Medical Professional Liability and Health Care System Reform

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Few issues elicit more emotion from physicians than medical malpractice. The very word “malpractice” implies guilt and immediately places the involved physician on the defensive. Defensive medicine adds 5% to 9% to the cost of medical care. Numerous solutions have been proposed, but special interests have blocked the implementation of these solutions in most states. Tort reform is necessary to control the escalation of medical costs.

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The concern about medical professional liability is widespread and pervasive, yet it remains notoriously difficult to access objective data about specific claims. Insurance carriers typically advise physicians to avoid open discussions about their cases, because such discussion could be discoverable. Individual cases are often quietly settled, and national databases like the National Practitioner Data Bank provide only sketchy information about the specific circumstances of each case. A report published in the American Journal of Cardiology provides useful information about medical professional liability claims, increasing our understanding of the issue as we look for ways to reform our health care system (1).

The paper summarizes data prospectively collected by the Physician Insurers Association of America over approximately 22 years. With information on 230,624 closed claims, this is one of the largest sources of data on malpractice claims available. It provides details regarding the type of physician involved, the type of claim, and the results of each claim. However, the database also has important limitations. It includes few claims against physicians in large groups or academic centers, who are generally self-insured, and it lacks information about the demographic data of the entire population of insured physicians. And, unfortunately, the database does not provide sufficient detail to tell the story about how a physician’s behavior is affected by a malpractice claim (2). Nevertheless, it adds needed information and enhances our understanding of medical professional liability litigation.

Interestingly, of the 4,248 closed claims involving cardiovascular physicians, only 18% were paid, as compared with 30% of the claims involving all physicians. This low rate of paid claims in both groups of physicians is open to interpretation but tends to support the notion held by physicians that many claims are frivolous and the malpractice system is capricious.

Among claims involving cardiovascular physicians, the most common allegation was diagnostic error, and the most common diagnosis was coronary artery disease. Diagnosis of aortic aneurysm or dissection was uncommon but had a high rate of paid claims (30%) and a very high average payment ($417,298, as compared with the average for all claims of $248,291 for cardiovascular physicians and $204,268 for all physicians). Of claims involving cardiovascular physicians, 53% involved a death, of which 21% were paid claims. These findings reflect the realities of cardiology practice: diagnosis of cardiac disease is often difficult, coronary artery disease is common, aortic disease can be obscure and catastrophic, and cardiac disease is life threatening. For all specialties, the total indemnity paid over the time period was $13.9 billion, reminding us that malpractice litigation is an expensive and pervasive part of medical practice.

This report comes at a time when our country is struggling with spiraling health care costs. Every physician knows that defensive medicine adds wasteful spending to health care costs through increased referrals, additional testing, and
over-interpretation of diagnostic tests. In a survey of 824 physicians, 93% of physicians reported practicing defensive medicine (3). A visit to any emergency room would confirm this. Headaches almost always prompt a computed tomography scan, and the complaint of chest pain consistently triggers some form of an imaging study. This “assurance behavior,” ordered by emergency physicians with no financial gain from the added test, is clearly driven by defensive medicine. Defensive medicine affects all practicing physicians who are acutely aware that behavior patterns based on the fear of litigation often add little to the care of the individual patient but add greatly to the financial costs to society. A recent commentary effectively emphasized this point (4). Although caps on noneconomic damages can contain the direct costs of malpractice premiums, more fundamental reforms are necessary to affect the psychology of defensive medicine that drives costly overuse (3).

Surveys and reports (3,5,6) have suggested that defensive medicine is significant and might add as much as 5% to 9% to overall health care costs. An often-quoted Government Accounting Office report (7) has disputed this assertion, stating that these reports are limited and not sufficient to be generalized to the overall health care costs. However, it is important to note that the Government Accounting Office report provides no contrary evidence to suggest that defensive medicine is not as prevalent as the prior reports have suggested.

There are other insidious and deleterious effects of practicing medicine in an overly litigious environment. Defensive medicine creates the suspicion that any patient or family is a potential litigant, diminishing trust and causing severe damage to the doctor-patient relationship. Furthermore, when doctors err, they are reluctant to apologize to patients and their families for fear that an apology could be viewed as an admission of guilt.

The threat of malpractice litigation and the perception that the system is unfair creates reluctance among physicians to report near misses, errors, and negligence. The adversarial nature of the current system is fixated on retrospectively fixing blame rather than prospectively repairing systems to prevent future error. In 2006, Senator Barack Obama, along with his fellow Senator Hillary Clinton, authored a 2008 New England Journal of Medicine paper calling for the creation of a National Medical Error Disclosure and Compensation program to open lines of communication and reporting of medical errors (8). Yet, we remain hunkered down in a defensive mode, lacking effective methods to address avoidable medical errors.

Many reforms have been proposed to improve the fairness, consistency, reliability, and predictability of medical professional liability litigation (9). One proposal would place the judgment of complex medical malpractice claims in the hands of experts. Cases could be judged in specialized health courts, which are tribunals of judges with expert training in medicine. Alternatively, administrative panels could judge cases on the basis of testimony by neutral experts who are hired by the administrative panel rather than by the litigants. Either system would avoid arbitrary and emotional judgments rendered by juries with little or no medical sophistication. Such a system also has the potential to quickly resolve legitimate claims, resulting in more rapid payment to the injured patient or family. Other necessary reforms include repeal of collateral source rules and allowing structured payments of claims, both of which mitigate the economic effects of large awards without negatively affecting the compensation of injured patients. Also, screening panels and certificate of merit laws could reduce the number of meritless lawsuits that reach the courtroom.

Another proposal for fundamental reform would create a “safe harbor” for physicians if they were practicing according to nationally-published guidelines. This proposal would create a rebuttable presumption that physicians acting according to accepted clinical practice guidelines were acting within the standard of care. This proposal would not only increase the fairness of medical malpractice litigation, it would elevate the importance of evidence-based medicine and increase the impact of clinical practice guidelines, appropriate use criteria, and the results of comparative effectiveness research. This proposal would emphasize the important concept that unanticipated poor outcomes do not imply negligence. Our legal system needs to clearly define this important difference, no matter what reforms are ultimately adopted.

Despite the broad scope of the recently passed health care legislation, further reforms will be required to adequately correct our medical professional liability system. Former Democratic Senator Bill Bradley called for linking malpractice reform with universal coverage as a way of achieving bipartisan support for health care reforms (10). Perhaps through amendments to the recent legislation and through further legislation, Senator Bradley’s hopes can be realized. Fundamental malpractice reform should be included in health system reform to avoid the ongoing financial and emotional costs to our country and our doctors. More importantly, such reform is essential in helping to provide the best care for our patients without exposing them to unnecessary procedures and without compromising the care of the highest-risk individuals. We need fundamental malpractice reform so that we can get back to practicing medicine based on scientific evidence and sound medical judgment.

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