Reviewer's report

Title: Conditions that influence the impact of malpractice litigation risk on physicians' behaviour regarding patient safety

Version: 2 Date: 29 September 2013

Reviewer: Anupam Jena

Reviewer's report:

I read with this interest the results of this qualitative study of multiple stakeholders on what factors influence the association between malpractice risk and physician behavior.

I agree with the basic conclusions that were reached by the authors regarding the importance of complexity of care, issues around individual versus team clinical responsibility, and openness of communication in determining the impact of malpractice risk on physician behavior.

I have no major compulsory revisions or minor essential revisions.

Discretionary revisions are as follows:

It would be useful for the authors to conceptually trace out why they think malpractice suits occur and how that relates to the authors findings. For example, it seems that malpractice suits occur when outcomes are significantly severe (e.g. death or significant morbidity) AND there was an expectation by patients of a dramatically different outcome. High risk patients who present with STEMI, for example, may not expect to survive PCI (nor may their families expect it), so that if death occurs, they are less likely to feel that malpractice occurred, irrespective of whether it did or not. In contrast, nobody expects adverse outcomes in childbirth, and when it does happen, malpractice is much more likely. How does this notion of deviation from expectations tie in?

I agree with the authors that highly complex cases may, in theory, face less likely malpractice risk for the reasons I mention above. However, these cases also involve higher mortality, which in and of itself would raise the likelihood of malpractice suit. In fact, that latter effect probably trumps the former since we know that the highest risk fields are neurosurgery, cardiothoracic surgery, and orthopedic surgery.

I finally think that the authors should comment on what they mean by defensive medicine. The term is commonly used and it really refers to additional ineffective care that is provided due to threat of malpractice liability. When doctors do more as a result of malpractice risk and that 'more' is actually effective, then this is a good thing, and we should not call it defensive medicine. Cancer screening is a great example of this - more liability pressure, more appropriate cancer screening, better outcomes.
Level of interest: An article whose findings are important to those with closely related research interests

Quality of written English: Needs some language corrections before being published

Statistical review: No, the manuscript does not need to be seen by a statistician.

Declaration of competing interests:

'I declare that I have no competing interests.