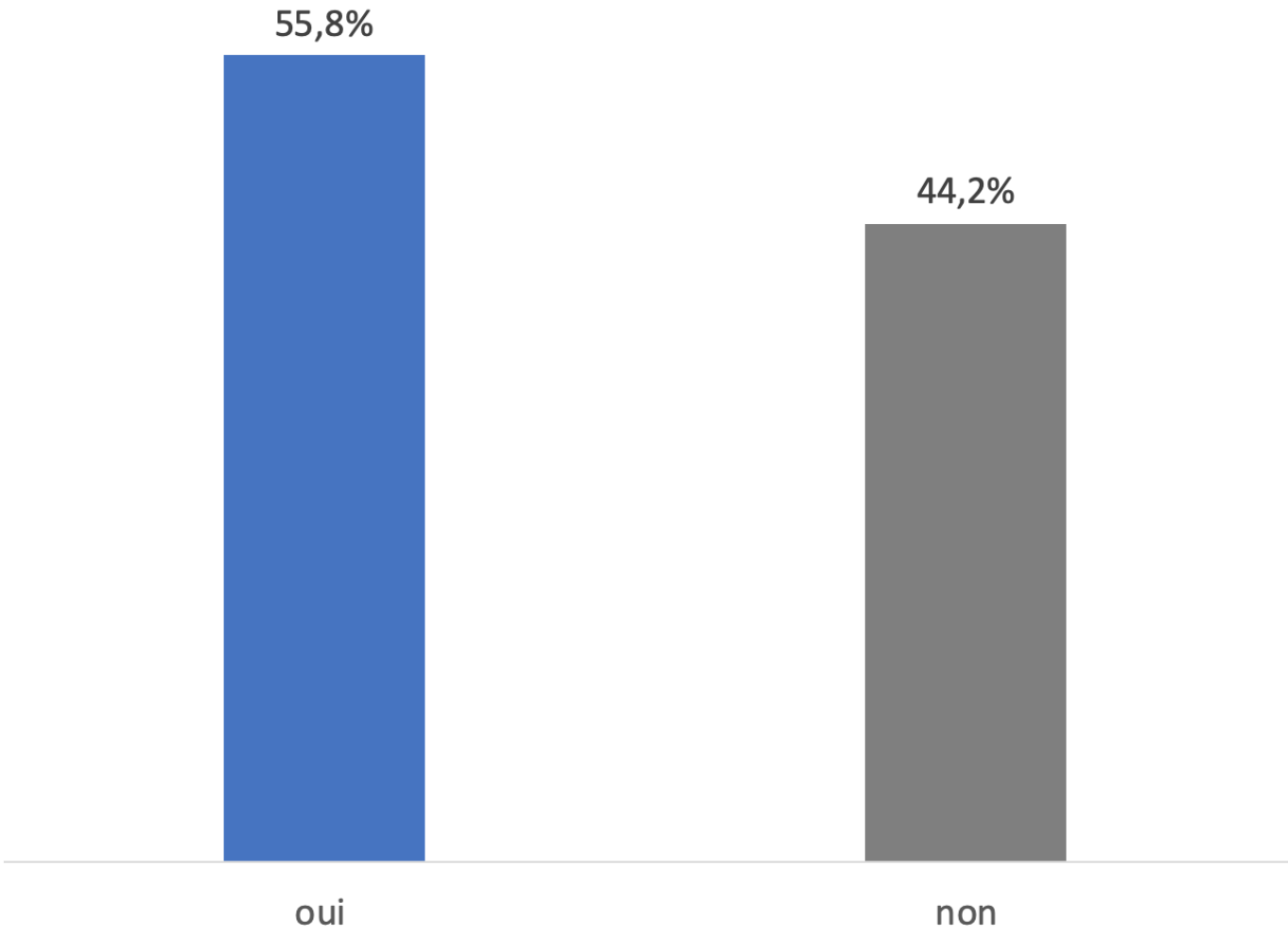
Pendant votre consultation, cherchez vous à détecter chez votre patient des signes évocateurs d'une personnalité procédurière?



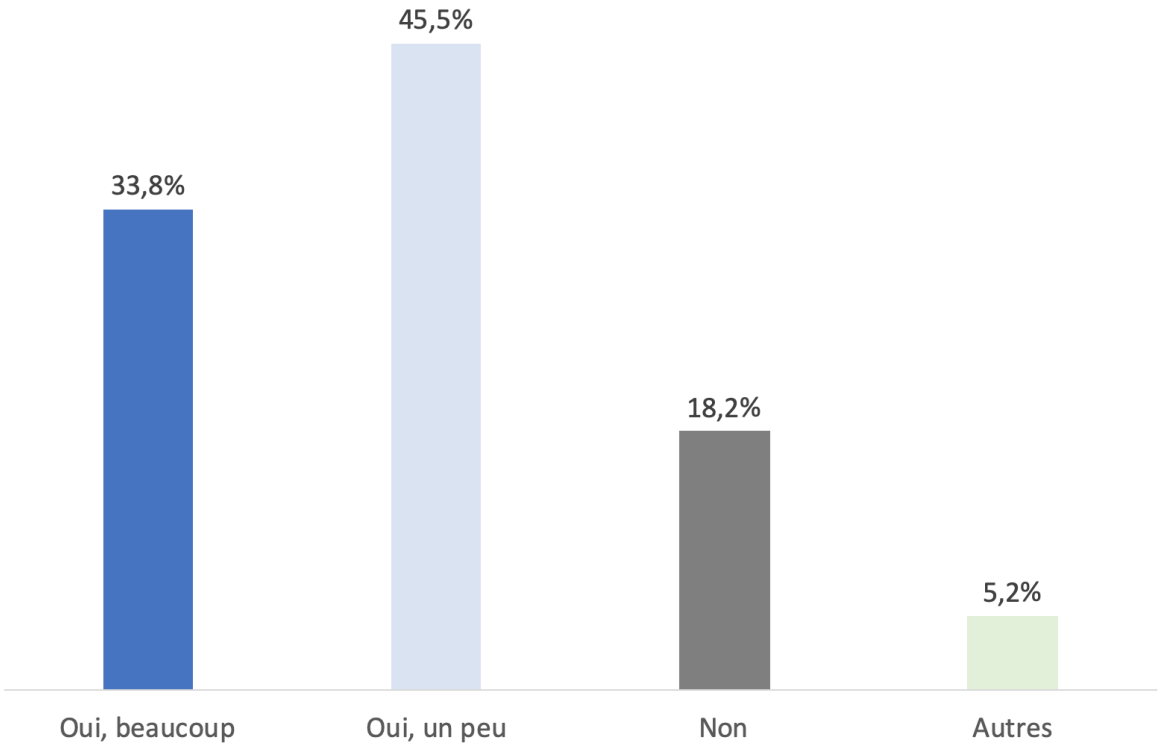
Vous arrive-t-il parfois de prendre une décision d'abstention thérapeutique car vous pensez être face à un patient qui risque de déclencher une procédure à votre encontre si tout ne se passe pas bien?



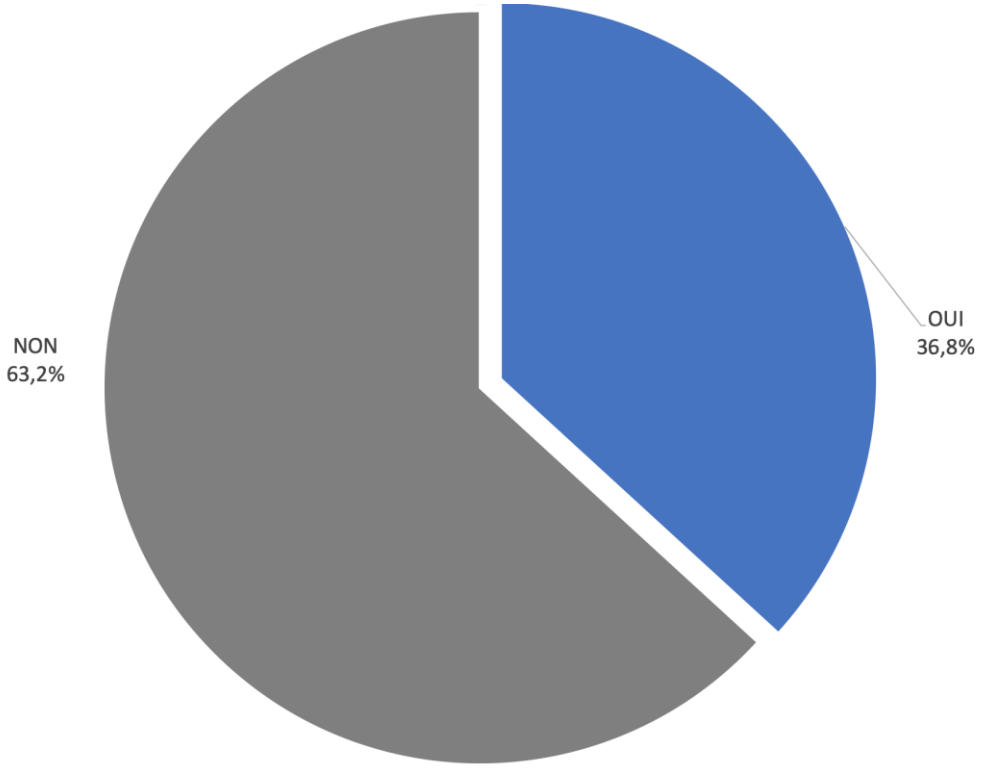
Vous est-il déjà arrivé de refuser d'effectuer une chirurgie lourde et donc à risque important de complication, uniquement par crainte des plaintes le cas échéant alors que vous vous sentiez tout à fait capable techniquement de la réaliser?



