Allegations: Current Trends in Medical Malpractice, Part 1

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In part 1 of this 2-part series, the authors review recent trends in medical malpractice, with a focus on alternative proposals to traditional tort law.

We're lost, but we're making good time.
Yogi Berra

As Yogi Berra alludes, it is very easy to get caught up "in the flow" and continue to move along at a good pace, even when one does not know where he or she is ultimately headed. Similarly, in terms of medical malpractice, everyone seems to have an opinion on what should be done to improve the climate of medical malpractice for both providers and patients. Yet, there are many differences in opinions on how to solve

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these issues, and the "cure" for what "ails" in the system are many—with an undetermined endpoint.

Tort reform is often conjured as the communal fix; yet each state in the Union has its own medical malpractice tort laws, which begs the question of how an issue with so many different facets can be resolved. Additionally, the risk alone of medical malpractice continues to be an important area of concern to emergency physicians (EPs), not only because of the looming threat of malpractice litigation—both real and perceived—but also because of its influence on practice patterns, resource utilization, and patient care in the ED.[1,2]

Physician Perception

Over the course of a career, an EP faces at least one claim, further perpetuating a common physician perception that the occurrence of a suit is not a condition of "if" but rather of "when."[3] This anxiety and fear among physicians in general are further provoked by the many headlines highlighting massive jury verdicts that dominate the news cycle.[4]

In addition, the EP's work and practice are increasingly affected by the impositions of multiple nationally reported quality metrics, institutional throughput goals, and process-improvement efforts. Each of these in turn has the effect of increasing the pace of care and can challenge one's real-time ability to recognize the dangers of inherent biases, to appreciate and act upon subtle clinical clues, and to rescue patient-experience misadventures. Accordingly, medical malpractice is a frequent topic of discussion for policy proposals among physicians and legislators.

Defensive Medicine and Tort Reform

As spending on health care in the United States topped $3 trillion, or 17.5% of the US gross domestic product in 2014, strategies for cost-containment have become a primary concern across all sectors of the health-care industry.[5,6] With defensive medicine proposed by some as a substantial driver of health-care costs, many physicians have focused on tort reform as an avenue to curb defensive testing. This has resulted in substantial policy shifts in a number of jurisdictions.[7,8] Some of the policy changes that have taken place over the past few decades have included state-imposed caps on medical malpractice awards and noneconomic damages, caps on attorney fees, and shortened statutes of limitations that require more timely filing of malpractice suits.

Defining Malpractice and Imposing Caps

In 2003, Texas changed its definition of the medical malpractice standard to "willful and wanton negligence"; in Georgia (2005) and South Carolina (2005) the definition was changed to "gross negligence." Both of these revised definitions are essentially synonymous in a legal sense and are intended to protect physicians working in a high-risk, limited-information, high-intensity environment (eg, the ED) by raising the plaintiff's responsibility to prove that the defendant physician was aware of the likelihood of serious injury but proceeded with "conscious indifference."[9]

