Professionally Responsible Malpractice Reform

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Medical malpractice reform is both necessary and desirable, yet certain types of reform are clearly preferable to others. We argue that “traditional” tort reform remedies such as stringent damage caps not only fail to address the root causes of negligence and the adverse effects that fear of suit can have on physicians, but also fail to address the needs of patients. Physicians ought to view themselves as professionals who are dedicated to putting patients’ interests ahead of their own. Professionally responsible malpractice reform should therefore be at least as patient-centered as it is physician-centered. Examples of more professionally responsible malpractice reform exist where institutions take a pro-active approach to identification, investigation, and remediation of possible malpractice. Such programs should be implemented more generally, and state laws enacted to facilitate them.

KEY WORDS: medical malpractice; professionalism; tort reform; patient-centered.

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INTRODUCTION

Previously we argued that malpractice reform was necessary and desirable for two reasons—first, that the present system is seriously flawed; and second, that American physicians will not embrace health reform and the accompanying need for cost containment without it.¹ Urging malpractice reform, however, leaves open the question of precisely what sort of reform is needed.

We argue that stringent damage caps and other “traditional” tort reform remedies offer a unidimensional approach. They not only fail to address the root causes of negligence and the adverse effects that fear of suit can have on physicians, but also fail to address the needs of patients, both those who suffer injury due to negligence, and those who receive unnecessary care as a result of defensive practices. Physicians ought to view themselves as professionals who are dedicated to putting patients’ interests ahead of their own.² Proper malpractice

reform should therefore be at least as patient-centered as it is physician-centered. Most standard tort-reform proposals fail this test.

PROFESSIONALISM AND TORT REFORM

Physicians tend to respond viscerally to malpractice litigation.^{3,4} There are several reasons for this. For one thing, malpractice represents the intrusion into medicine of a foreign world—tort law—about which physicians have little training or understanding. Second, a charge of malpractice represents a near-total upheaval of the physician’s view of the way the world is supposed to be.

In the normal medical world, physicians see themselves as confident in their skills and knowledge. Patients come seeking assistance, and physicians respond with compassion and concern. Patients then ought to show appropriate gratitude.

The physician named in connection with a malpractice action, by contrast, is publicly accused of possessing substandard knowledge and skills. She feels as if the patient has repaid her assiduous care and concern with a rank betrayal. Anger is a common response.^{3,4} The physician’s very sense of herself as a practitioner is shaken. Physicians commonly report that a lingering consequence of tort litigation is doubting their own clinical judgment even in straightforward cases.^{3,5,6}

It seems that when patients who ought to be grateful for our care instead turn against us, our sense of professional responsibility flees. One indirect indication of this is physicians’ attitudes toward defensive medicine. A bit of careful thinking reveals that a physician’s act that is accurately labeled as “defensive medicine” represents a deviation from ideal professionalism. Our professional commitment calls for us to do what is for the patient’s benefit. Defensive medicine, *by definition*, is intended for our own benefit and only incidentally, if at all, the patient’s.^{1,7–16} Yet physicians who self-report defensive medical practices do so quite unblushingly and with no sense that their behavior could be challenged as lacking in professionalism.^{17,18} They appear not to regard practicing defensively as a *choice*; rather they appear to see it as being forced upon them by circumstances. In this way, according to common medical thinking, malpractice becomes a zone of diminished professionalism.

The typical physician’s response to malpractice deserves our sympathy; and indeed, the fact that the present system exacts such a psychological toll among decent, well-trained physicians (and not merely among “bad apples”) is itself a strong argument in favor of junking that system in favor of something

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better. But “something better” cannot be determined by dismissing professionalism.

FAIR GOALS OF MALPRACTICE REFORM

A resolutely professional approach to malpractice reform demands that measures be *clearly in the interests of both patients and physicians*—which also constitutes a fairness standard.¹⁹ The goals of reform would then include:

- Socially affordable; access of patients to needed care not threatened by high costs associated with malpractice or insurance
- Focused on error avoidance and quality improvement (which the best evidence has shown usually requires system changes rather than blaming individuals)²⁰
- Respectful to patients; acknowledges legitimate anger of avoidably injured patients and provides meaningful apologies and compensation
- Truthful; discloses true causes of injury to patients as soon as facts are reasonably known
- Psychologically supportive of dedicated physicians; encourages compassionate and open relationships with their patients rather than defensive or adversarial posture
- Efficient; the maximum possible proportion of the costs of the system actually pay injured patients appropriate compensation

We have not included “punishing bad apples” on this list even though it would be in the interests of patients generally to remove such individuals from practice. There exist other means to protect the public from repeat offenders, most notably the licensing system (which would itself require reform). There is little evidence that today’s malpractice system separates good from bad physicians reliably, fairly, or efficiently. It may be better *not* to expect the malpractice system to perform this function. If, for example, the focus should be on quality improvement and error prevention, punishing individual physicians through the same system may actually be counterproductive.²⁰

The interests of physicians and patients must be balanced and brought into alignment in reform efforts. We need to ask whether a system that is designed to be maximally patient-centered (professional) is *also* in the interests of the physician community, or whether vital physician interests are neglected. One way to address that question is to compare our “professional” list of goals with the tort reforms most commonly advocated by medical organizations.