La peur de la plainte ajoute-t-elle une pression négative sur vos épaules pendant un geste chirurgical?



L'augmentation du nombre de procédures a-t-elle une répercussion sur votre amour du métier et votre plaisir à l'exercer ?



Avez vous déjà envisagé d'arrêter votre activité en raison de cette pression médico-légale?

Neurochirurgie 66 (2020) 219–224

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Original article

Impact of malpractice liability among spine surgeons: A national survey of French private neurosurgeons

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Practice pattern
Spine surgery
Insurance liability
Burn-out
Claim

ABSTRACT

Purpose. – In the general context of medical judicialization, spine surgeons are impacted by the part that medical responsibility and the risk of malpractice play in their actions and decisions. Our aim was to evaluate possible shifts in practices among private neurosurgeons who are highly exposed to this judicial risk and detect alterations in their pleasure in exercising their profession. We present the first national survey on French physicians' perception of surgical judicialization and consequences on their practice.
Methods. – An online survey was submitted to the 121 members of the French Society of Private Neurosurgery, who represent 29.1% of the total number of spine surgeons and perform 36.0% of the national total spine surgery activity. The French law (no-fault out-of-court scheme) significantly impacts these surgeons in the event of litigation.
Results. – A total of 78 surveys were completed (64.5% response rate): 89.7% of respondents experienced alteration of doctor-patient relationship related to judicialization and 60.2% had already refused to perform risky surgeries. Fear of being sued added negative pressure during surgery for 55.1% of respondents and 37.2% of them had already considered stopping their practice because of this litigation context.
Conclusion. – The increasing impact of medical liability is prompting practitioners to change their practice and perceptions. The doctor-patient relationship appears to be altered, negative pressure is placed on physicians and defensively, some neurosurgeons may refuse high-risk patients and procedures. This situation causes professional disenchantment and can ultimately prove disadvantageous for both doctors and patients.

1. Introduction

The ever-increasing judicialization of medicine adversely impacts many areas, including spinal surgery [1], resulting in the deterioration of professional fulfillment among practitioners who describe insurance consequences and the advent of defensive practices [2,3]. Some authors have even proposed the concepts of second victim surgeon and litigaphobia [4].

Spinal surgery, particularly for degenerative diseases, carries risks of complications and subsequent complaints due to intrinsic neurological risks and the random nature of its functional results, which may disappoint patients' expectations [2].

In France, a law enacted in 2002 created the concept of a no-fault out-of-court scheme, avoiding a court trial. However, this facilitated the potential for frivolous lawsuits due to the simplicity and cost-free nature of the procedure for patients [5]. This is one of the elements that contributed to the development of a growing and significant demand for compensation for malpractice in spinal surgery [6].

Private neurosurgeons, subject to civil law and performing spinal surgery, are therefore a highly exposed group to the consequences of judicialization in their professional and personal lives

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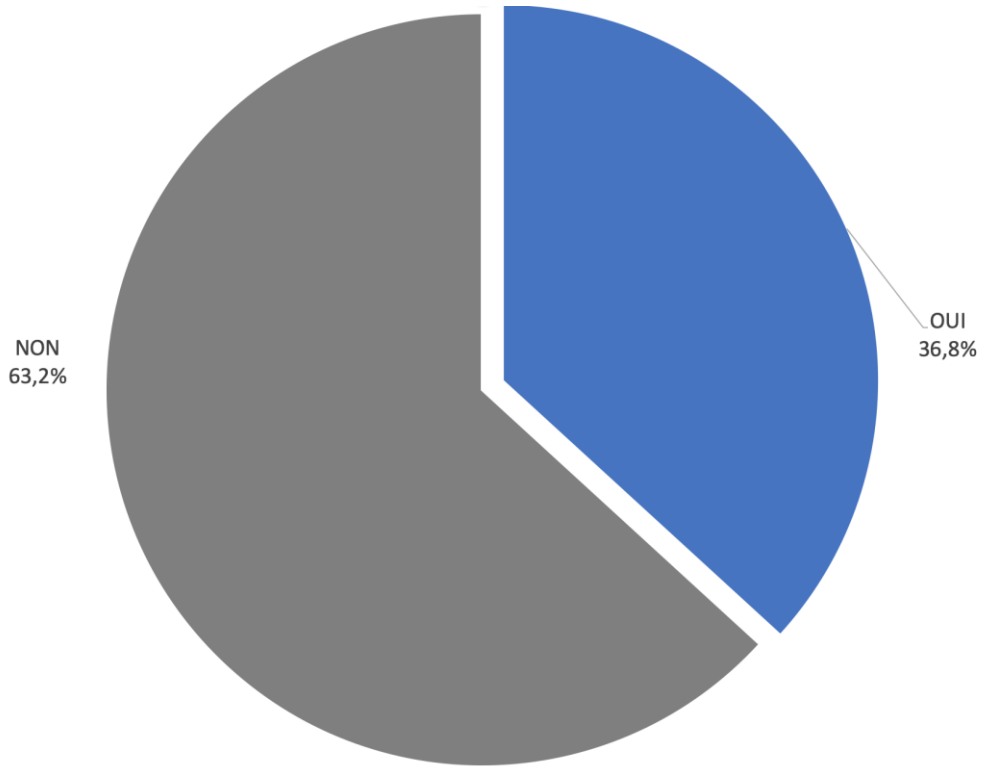


Avez vous déjà envisagé d'arrêter votre activité en raison de cette pression médico-légale?

En complément de ce travail quantitatif…

Il y une place pour les méthodologies des Sciences Humaines et Sociales pour décrire conjointement des phénomènes de santé

→L'idée d'un travail qualitatif (anthropologue de la santé)

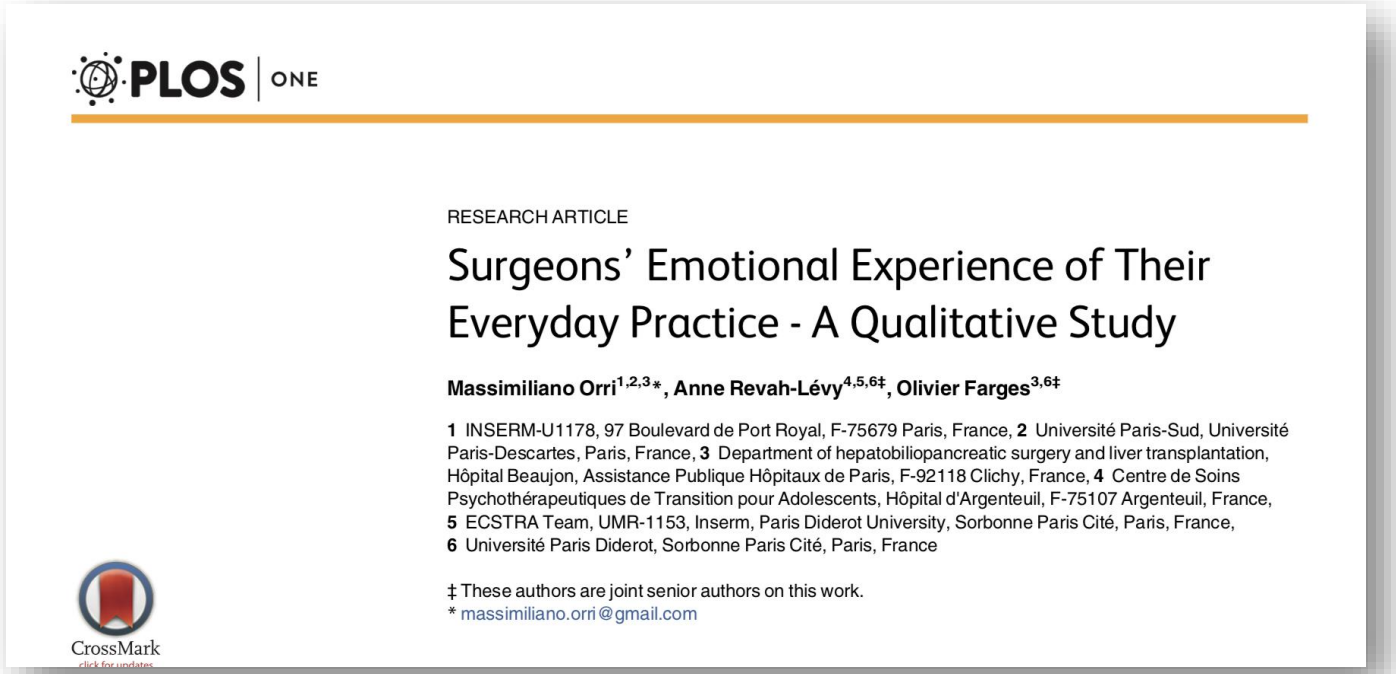
La recherche qualitative

- pas opposition mais complémentarité / recherche quantitative (elles n'explorent pas les mêmes champs de la connaissance)

- Recueil des données verbales permettant une démarche interprétative.