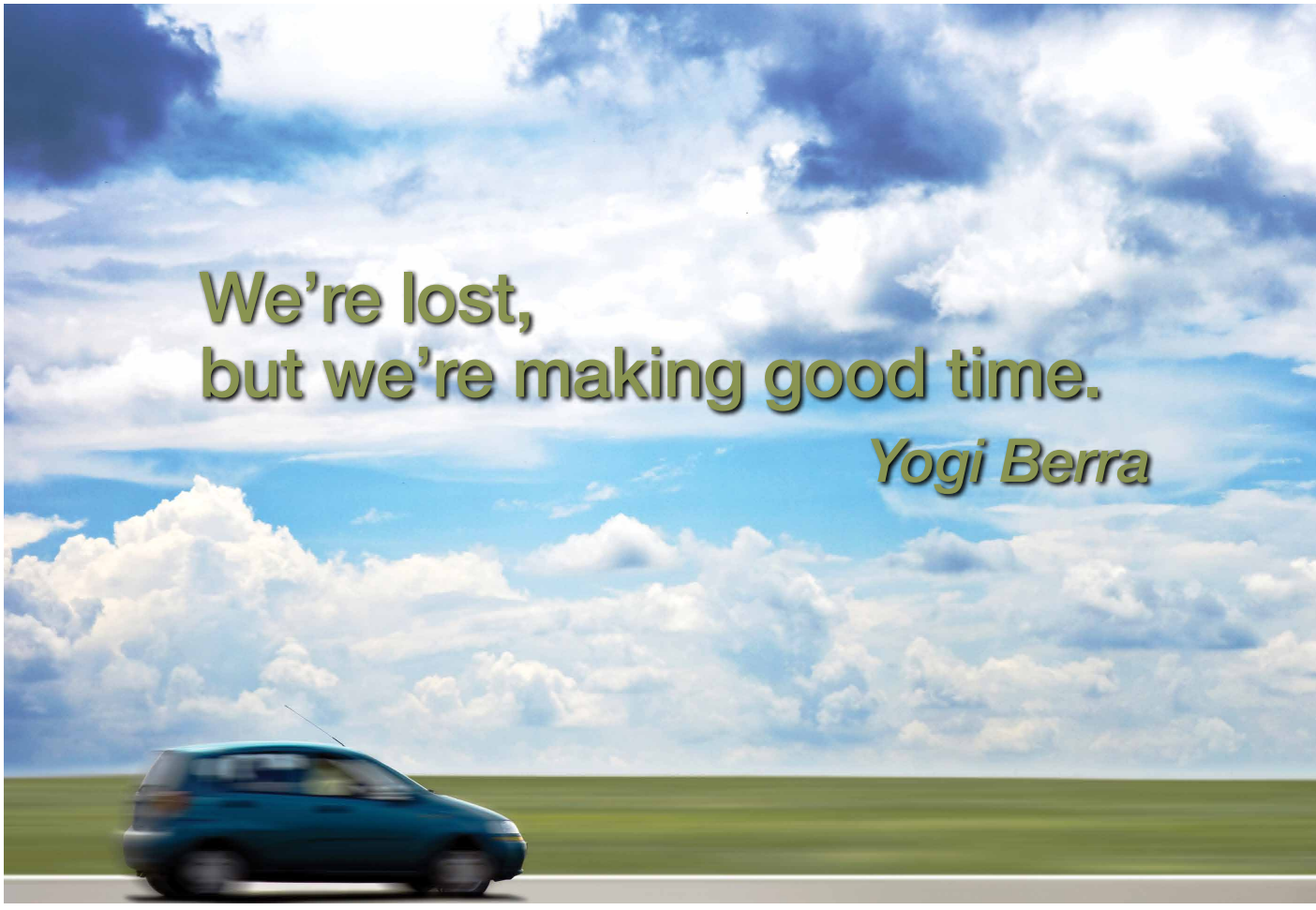
It seems, however, that such efforts have been not been entirely effective in reigning in costs of care, decreasing insurance costs, and limiting defensive medicine, particularly in the ED.[9] A study by Paik et al[10] on the effect of caps on malpractice claims and payouts found that in states with caps, both claims and payouts were effectively reduced, with a large impact on payout per physician and a drop in claims for those cases with larger payouts. While stricter caps had larger effects, the authors did not examine the impact of caps on "defensive medicine."[10] Furthermore, many physicians, health systems, and patient advocacy groups have been exploring and implementing alternative models of claim resolution outside of the legal process.[11]

Alternative Compensation Models

In the state legislatures of Georgia and Florida, alternative patient-compensation models are currently under proposal. Both models are designed to eliminate the current medical tort system and replace it with an administrative system to compensate patients for medical errors that have caused them harm.[12] These proposals are similar to the existing Birth-Related Neurological Injury Compensation Programs (BRNICP) in effect in both Florida and Virginia. The BRNICP in each of these states serves as an administrative system to provide monetary compensation to patients who have clearly suffered only birth-related medical injuries, thus keeping this type of liability out of the court system.

