

Malpractice Reform Must Include Steps To Prevent Medical Injury

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In the current malpractice insurance crisis, physicians have focused their advocacy and energy primarily on rapidly increasing liability premiums; problems in access to care; and demands for legal reform, especially caps on damages. An even more important focus, however, is prevention of injury and improvement of patient safety. Physicians largely control patient care and can play a critical role in systematically reducing injury. Reforms should go beyond liability issues; they should also harness and enhance physicians' ability to act. More visible efforts by physicians to

reduce harm, better communication with patients and others, and true evidence of improved patient safety should reduce patient anger and litigiousness. Individually and collectively, physicians can and should ensure that "doing no harm" comes first in the malpractice debate.

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The latest malpractice crisis has affected most U.S. states, sometimes leading to physician job actions and almost always resulting in political action. Steep increases in malpractice premiums come atop stagnating fees, and some physicians report dropping certain types of practice, retiring early, or relocating, all of which raise concerns about access to care. Physician groups also promote legislative caps on "pain and suffering" awards and other tort reforms (1, 2).

The heated debate on insurance costs and legal change has cast little useful light on how much physicians can contribute to making care safer and injuries rarer. Reforms that fail to harness the intellect and energies of physicians to address the largest problem—patient injury—miss a central cause of claims as well as a central issue for better health care.

A SYSTEM IN PAIN

The medical liability system needs fundamental improvement (3, 4). Large numbers of Americans suffer preventable medical injuries (5), although the exact tally is disputed (6). Moreover, the current legal system provides too little help, either in covering injured people or promoting patient safety. Most negligently injured patients do not sue, and many litigants suffered no negligence (7, 8). Any compensation provided arrives slowly and with high overhead costs (9). Fear of litigation may make some physicians more careful or promote new guidelines (10), but systemic improvement is undocumented (11), and the existing system has presided over the current rate of preventable injury. This fear also prompts unnecessary medical tests, procedures, and referrals ("defensive medicine") (12), and quality reformers complain that the "tort system poisons the openness and honesty that are preconditions to safety improvement" (13).

Like patients, physicians feel poorly served. They typically think that liability determinations are unscientific and premiums excessive. Malpractice premiums have increased sharply, doubling within 1 or 2 years in some localities or specialties. The increasing cost of claims seems the predominant reason, especially given the large variation in circumstances from state to state (2). Also implicated are

insurers' decreasing investment returns and increased reinsurance premiums (14). Previous rates had been unusually low, owing to high competition for market share in the 1990s. Since then, many companies have gone bust or pulled out, causing crises of availability in some areas and affordability problems in many more.

Problems seem less severe where legal risks are perceived to be lower, whether because of successful tort reform or a less litigious culture (15). Some state tort reforms demonstrably hold down claims trends and premiums (16–18) and may improve physician supply (19). More states have recently enacted caps and other reforms, but both houses of the U.S. Congress seem unlikely to agree (20), and such reforms by themselves can achieve no fundamental changes that promote patient safety.

The liability system thus works poorly for patients and physicians. A fundamental change in the system is warranted to improve compensation and promote patient safety (9, 11, 21, 22). Although broad legal change seems very unlikely in the current political climate, we believe that even within the current system, physicians can and should do more to promote patient safety and reduce harm to patients.

PHYSICIANS: THE KEY TO IMPROVEMENT

Physicians can play a critical role in finding, developing, researching, and implementing safety improvements. Encouraging reports abound from physician groups, hospitals, medical societies, physician-run liability insurers, foundations, associations, and government (23–25). Collective physician effort was especially successful for anesthesiology. In the mid-1980s, high malpractice awards made anesthesiologists pay very high premiums that were increasing even faster than those for other specialties. After the American Society of Anesthesiologists adopted practice guidelines to reduce patient harm (10), deaths and premiums both decreased dramatically. The 2002 average premium was \$18 000—about the same as in 1985 (26) and much lower than for most specialties. Anesthesia is the only health sector to achieve "six sigma" quality, or fewer than 4 deaths per 1 million exposures, the same maximum rate of defects routinely achieved by such corporations as

General Electric and Motorola (27). In contrast, a surgical instrument or sponge is left in 1000 to 1500 surgical patients each year (28)—more than 15 times the six sigma rate.