- terme générique : perspectives diverses en termes de bases théoriques, méthodes, techniques de recueil et analyse des données.

Quelques exemples ….



PLOS ONE

RESEARCH ARTICLE

Surgeons' Emotional Experience of Their Everyday Practice - A Qualitative Study

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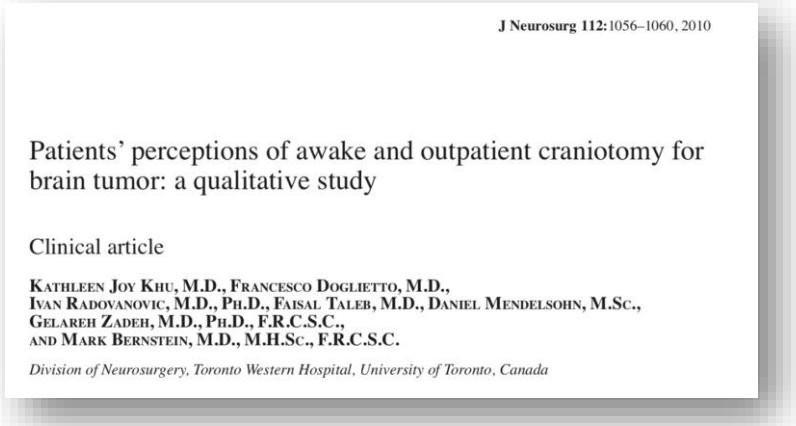
CrossMark

Chronological description	Descriptive themes	Main elements (subthemes)	
Emotions Before Surgery	Preoperative Consultation as a Source of Emotion	Emotions	Responsibility of decision making
			Uncertainty surrounding this decision
			Taking a risk
		Causes	Subjectivity of clinical decisions
			Personal decisions prevail over team decisions
		Coping	Working in a team (but team decision not always applied)
			Shaping information and establishing an implicit contract
			Dealing with patients' emotion
	Awaiting Surgery: Surgeons' Anticipation of Difficulty	Emotions	Anxiety and fear
		Causes	Ubiquitous presence of the possibility of complication
		Coping	Mastering preoperative anxiety
Emotions During Surgery	Attempting to master their emotions through distancing and focusing on surgery as a technical activity	Emotions	Pleasure of operating, in a pleasant atmosphere
			Emotional identification with the patient
		Causes	Surgery as an aggressive act
			Operating on an individual human being
		Coping	Finding a balance between emotional involvement and neutralityThinking of surgery as a technical activity
	Occurrence of a complication	Emotions	Distress caused by the occurrence of a complication
			Anxiety due to losing a clear state of mind
		Causes	Occurrence of an intraoperative complicationFeeling responsible for this complication
		Coping	Cognitive re-centeringMinimizing evidence
	Distress caused by problems of time management and fatigue	Emotions	Pressure to be recognized as a good surgeon by the others
			Discomfort because of time pressure and fatigue
		Causes	No clear separation between work life and private life
			Perceived role expectations
		Coping	Acceptance of fatigue and satisfying the ideal surgeon image
			Further increase their work load and multitask
Emotions After Surgery	Repercussion of a complication	Emotions	Long-term burden of a complication
			Feeling of personal guilt and accountability
		Causes	Osmotic link between surgeon and patient
			Strengthened emotional link when complication occurs
	Pressures of the surgical ideal		Failure of case/facts to accord with the ideal position that of "surgery is the only chance for cure"
			Lack of a culture of non-accusatory error management
		Coping	"Image" of the surgeon; playing a roleMorbidity and Mortality meetings but their rationale (blame-free) not applied

Orri, PLOS ONE 2015

Dans le domaine de la neurochirurgie



J Neurosurg 112:1056–1060, 2010

Patients' perceptions of awake and outpatient craniotomy for brain tumor: a qualitative study

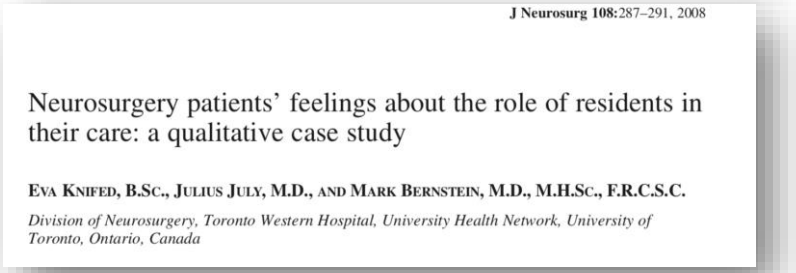
Clinical article

Kathleen Joy Khu, M.D., Francesco Doglietto, M.D., Ivan Radovanovic, M.D., Ph.D., Faisal Taleb, M.D., Daniel Mendelsohn, M.Sc., Gelareh Zadeh, M.D., Ph.D., F.R.C.S.C., and Mark Bernstein, M.D., M.H.Sc., F.R.C.S.C.

Division of Neurosurgery, Toronto Western Hospital, University of Toronto, Canada

Khu et al
JNS 2010

Perception de la chirurgie éveillée



J Neurosurg 108:287–291, 2008

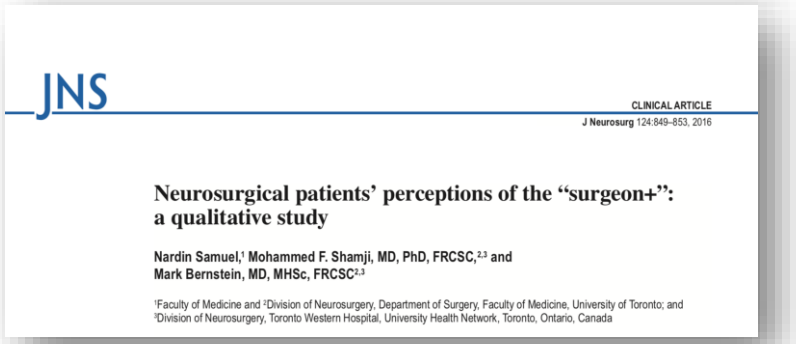
Neurosurgery patients' feelings about the role of residents in their care: a qualitative case study

Eva Knifed, B.Sc., Julius July, M.D., and Mark Bernstein, M.D., M.H.Sc., F.R.C.S.C.

Division of Neurosurgery, Toronto Western Hospital, University Health Network, University of Toronto, Ontario, Canada

Knifed et al
JNS 2018

Perception du rôle des internes



JNS

CLINICAL ARTICLE

J Neurosurg 124:849–853, 2016

Neurosurgical patients' perceptions of the "surgeon+": a qualitative study

Nardin Samuel,[1] Mohammed F. Shamji, MD, PhD, FRCSC,[2,3] and Mark Bernstein, MD, MHSc, FRCSC[2,3]

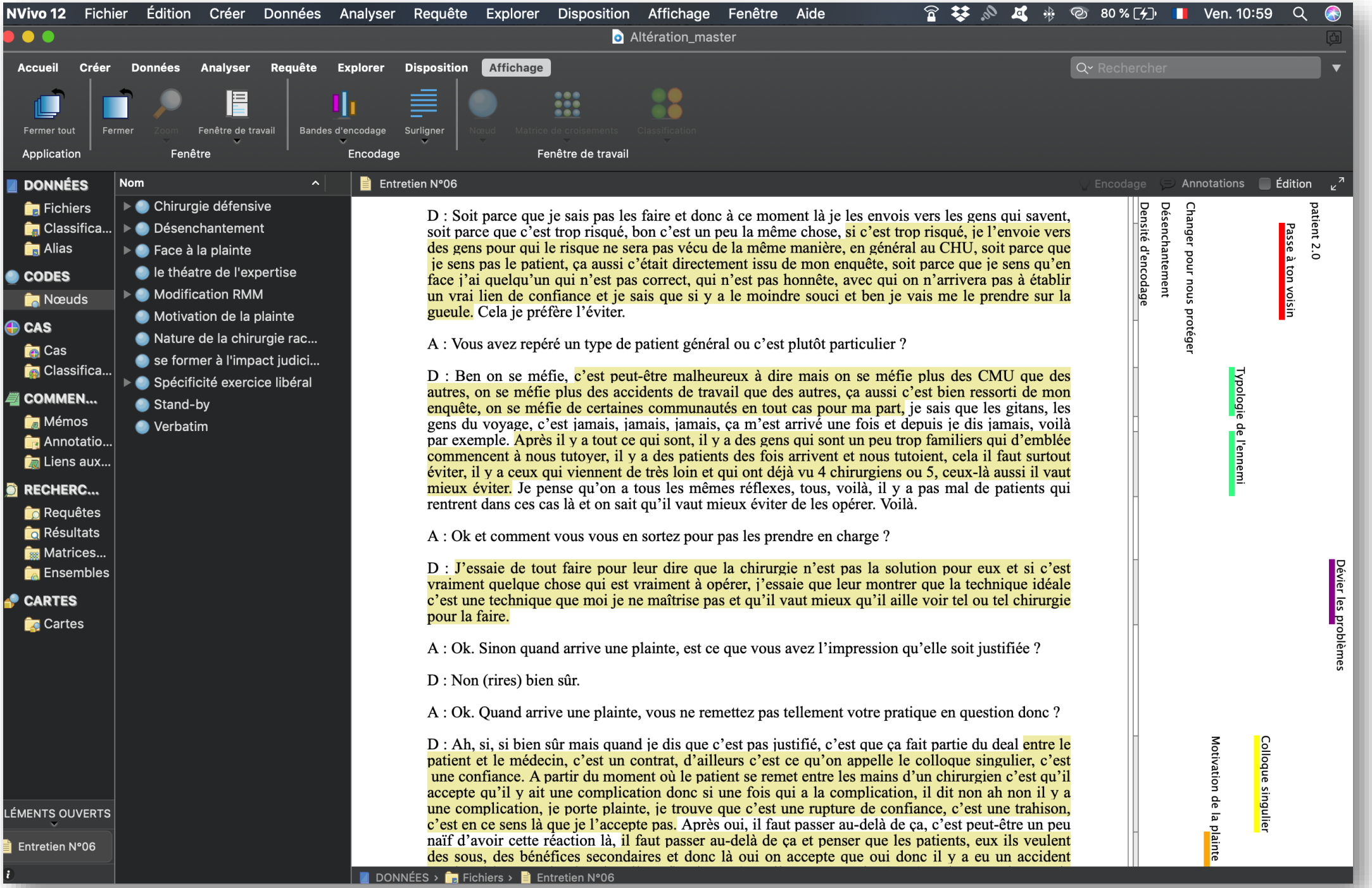
[1]Faculty of Medicine and [2]Division of Neurosurgery, Department of Surgery, Faculty of Medicine, University of Toronto; and [3]Division of Neurosurgery, Toronto Western Hospital, University Health Network, Toronto, Ontario, Canada