PHYSICIAN-CENTERED TORT REFORMS

The sorts of tort reforms commonly advocated by physicians include limits on or elimination of contingency fees, damage award caps, and a shortened statute of limitations.^{16,21} If the goals listed above are “pro-patient,” then these proposals are instead “anti-plaintiff.” The object appears to be first, to protect physicians by limiting the number of malpractice suits filed; and second, to punish the lawyers who are blamed for the malpractice “crisis” by their alleged penchant for filing frivolous suits.

In our previous commentary we noted that physicians and health policy analysts commonly talk past each other about malpractice.¹ One reason for this (we frankly concur with the analysts) is that physicians who support traditional tort reform appear to misunderstand the empirical facts. There is no good evidence that periodic malpractice “crises” are caused by sudden increases in the number of lawsuits, and much evidence to show that these crises relate to insurance industry business cycles.^{19,22,23} When measures such as damage caps have been implemented, they do not distinguish between meritorious and frivolous suits. Given the psychological reactions physicians have to the malpractice threat, it is not surprising that relatively punitive “reforms” would be recommended. But empirically informed policy analyses warn that they are unlikely to have the desired consequences.^{24,25} At present, there is little if any reliable and reproducible evidence that these punitive tort reforms have reduced health care costs attributable to defensive medicine in the states where they have been enacted.^{1,14,25,26}

It seems, therefore, that tort reforms that physicians have singled out as being in their own interests (though commonly argued for in the rhetoric of the larger public good) would not necessarily have any of the hoped-for consequences. These reforms might succeed in deterring lawsuits generally, but only at the price of eliminating meritorious suits alongside the frivolous ones. This gives us all the more reason to explore reforms that are arguably more in the interests of patients, to see whether they might, in fact, advance physicians’ interests at the same time.

PURSuing PATIENT-CENTERED REFORM

Mello and Gallagher describe “disclosure-and-offer” approaches,²⁷ two variants of which are presently used by one or more private health institutions or insurers in the U.S. The first offers tightly limited “reimbursement” to patients for expenses and loss of time due to iatrogenic injury. It is available only when fault cannot clearly be ascribed to the provider, and does not foreclose the possibility of suit. The second functions like an arbitration system. The provider only offers settlement of injury, lost wages, lost time, and other damages if its investigation finds that the care provided was likely negligent, and if the patient agrees not to sue if she accepts the settlement. Mello and Gallagher find both promising, despite the systems’ patchwork nature, potentially problematic power dynamics, and difficulty in effective evaluation.

Evidence suggests these alternatives can make tremendous strides toward not only eliminating the “roulette” qualities of the tort system, but also in increasing trust and reconciliation between providers and patients and improving patient care – advancing the goals of professionalism while decreasing the likelihood, costs, and unpredictability of litigation. The University of Michigan Health System [UMHS], for example, realized significant declines in claims, lawsuits, and costs after adopting a medical error identification and disclosure system in 2001.²⁸ Its pro-active approach, similar to a successful program pioneered by the Lexington, Kentucky Veterans Administration hospital, identifies patient injuries, investi-

gates them internally and, where the investigation reveals avoidable error as the cause, offers a settlement to the patient and institutes quality control measures to help prevent a similar error in the future.²⁹ With program implementation, UMHS's monthly lawsuit initiation rate dropped from 2.13 per 100,000 patient encounters to 0.75 per 100,000. Resolution times decreased, and, while costs of claims that did not proceed to lawsuit remained largely unchanged, liability costs for claims going to suit declined from an average of over \$400,000 to just over \$225,000. The authors of the study believe much of the savings resulted from increased resources and attention devoted to patient safety improvement.²⁸

UMHS offers this program despite Michigan's lack of an "apology law" that protects from liability when a provider expresses sympathy for an adverse outcome.³⁰ Rather, UMHS probably relies on its good reputation in the local legal system. Ample trust and goodwill generated through a good reputation is likely worth more in practice than the anonymous protection of a law. It suggests, however, that a disclosure system such as UMHS's may function best for large health care entities. If a health provider is so small that it only rarely encounters avoidable error claims, it may not have enough contact with the legal system and local plaintiffs' attorneys for its diligence and honesty in claims investigation to be assumed or trusted. Further research would be necessary to investigate this issue. Additionally, some larger providers may, despite future good intentions, be saddled with substantial community mistrust due to prior practices.

For such entities, it may be advisable not to adopt a disclosure program voluntarily, but only after a state has adopted a legal framework for doing so. Appropriate legislative frameworks enacted at the state level are generally superior as public policy to piecemeal approaches. While awaiting the passage of state laws protecting disclosure, more vulnerable institutions may get a head start toward professionalism by improving and expanding their internal safety and quality assurance mechanisms. The results of several of the medical liability reform demonstration programs recently funded by the Department of Health and Human Services under the Patient Protection and Affordable Care Act may offer some insights into next steps.³¹ Encouraging results should be quickly translated into broader action.

Examples such as UMHS demonstrate a clear path forward toward systems which embody the highest standards of physician professionalism, and which simultaneously possesses most of the features required to meet physicians' own vital interests. Because the systems are demonstrably patient-centered, they ought to gain the support of a wide public coalition.

CONCLUSION

Physicians generally take their professional obligations to patients very seriously, as a burgeoning literature in medical professionalism demonstrates.^{32, 33} Malpractice reform, however, has been traditionally addressed by physicians outside the ongoing conversation about professionalism. The time is overdue for the medical community to rally behind comprehensive proposals for malpractice reform that adhere to the highest professional standards. By doing so, physicians will

neglect none of their own vital interests, but may greatly expand their coalition of supporters.

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