Our emphasis on the key role of physicians is not inconsistent with findings by patient safety experts that effective improvement requires fixing organizational systems rather than blaming individuals (5, 29). Achieving systems improvement, even within institutions, presupposes cultural change among physicians, and learning about safety requires input from those on the frontlines of clinical care, including physicians (30). Few inpatient changes can succeed against even passive resistance from clinicians, and changes in the physician's office clearly depend on responsible physicians (31). Physicians must take more responsibility for systems safety as well as for clinical quality. They already place "overwhelming importance" on sharing in decisions and power when they affiliate with hospitals or large group practices (32), but they seldom lead systematic safety improvement efforts. Traditional, case-by-case peer review is not enough, and physicians cannot leave safety to "systems people." Physicians must advocate for and participate in internal organizational change, and other health care leaders can work effectively with physicians to achieve organizational change (33).

FACILITATING PHYSICIAN ACTION

Both sides in the current malpractice battles call for more public intervention: physicians for more tort reform, trial lawyers for tougher discipline. It is therefore appropriate to suggest how legislation or regulation might encourage physicians to promote patient safety, through individual or collective effort. Potential motivators include "carrots and sticks" and development of better information sources to support and facilitate change. We present a few examples below.

A standard "stick" is licensure requirements. In response to the malpractice crisis of the 1980s, the Massachusetts Board of Registration required physicians to devote some continuing medical education credits to learning risk management. Qualifying activities included seminars about improving patient communication and office practices. These are important to address because one fifth of adults report difficulty in communicating with their physician (34) and most physicians' offices do not track receipt and follow-up on results of diagnostic tests, referrals, or procedures.

In the long run, better quality and safety can save money (35). Up front, however, time, effort, and financial investment are required. Thus, one "carrot" might be premium discounts on malpractice insurance. These could be ordered by insurance regulators, contingent on specific performance by physicians. The success of discounts from private insurers is mixed, and more study is needed of the amount and implementation of such discounts. Alternatively, a state might make legislative tort reform contingent on reporting of errors by beneficiaries or implementing

specific activities that increase patient safety (36). Similarly, although most attention in the malpractice debate has been on legislative reforms, another consideration is urging changes in payment practices. Health plans, Medicare, and Medicaid could subsidize a portion of physicians' malpractice premiums in return for specific enhancements to patient safety.

A key challenge is to determine what standards to set for performance. Decision makers need to know what efforts probably bring lasting benefit to the public or profession. Possibilities include risk management training (such as that in Massachusetts), investments by physicians in useful tools (for example, decision-support tools, electronic prescribing aids, automated systems for tracking of tests, test results, and appropriate follow-up), participation in approved quality improvement or patient safety activities in hospitals (for example, simulator training or team training for emergencies and procedures), and periodic participation by physicians in a review of their practice and performance that includes structured input from peers and patients. Achieving active physician participation and progressive improvement of patient safety will require continuous monitoring and updating of any requirements set over time.

Better information on patient safety would facilitate improvement and physician involvement, both by making private action easier and cheaper and by helping regulators to decide whether and how to set standards. Government can facilitate generation of information for performance improvement in several ways. One is assuring the confidentiality of cross-organizational sharing of incident reports (5). This would extend the removal of legal regulatory barriers, such as now occurs under state statutes that protect good-faith intra-institutional peer review from "discovery" in court cases. Another is performing or funding more research on improving patient safety and on physician roles in improving patient safety.

A BETTER SYSTEM

More active work on the part of physicians to improve care and reduce harm is clearly in the best interest of the public. Ultimately, it also is in the best interest of physicians. In a culture in which physicians actively seek to guard and improve patient safety and learn from problems, talking with patients about those problems is easier and patients are likely to be more forgiving. Avoiding liability claims or reaching reasonable settlements becomes more likely. As the public at large appreciates that health care is becoming much safer, poor outcomes should be seen as less likely to result from medical error. Anger and litigiousness should decline. For all of these reasons, reduction of harm should be an essential part of any reform of medical liability or discipline. Physicians can undoubtedly devise successful mechanisms to harness their considerable knowledge and skills to reduce harm. They can be effective by working individually or collectively within medical organi-

zations or specialty societies, sometimes along with law-makers, malpractice insurers, hospital representatives, and payers or insurers. Simply capping awards applies a Band-Aid to the increases in premiums now bleeding many physicians, while leaving patient wounds unattended.

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