Samuel et al
JNS 2013

Chirurgiens et réseaux sociaux

Enquête qualitative

- *Grounded Theory*
- Basée sur entretien semi dirigé
- Anonymisation des entretiens
- Codages en thèmes et sous-thèmes jusqu'à saturation
- Analyse croisée par anthropologue, chirurgien et psychiatre légale
- Triangulation et consensus
- Logiciel NVivo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Rechercher
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Fermer
Zoom
Fenêtre de travail
Bandes d'encodage
Surligner
Nœud
Matrice de croisements
Classification
Application
Fenêtre
Encodage
Fenêtre de travail
DONNÉES
Fichiers
Classifica...
Alias
CODES
Nœuds
CAS
Cas
Classifica...
COMMEN...
Mémos
Annotatio...
Liens aux...
RECHERC...
Requêtes
Résultats
Matrices...
Ensembles
CARTES
Cartes
Nom
Chirurgie défensive
Désenchantement
Face à la plainte
le théatre de l'expertise
Modification RMM
Motivation de la plainte
Nature de la chirurgie rac...
se former à l'impact judici...
Spécificité exercice libéral
Stand-by
Verbatim
LÉMENTS OUVERTS
Entretien N°06
Entretien N°06
Encodage
Annotations
Édition
D : Soit parce que je sais pas les faire et donc à ce moment là je les envois vers les gens qui savent, soit parce que c'est trop risqué, bon c'est un peu la même chose, si c'est trop risqué, je l'envoie vers des gens pour qui le risque ne sera pas vécu de la même manière, en général au CHU, soit parce que je sens pas le patient, ça aussi c'était directement issu de mon enquête, soit parce que je sens qu'en face j'ai quelqu'un qui n'est pas correct, qui n'est pas honnête, avec qui on n'arrivera pas à établir un vrai lien de confiance et je sais que si y a le moindre souci et ben je vais me le prendre sur la gueule. Cela je préfère l'éviter.
A : Vous avez repéré un type de patient général ou c'est plutôt particulier ?
D : Ben on se méfie, c'est peut-être malheureux à dire mais on se méfie plus des CMU que des autres, on se méfie plus des accidents de travail que des autres, ça aussi c'est bien ressorti de mon enquête, on se méfie de certaines communautés en tout cas pour ma part, je sais que les gitans, les gens du voyage, c'est jamais, jamais, jamais, ça m'est arrivé une fois et depuis je dis jamais, voilà par exemple. Après il y a tout ce qui sont, il y a des gens qui sont un peu trop familiers qui d'emblée commencent à nous tutoyer, il y a des patients des fois arrivent et nous tutoient, cela il faut surtout éviter, il y a ceux qui viennent de très loin et qui ont déjà vu 4 chirurgiens ou 5, ceux-là aussi il vaut mieux éviter. Je pense qu'on a tous les mêmes réflexes, tous, voilà, il y a pas mal de patients qui rentrent dans ces cas là et on sait qu'il vaut mieux éviter de les opérer. Voilà.
A : Ok et comment vous vous en sortez pour pas les prendre en charge ?
D : J'essaie de tout faire pour leur dire que la chirurgie n'est pas la solution pour eux et si c'est vraiment quelque chose qui est vraiment à opérer, j'essaie que leur montrer que la technique idéale c'est une technique que moi je ne maîtrise pas et qu'il vaut mieux qu'il aille voir tel ou tel chirurgie pour la faire.
A : Ok. Sinon quand arrive une plainte, est ce que vous avez l'impression qu'elle soit justifiée ?
D : Non (rires) bien sûr.
A : Ok. Quand arrive une plainte, vous ne remettez pas tellement votre pratique en question donc ?
D : Ah, si, si bien sûr mais quand je dis que c'est pas justifié, c'est que ça fait partie du deal entre le patient et le médecin, c'est un contrat, d'ailleurs c'est ce qu'on appelle le colloque singulier, c'est une confiance. A partir du moment où le patient se remet entre les mains d'un chirurgien c'est qu'il accepte qu'il y ait une complication donc si une fois qui a la complication, il dit non ah non il y a une complication, je porte plainte, je trouve que c'est une rupture de confiance, c'est une trahison, c'est en ce sens là que je l'accepte pas. Après oui, il faut passer au-delà de ça, c'est peut-être un peu naïf d'avoir cette réaction là, il faut passer au-delà de ça et penser que les patients, eux ils veulent des sous, des bénéfices secondaires et donc là oui on accepte que oui donc il y a eu un accident
Densité d'encodage
Désenchantement
Changer pour nous protéger
patient 2.0
Passe à ton voisin
Typologie de l'ennemi
Dévier les problèmes
Colloque singulier
Motivation de la plainte
DONNÉES › Fichiers › Entretien N°06

Participants (n=23, après saturation)

- Age (ans) = 52,5 (39-68)
- Carrière (ans) = 22 (8-35)
- Activités (Patients/an) = 450 (300-650)

Thématique

Contextualisation de la pratique de la chirurgie rachidienne en libéral

Transformation sociétale – Altération de la relation médecin-malade

Judiciarisation de la chirurgie rachidienne

Stratégies d’adaptation

Désenchantement professionnel

Contextualisation de la pratique de la chirurgie rachidienne en libéral

L’incertitude fonctionnelle

- Contraste entre attente et résultats - subjectivité

Le risque neurologique

- Impact des complications

L’exposition juridique et assurantielle

- Droit civil : chirurgie privé plus exposé?
- Hausse des primes d’assurances

Contextualisation de la pratique de la chirurgie rachidienne en libéral

C'est une chirurgie qui a des résultats qui ne sont pas de 100%... donc on sait très bien qu'il y a un certain pourcentage où les gens ne seront pas tout à fait satisfaits

Nch#13

C'est sûr que le patient qui rentre pour se faire opérer d'une sciatique et qui ressort avec un grand déficit de la jambe ou même pire que ça bon ben forcément dans ce cas-là c'est une motivation qui est évidemment tout à fait légitime.

Nch#8

Contextualisation de la pratique de la chirurgie rachidienne en libéral

On sait qu'à l'Hôpital ils sont couverts, c'est l'Hôpital qui prend en charge, ils viennent même pas aux expertises d'ailleurs pour beaucoup quand c'est des hospitaliers, ben oui c'est l'Hôpital donc y a le médecin conseil, l'avocat qui représente l'Hôpital, de temps en temps le praticien mais pas toujours…

Nch#7

…ces problèmes de plaintes aboutissent à des augmentations de tarifs assurantiels, et à des modifications de pratique des uns et des autres…

Nch#8

Transformation sociétale – Altération de la relation médecin-malade

Disparition de la relation verticale classique et du modèle du sachant

L'intolérance sociétale à la frustration et à l’attente

La santé devenue un droit : l'exigence de résultats

Patient ou "consommateur de soins" ?

Transformation sociétale – Altération de la relation médecin-malade

On a quand même l'impression que cette image n'est plus la même aujourd'hui et que forcément il y a peut-être moins de respect, il y a peut-être moins de compréhension des difficultés du métier, il y a des patients qui considèrent qu'on est là pour les réparer au même titre que quelqu'un qui va réparer une voiture…

Surgeon_8

Transformation sociétale – Altération de la relation médecin-malade

« Maintenant plus personne peut supporter la moindre complication, le moindre retard, le moindre problème. »

Nch#1

« La bonne santé n'est plus un privilège mais un droit, ça c'est terrible dans le relationnel que les patients ont à leurs maladies, à leurs douleurs, à leurs séquelles »

Nch#19

les gens ils veulent tout, tout de suite, il faut vraiment… c'est la société internet où on commande en un clic, voilà ben maintenant c'est tout en un clic quoi.

Nch#15

Judiciarisation de la chirurgie rachidienne

Évolution d'un paradigme national (Loi 2002)

- Facilité à déclencher une procédure

Perspectives chirurgicales sur les motifs des plaintes

- Motivation financière?

Le méta-responsable

- Le chirurgien au milieu de la cible

Faire face à la plainte : une expérience traumatisante

Judiciarisation de la chirurgie rachidienne

c'est bien sauf que la procédure est entièrement gratuite, vous allez sur internet, vous remplissez un formulaire et c'est tout et là ça a fait monter les plaintes

Nch#2

C'est difficile à vivre quand on va à une expertise parce qu'on sait qu'on va être jugé, qu'on va être jugé non pas avec impartialité mais avec agressivité de la part de quasiment l'ensemble des gens qui sont là parce qu'on a quelqu'un qui a statut de victime et nous on a un statut de coupable à priori

Nch#10

Comment dire ça, du désarroi (rires) ouais c'est chiant quoi, c'est chiant. Après je pense que le premier sentiment c'est la peine, puis après on voit qui c'est, on voit dans quelle condition c'est, et là ça peut être soit de l'injustice ou de la colère… parce qu'on trouve qu'il y a des plaintes pas du tout adaptées.

Nch#3

Stratégies d’adaptation

Typologie du patient « à risque » de plainte : ?

Changer pour se protéger :

- Blinder l'information
- Retarder la décision finale – multiplier les consultations
- Impliquer le collectif - Staff
- Transférer le patient dans un établissement « mieux assuré »

Impacts positifs sur l’amélioration des pratiques?

Stratégies d'adaptation

C'est pas forcément que ça amène quelque chose au patient mais le chirurgien il sera protégé dans son dossier, tu vois, il aura coché la case. Ça c'est une modification importante des pratiques c'est-à-dire faire quelque chose pas pour le patient mais faire quelque chose pour se protéger soi encore une fois.

Nch#1

S'ils sont physiologiquement médiocres, un peu agressifs et en CMU alors là ça fait un trio trop risqué d'un point de vue médico-légal,

Nch#10

Parfois il y a des confrères où franchement je me pose la question ce qu'ils ont fumé quand ils ont vu ce patient, y a aucune documentation, la documentation est super mauvaise, y a aucun consentement éclairé, tout est très très flou et c'est des gens que je connais bien, qui sont des bons chirurgiens…mais se préparer à être expertisé c'est aussi un art mais on a aucune formation et ça c'est un truc qui manque.

Nch#20

Désenchantement professionnel

Le chirurgien, « deuxième victime »

Désenchantement

« Autres rivages »

Désenchantement professionnel

Avec les années, on subit des choses et comme il n'y a pas une chose qui est violente d'un coup, on bascule pas d'un coup, non, c'est des petites choses qui se mettent en place qui fait que dans notre tête progressivement sans s'en rendre compte, on met en place des tas de choses pour préparer un éventuel changement radical.

Nch#1

Ils travaillent dans des conditions formidables dans d'autres pays : ils travaillent beaucoup moins parce que leurs honoraires sont beaucoup plus élevés et les mecs putain ils sont apaisés, ils sont tranquilles !

Nch#11

je supporte sans doute moins bien les gens et leurs plaintes continuelles mais bon il y a une certaine lassitude qui est en train de s'installer et qui d'un autre côté c'est pas plus mal parce que ça me permettra de m'arrêter.

Nch#14

Régulièrement on se dit mince ils font chier, est-ce qu'il faut continuer à travailler, est-ce qu'il faut pas que je fasse autre chose, un métier moins compliqué?

Nch#9

Quelle évaluation du changement de paradigme sociétal par les chirurgiens?

Altération de la relation médecin-malade ?

Obligation de résultat?

Patient ou consommateur de soins?

Le patient expert - Internet

Les patients : de l'espoir à la revendication

Identification des attentes complexes

Loi 2002 – Consentement éclairé

Aléas thérapeutique

Typology of the enemy

Vers une chirurgie défensive?

Le chirurgien : de la déception au ras-le-bol

Héritiers de héros machos (Cassel, 1986)

L’acte chirurgicale : de l’élation à la frustration

Litigaphobie - une crainte irrationnelle?

Une épée de Damoclès

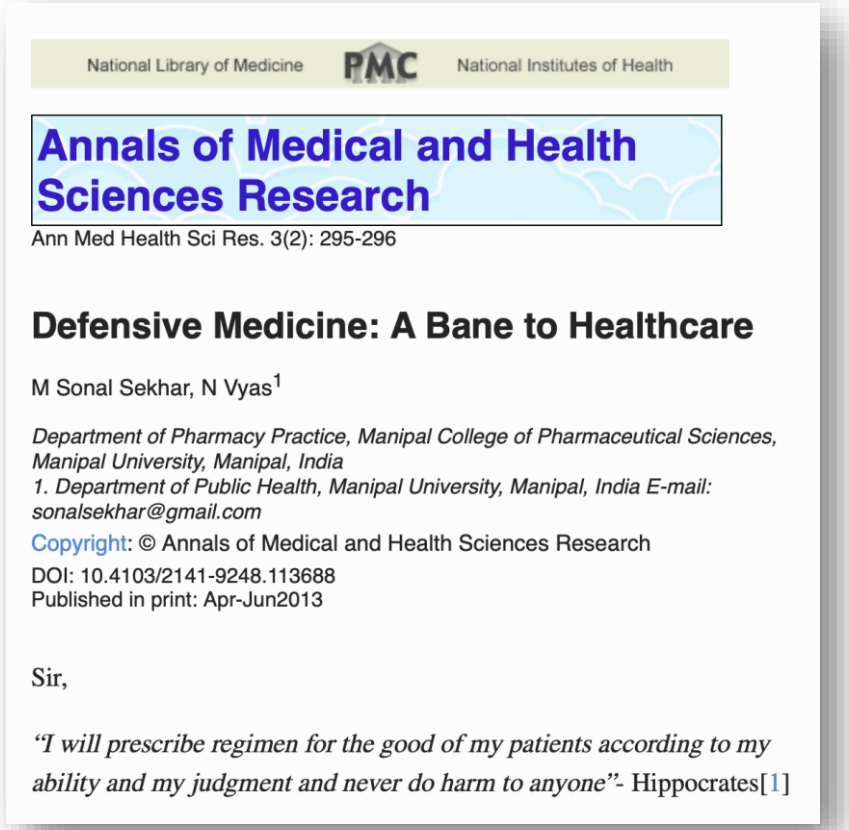
Le plaisir enfui d’exercer la chirurgie

Fatigue compassionnelle

Premiers états de burn-out

Cercle vicieux

Changer, un peu beaucoup, passionnément….



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Annals of Medical and Health Sciences Research

Ann Med Health Sci Res. 3(2): 295-296

Defensive Medicine: A Bane to Healthcare

M Sonal Sekhar, N Vyas[1]

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Sir,

"I will prescribe regimen for the good of my patients according to my ability and my judgment and never do harm to anyone"- Hippocrates[1]

« Dérive à l'américaine »?

Defensive practices

« Conventional medicine says take paracetamol.
Defensive medicine says blood test, MRI and PET-Scan »

« Your medical problem is more complicated that I thought.
I am going to refer you to another doctor, who as more
medical insurance than I have »

The NEW ENGLAND JOURNAL of MEDICINE

HEALTH POLICY REPORT

Medical Malpractice

David M. Studdert, LL.B., Sc.D., M.P.H., Michelle M. Mello, J.D., Ph.D., and Troyen A. Brennan, M.D., J.D., M.P.H.

Few issues in health care spark as much ire and angst as medical-malpractice litigation. Physicians revile malpractice claims as random events that visit unwarranted expense and emotional pain on competent, hardworking practitioners. Commentators lament the "lawsuit lottery," which provides windfalls for some patients, but no compensation for the vast majority of patients injured by medical care.[1,2] Within the health care industry, there is a nearly universal belief that malpractice litigation has long since surpassed sensible levels and that major tort reform is overdue.

Yet the drive to litigate continues. Plaintiffs' attorneys and some consumer groups interpret providers' grievances as little more than predictable chafing on the part of a profession that is unaccustomed to external policing. They view litigation as an indispensable form of protection against medical carelessness. The response of trial attorneys to recent research on medical errors illustrates their perception of themselves as champions of patient safety: new knowledge of the burden of medical errors is seen as vindication of the battles fought on behalf of patients, and the imperative such findings announce is clear — more litigation.[3]

With a malpractice crisis spreading across the United States today, it is an opportune time to review the current situation in the light of the goals of the liability system, previous crises, and available evidence on the performance of the system. A survey of the field yields a picture of a system that has internal logic but falls far short of its social goals of promoting safer medicine and compensating wrongfully injured patients.

FRAMEWORK AND GOALS OF THE SYSTEM

Malpractice law is part of tort, or personal-injury, law. To prevail in a tort lawsuit, the plaintiff must prove that the defendant owed a duty of care to the plaintiff, that the defendant breached this duty by failing to adhere to the standard of care expected, and that this breach of duty caused an injury to the plaintiff.[4]

The standard traditionally used to evaluate whether the breach in question rises to the level of negligence is medical custom — the quality of care that would be expected of a reasonable practitioner in similar circumstances. Custom is determined primarily through the testimony of experts in the same field as the defendant, although some encapsulations of expert opinion, such as practice guidelines, may also be used.[5,6] In at least 20 states, there has been a discernible shift in recent years away from custom and toward a more independent determination by the court of whether the defendant deviated from "reasonable" conduct.[7]

There are three social goals of malpractice litigation: to deter unsafe practices, to compensate persons injured through negligence, and to exact corrective justice.[4] Theoretically, lawsuits deter physicians by reminding those who wish to avoid the emotional and financial costs of litigation that they must take care.[8] With respect to compensation, reasons of fairness and efficiency dictate that the party at fault for an injury should bear the associated costs, including lost earnings, medical bills, and "pain and suffering."

Clinicians and health care facilities are well placed to bear the costs of injury because they are able to pool risk and resources through insurance.[9] Nearly all hospitals and physicians carry deep coverage, usually through separate lines of insurance. The cost of insurance coverage for hospitals is typically linked to the history of claims from year to year, an arrangement known as "experience rating." Physicians, on the other hand, generally are not risk rated unless they have been repeatedly sued, in which case they may be forced to obtain coverage from high-cost insurers or may have trouble obtaining any coverage.[10] In recent years, anecdotal evidence suggests that some insurers in states experiencing tort crises are declining to renew policies for physicians with even a single claim.

Dépenses de santé inutiles motivées par la crainte d'une faute professionnelle

210 milliard $

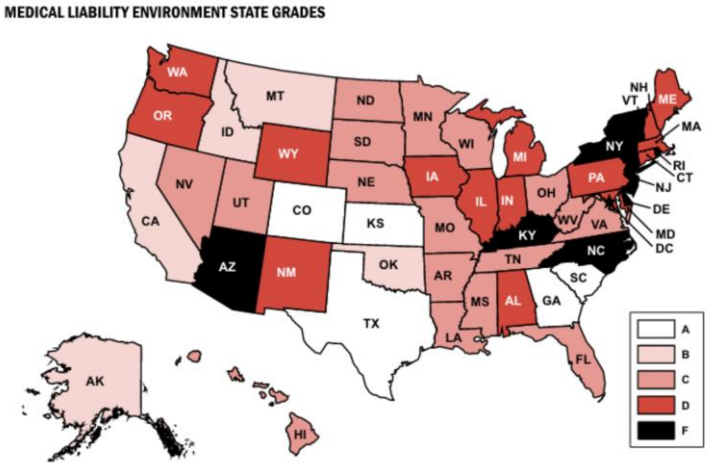
Spine

SPINE Volume 42, Number 3, pp 177–185

HEALTH SERVICES RESEARCH

Defensive Medicine in U.S. Spine Neurosurgery

Ryan S. Din, BS, Sandra C. Yan, BS, David J. Cote, BS, Michael A. Acosta, BS, and Timothy R. Smith, MD, PhD, MPH



The average annual malpractice premium for spine neurosurgeons was similar to nonspine neurosurgeons ($104,480.52 vs $101,721.76, p=0.60).

$75,857 / low-risk states, and $128,181 / high-risk states

89.2% of spine and 84.6% of non-spine neurosurgeons reported engaging in defensive medical practices, i.e. ordering labs, medications, referrals, procedures, and imaging solely for liability concerns p=0.031

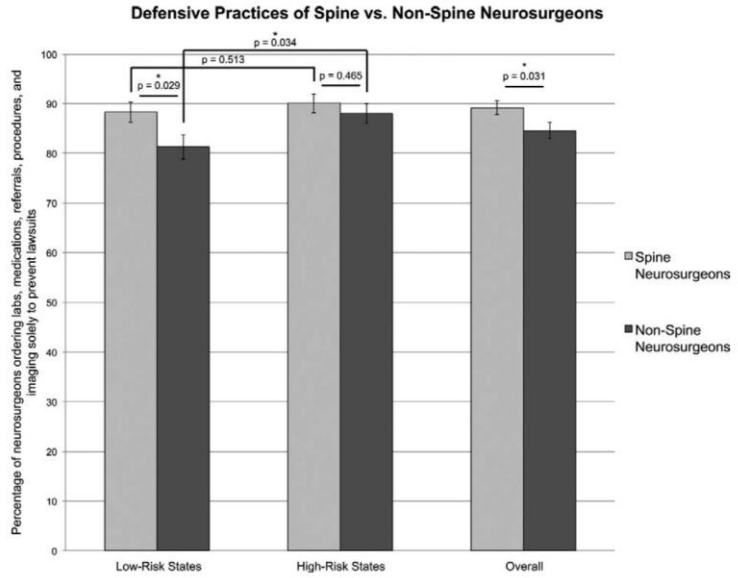


Figure 1. Nonspine neurosurgeons practice defensively more in high-risk states than low-risk states ($P=0.034$), whereas spine neurosurgeons practice similarly regardless of the state liability risk ($P=0.513$). In low-risk states, spine specialists practice more defensively than non-spine neurosurgeons ($P=0.029$). However, in high-risk states, both practice defensively equally ($P=0.465$).

OPEN ACCESS Freely available online PLOS one

Malpractice Liability and Defensive Medicine: A National Survey of Neurosurgeons

Brian V. Nahed[1*], Maya A. Babu[2*], Timothy R. Smith[3], Robert F. Heary[4]

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Abstract

Background: Concern over rising healthcare expenditures has led to increased scrutiny of medical practices. As medical liability and malpractice risk rise to crisis levels, the medical-legal environment has contributed to the practice of defensive medicine as practitioners attempt to mitigate liability risk. High-risk specialties, such as neurosurgery, are particularly affected and neurosurgeons have altered their practices to lessen medical-legal risk. We present the first national survey of

Enquête parmi 3344 neurochirurgiens (AANS)

1028 réponses (31%)

Pratiques de médecine défensive

- additional imaging studies (72%)
- laboratory tests (67%)
- prescribing additional medications (40%)
- referring patients to consultants (66%)

Primes d'assurance : fardeau " majeur ou extrême " par 64 % des répondants,

→ 45 % éliminent les procédures à risque élevé de leur pratique en raison de problèmes de responsabilité.


patient
problème
faire
dire
dit
oui
chose
problèmes
gens
chirurgie
choses
fois
va
avoir
temps
pense
beaucoup
médecin
plainte
vois
cas
puis
opérer
complication
j'ai
là
n'a
d'accord
exemple
qu'elle
chirurgien
sais
truc
dossier
question
travail
chirurgiens
bon
irm
l'expert
patients
effectivement
sait
sûr
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risque

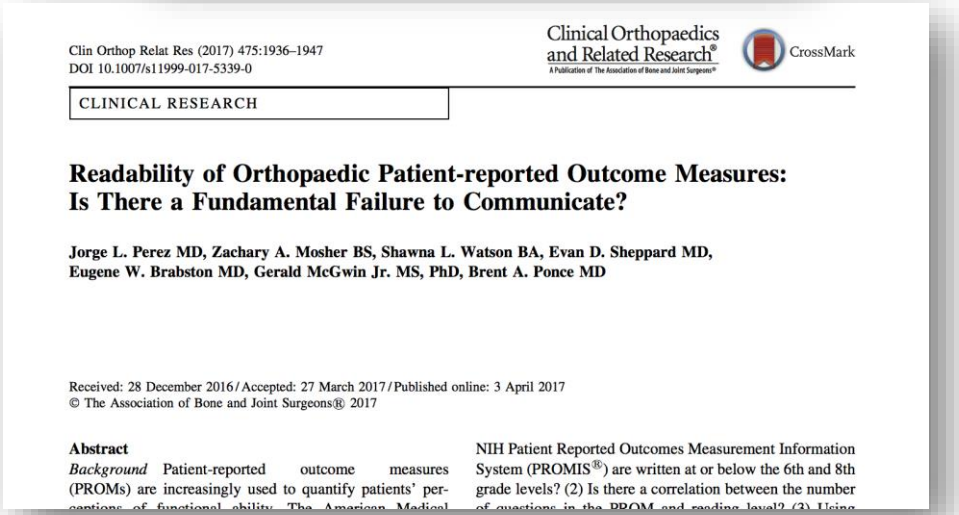
faire

patient

problème

plaire

The growing influence of Patient Reported Outcomes (PROMs)



Patient-expert…ou faux expert, enfin expert de la recherche sur internet. Moi, je leur dis souvent, je ne peux pas vous expliquer en 5 minutes ce que j'ai mis 15 ans à apprendre!

Nch#3

BMJ

BMJ 2012;344:e256 doi: 10.1136/bmj.e256 (Published 27 January 2012)

ANALYSIS

Shared decision making: really putting patients at the centre of healthcare

A M Stiggelbout *professor of medical decision making* [1], T Van der Weijden *professor of implementation of evidence* [2], M P T De Wit *patient representative* [3], D Frosch *associate investigator* [4], F Légaré *Canada research chair in implementation of shared decision making in primary care* [5], V M Montori *director of healthcare delivery research programme* [6], L Trevena *associate professor* [7], G Elwyn *professor of primary care* [8]

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LE FIGARO
MAGAZIN
SPÉCIAL
AL MARÈS 2012
Les meilleurs
établissements
en France et
ans votre région
par spécialité
HÔPITAL


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Photos
ACTU-MATCH | MERCREDI 29 DÉCEMBRE 2010
CHIRURGIES MINI INVASIVES DE LA
LAN TRÈS POSITIF


Se connecter
affinitiz
SPONDYLOBLOG
"La communauté de tous ceux qui souffrent d'un spondylolisthesis"
Accueil
Publications
Dossier d'information
Témoignages
Forum - discussions
Sondages
Photos
Praticiens
Membres
MARS 19
Une opération « ratée »
Par sd13 le 19/03/12 - 19:26
Dernier commentaire ajouté il y a 2 jours
0 votes
Voter
Vous êtes déjà membre de la communauté?
Se connecter
Vous n'êtes pas encore membre?


SPONDYLOBLOG
"La communauté de tous ceux qui souffrent d'un spondylolisthesis"
Accueil
Publications
Dossier d'information
Témoignages
Forum - discussions
Sondages
Photos
Praticiens
Membres
MARS 18
Scandaleux!!!!
Par lounajb le 18/03/10 - 18:25
Dernier commentaire ajouté il y a 3 semaines
0 votes
Voter
Vous êtes déjà membre de la communauté?
Se connecter


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Forum
Profil
Mes messages
Aide
Créer une discussion +
Recherche
« Retour au forum
Arthrodese qui a foutu ma vie en l'air
Voilà maintenant deux ans jour pour jour que j'ai subie une arthrodèse par voie antérieur avec une greffe spongieuse (L5/S1), suite à un spondylolésthésiste par lyse isthmique + double discopathie dégénerative...Avant de me faire opérer j'ai tout essayer anti inflammatoire, kiné, infiltration,

Série d'été Onfray raconte les inventions de Montaigne
Hongkong Avec les combattants de la liberté
Municipales Les secrets du vote RN
Le Point
Hôpitaux et cliniques
LE PALMARÈS 2019
1400 établissements au banc d'essai pour 79 spécialités
INÉDIT
La liste des urgences qui manquent de médecins


Forbes
Why You Should Never Get Fusion Surgery For Plain Back Pain
Robert Langreth
28
A recent Bloomberg article should put the fear of God in anyone who wants to get a fusion operation for low back pain blamed on worn-out spinal discs. I've written about the lack of evidence behind surgery for pain for years. This is one of the best indictments of this highly controversial and lucrative operation that has been growing like wildfire, despite multiple studies that say it is no better than a good physical therapy and exercise program–and a lot more dangerous.
The article has several great examples of what can happen when the operation goes wrong. It somehow manages to put much of the best stuff at the end, so I will summarize some it for you. There is one patient in the story who was still in such pain after the operation he ended up dying of a painkiller overdose at age 41. Another125 patient study touted as having positive results for fusion is missing followup data from a full 45 patients. In another study more than 5% of people who got complex fusion operations had life-threatening complications. I'll add another detail: the theory behind this operation is poor, as there is no surefire way to pinpoint the pain to the degenerated discs being operated on.
Another amazing fact: Even if the doctor performs the operation properly, you may still end up paralyzed from the waist down:

The NEW ENGLAND JOURNAL of MEDICINE

Perspective

Medical Education in the Era of Alternative Facts

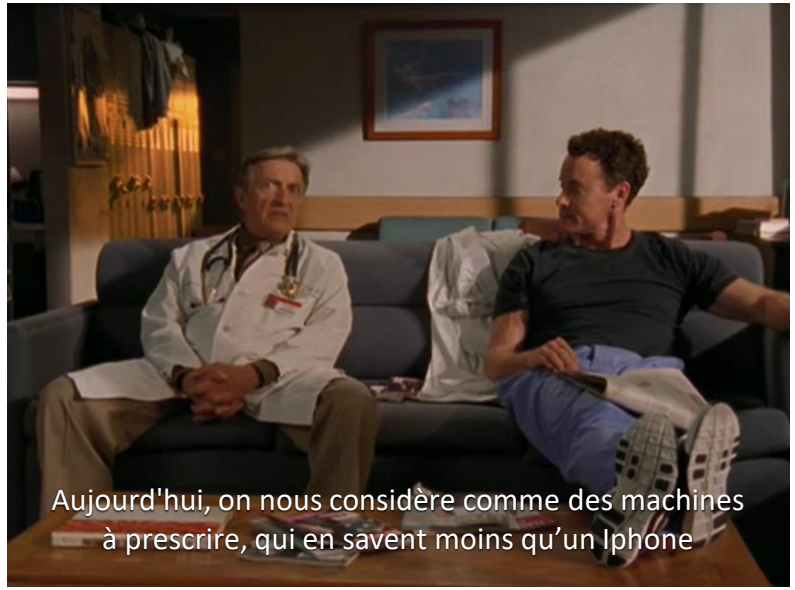
Richard P. Wenzel, M.D.

N Engl J Med 2017; 377:607-609 | August 17, 2017 | DOI: 10.1056/NEJMp1706528

Réflexions

- Impact incontestable
- Ressenti négatif des praticiens – Gauchissement de la relation médecin-malade
- Aspect irrationnel ou subjectif
- Patient 2.0 : rapport commercial, millenials, patient-expert, démocratie médicale
- Rapport commercial

À la recherche d’un temps disparu…



Reconfiguration d'un segment professionnel

Nouvelles formes d'exercice (standards scientifiques, collégialité, principe de sécurité sanitaire, intégrant les modifications sociétales, mesures défensives)

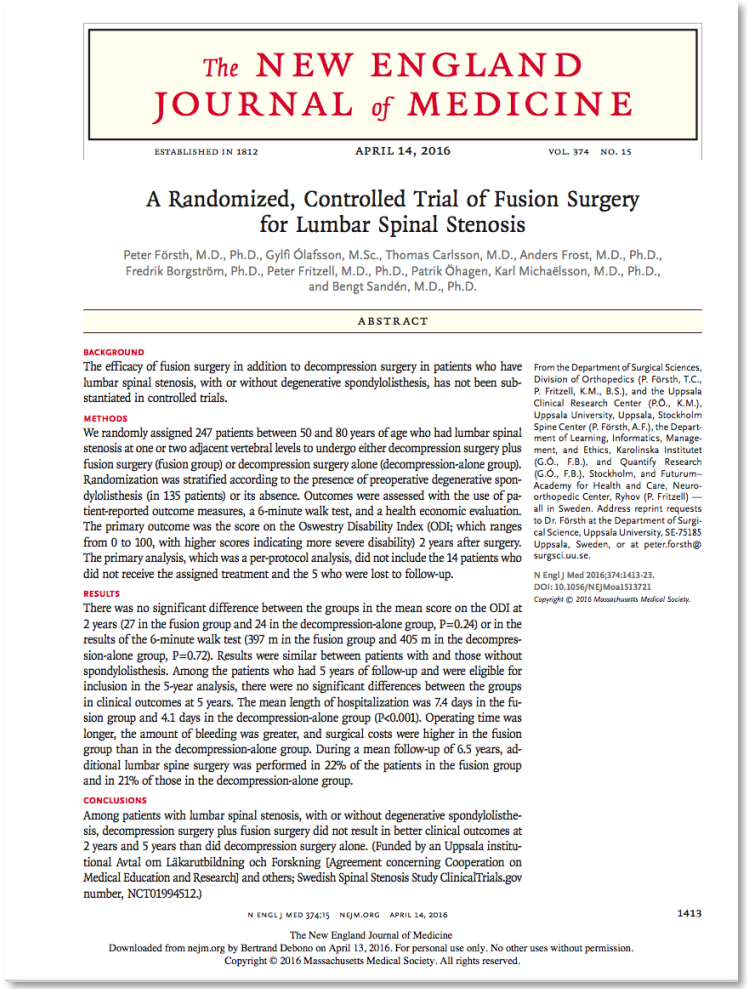
Réactions très contrastées

Pratiques d'évitement « défensives »

intégration de nouveaux standards individuels et collectifs

nouvelle relation au malade → dimension juridique et judiciaire

S'en sortir par le haut



The NEW ENGLAND JOURNAL of MEDICINE

ESTABLISHED IN 1812 APRIL 14, 2016 VOL. 374 NO. 15

A Randomized, Controlled Trial of Fusion Surgery for Lumbar Spinal Stenosis

Peter Försth, M.D., Ph.D., Gylfi Ólafsson, M.Sc., Thomas Carlsson, M.D., Anders Frost, M.D., Ph.D., Fredrik Borgström, Ph.D., Peter Fritzell, M.D., Ph.D., Patrik Öhagen, Karl Michaëlsson, M.D., Ph.D., and Bengt Sandén, M.D., Ph.D.

ABSTRACT

BACKGROUND

The efficacy of fusion surgery in addition to decompression surgery in patients who have lumbar spinal stenosis, with or without degenerative spondylolisthesis, has not been substantiated in controlled trials.

METHODS

We randomly assigned 247 patients between 50 and 80 years of age who had lumbar spinal stenosis at one or two adjacent vertebral levels to undergo either decompression surgery plus fusion surgery (fusion group) or decompression surgery alone (decompression-alone group). Randomization was stratified according to the presence of preoperative degenerative spondylolisthesis (in 135 patients) or its absence. Outcomes were assessed with the use of patient-reported outcome measures, a 6-minute walk test, and a health economic evaluation. The primary outcome was the score on the Oswestry Disability Index (ODI; which ranges from 0 to 100, with higher scores indicating more severe disability) 2 years after surgery. The primary analysis, which was a per-protocol analysis, did not include the 14 patients who did not receive the assigned treatment and the 5 who were lost to follow-up.

RESULTS

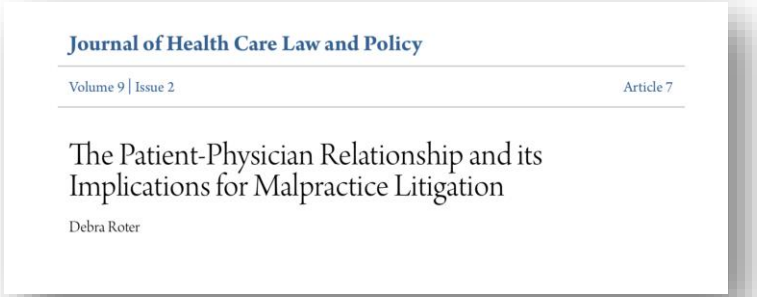
There was no significant difference between the groups in the mean score on the ODI at 2 years (27 in the fusion group and 24 in the decompression-alone group, P=0.24) or in the results of the 6-minute walk test (397 m in the fusion group and 405 m in the decompression-alone group, P=0.72). Results were similar between patients with and those without spondylolisthesis. Among the patients who had 5 years of follow-up and were eligible for inclusion in the 5-year analysis, there were no significant differences between the groups in clinical outcomes at 5 years. The mean length of hospitalization was 7.4 days in the fusion group and 4.1 days in the decompression-alone group (P<0.001). Operating time was longer, the amount of bleeding was greater, and surgical costs were higher in the fusion group than in the decompression-alone group. During a mean follow-up of 6.5 years, additional lumbar spine surgery was performed in 22% of the patients in the fusion group and in 21% of those in the decompression-alone group.

CONCLUSIONS

Among patients with lumbar spinal stenosis, with or without degenerative spondylolisthesis, decompression surgery plus fusion surgery did not result in better clinical outcomes at 2 years and 5 years than did decompression surgery alone. (Funded by an Uppsala institutional Avtal om Läkarutbildning och Forskning [Agreement concerning Cooperation on Medical Education and Research] and others; Swedish Spinal Stenosis Study ClinicalTrials.gov number, NCT01994512.)

From the Department of Surgical Sciences, Division of Orthopedics (P. Försth, T.C., P. Fritzell, K.M., B.S.), and the Uppsala Clinical Research Center (P.Ö., K.M.), Uppsala University, Uppsala, Stockholm Spine Center (P. Försth, A.F.), the Department of Learning, Informatics, Management, and Ethics, Karolinska Institutet (G.Ó., F.B.), and Quantify Research (G.Ó., F.B.), Stockholm, and Futurum–Academy for Health and Care, Neuro-orthopedic Center, Ryhov (P. Fritzell) — all in Sweden. Address reprint requests to Dr. Försth at the Department of Surgical Science, Uppsala University, SE-75185 Uppsala, Sweden, or at peter.forsth@surgsci.uu.se.

N Engl J Med 2016;374:1413-23.
DOI: 10.1056/NEJMoa1513721



Journal of Health Care Law and Policy

Volume 9 | Issue 2 Article 7

The Patient-Physician Relationship and its Implications for Malpractice Litigation

Debra Roter

« Relationships matter to both patients and physicians and the relationship itself may be the most powerful antidote to the malpractice crisis that medicine can provide. »

Roter 2006

Acta Neurochirurgica (2020) 162:1379–1387
https://doi.org/10.1007/s00701-020-04302-z

ORIGINAL ARTICLE - SPINE - OTHER

Spine neurosurgeons facing the judicialization of their profession: disenchantment and alteration of daily practice—a qualitative study

Antoine Guillain[1,2] · Anne-Hélène Moncany[3] · Olivier Hamel[4] · Carole Gerson[5] · Renaud Bougeard[6] · Grégory Dran[7] · Bertrand Debono[4]

Received: 8 January 2020 / Accepted: 19 March 2020 / Published online: 27 March 2020

Abstract

Background The judicialization of medicine can lead to professional disenchantment and defensive attitudes among surgeons. Some quantitative studies have investigated this topic in spine surgery, but none has provided direct thematic feedback from physicians. This qualitative study aimed to identify the impact of this phenomenon in the practice of spine neurosurgeons.

Methods We proposed a qualitative study using grounded theory approach. Twenty-three purposively selected private neurosurgeons participated. Inclusion took place until data saturation was reached. Data were collected through individual interviews and analyzed thematically and independently by three researchers (an anthropologist, a psychiatrist, and a neurosurgeon).

Results Data analysis identified five superordinate themes that were based on items that recurred in interviews: (1) private practice of spinal surgery (high-risk surgery based on frequent functional symptoms, in an unfavorable medicolegal context); (2) societal transformation of the doctor-patient relationship (new societal demands, impact of the internet and social network); (3) judicialization of spine surgery (surgeons' feelings about the frequency and motivation of the complaints they receive, and their own management of them); (4) coping strategies (identification and solutions for "at risk" situations and patients); and (5) professional disenchantment (impact of these events on surgeons' daily practice and career planning). Selected quotes of interviews were reported to support these findings.

Conclusions Our study highlights several elements that can alter the quality of care in a context of societal change and the judicialization of medicine. The alteration of the doctor-patient relationship and the permanent pressure of a possible complaint encourage surgeons to adopt defensive attitudes in order to minimize the risks of litigation and increased insurance premiums. These phenomena can affect the quality of care and the privacy of physicians to the extent that they may consider changing or interrupting their careers earlier.

Keywords Malpractice litigation · Practice pattern · Qualitative study · Spine surgery · Insurance liability · Burnout

This article is part of the Topical Collection on *Spine - Other*

Electronic supplementary material The online version of this article (https://doi.org/10.1007/s00701-020-04302-z) contains supplementary material, which is available to authorized users.

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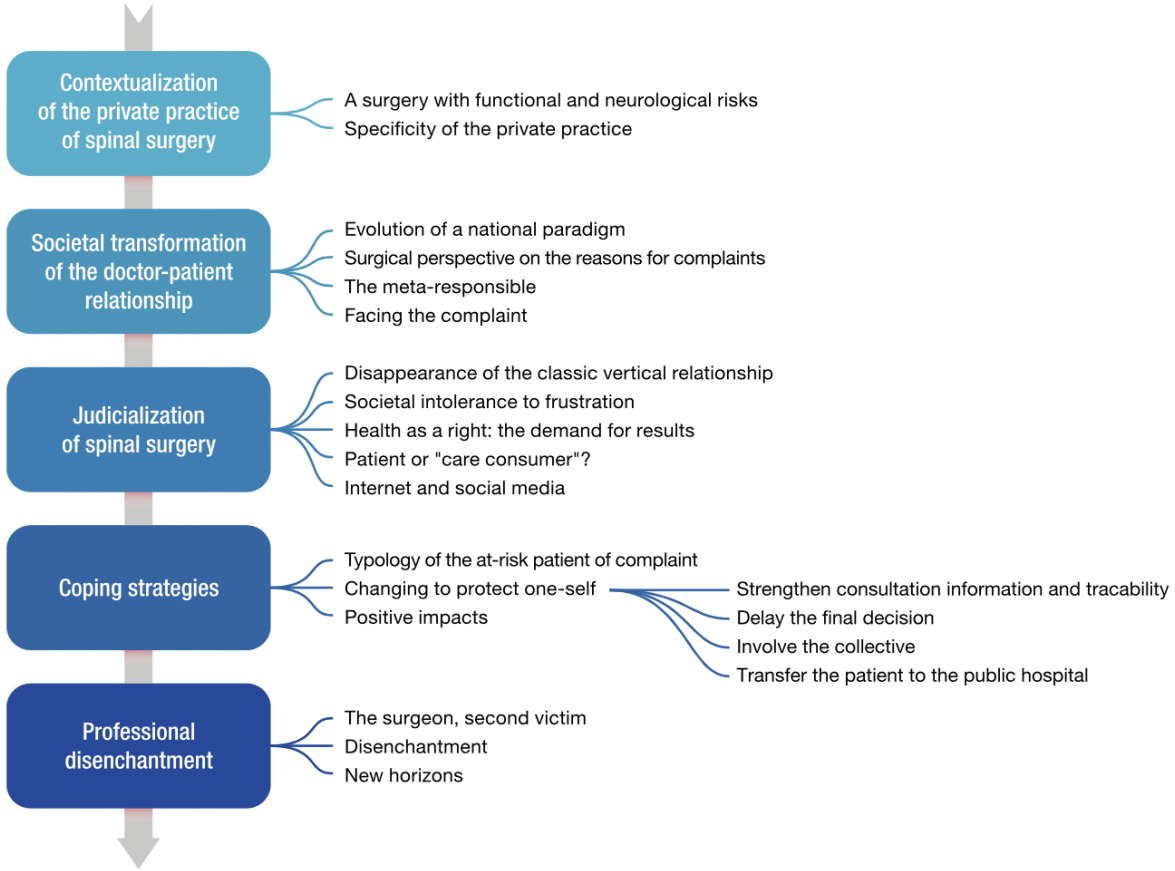

Fig. 2 Description of the main themes and subthemes

Guillain et al, Acta Neurochirurgica 2020