Program Structure

Compensation programs such as the BRNICP in Florida and Virginia would replace traditional tort law. In this system, physicians would pay annually into a compensation fund (as do the physicians in Virginia and Florida), with amounts prorated to liability risk based on practice specialty. A patient harmed by a claimed medical injury that was allegedly caused by the proximate treatment rendered, would apply to the patient compensation system via a designated patient advocate. The advocate would initiate the claim process on behalf of the patient, after which the claim would be reviewed by a panel of medical experts in the appropriate field. If the panel finds the injury was preventable



or avoidable, the case would then proceed to a compensation committee to render payment to the injured individual.

This compensation model not only eliminates the need for legal counsel for the patient, but also the need for medical malpractice liability insurance and defense counsel for the physician. Unlike traditional tort law, this alternate process encourages a system of transparency that supports appropriate disclosure of medical error rather than delaying late discovery of error and increased angst both for the patient and the physician.

Challenges to these bills [that propose alternate compensation models] include resistance from those who may be adversely affected by such legislation—mainly medical malpractice trial lawyers (both plaintiff and defendant) and medical malpractice insurance companies.

Potential Benefits

One would anticipate that an alternate compensation model such as the BRNCIP that eliminates the fear of a lawsuit (ie, if patients no longer sued physicians for medical malpractice) would have a significant impact on defensive medicine and its associated costs. A study conducted by Emory University concluded that as much as $7 billion in the state of Georgia could be saved each year if such a program was enacted.[13] In addition to the financial benefits, the care of all patients would improve through increased efficiency and better appropriation of finite resources. Moreover, patients harmed in a medical mishap would have a more direct, expedited, and less expensive mechanism of compensation compared to traditional tort systems.

The alternate compensation model would also benefit patients by negating the need for legal counsel. In the current tort system, many cases go unaddressed either because the patient does not have the means to hire counsel or the case seems too inconsequential for a lawyer to accept it. The compensation system would improve access for patients with valid claims, from egregious high impact errors to the lower impact errors, which are still significant.

There are also public health benefits to the alternate compensation model, including advances in patient safety as a result of the transparency of medical error and addressing medical mishaps in a timelier manner, providing an opportunity to improve knowledge and system gaps closer to real-time events. No longer would a patient have to forge an adversarial offensive on a physician. The panel of experts, who becomes the peer of the physician, can fairly assess the conditions of the case and bring forth an impartial recommendation to either reimburse or not reimburse the patient.

By eliminating the punitive nature of tort law upon the physician, and because this system compensates through a state-based compensation program, there is no indelible report made naming the physician to the National Practitioner Data Bank. Further, if a provider is identified as a significant risk to the public, the panel of medical experts can report that physician to the state licensing board immediately, which would prove more effective and efficient than the traditional method of data collection and referral currently in place in most states.

Challenges

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Conclusion

In consideration of innovative solutions to medical malpractice reform, the efforts in the states of Georgia and Florida clearly think outside the box. Neither of these proposed solutions is currently operational, but certainly if they become state statutes, they will create a very interesting environment to observe while the effects of such systems play out. The operations of the birth-related injury funds have been successful in states that have already implemented such programs. In the meantime, pending such changes in policy and legislation, EPs can mitigate malpractice risk by maintaining board certification and specialty training requirements, and by employing the following:

- Follow the basic principles for every patient. Vital signs are vital for a reason, and all abnormal data must be accounted for;
- Maintain open communication with patients—a paramount component in reducing the risk of a malpractice allegation;
- Ensure that all members of the care team engender an environment that is focused on patient safety, including open communication with nursing staff and technical support;
- Be aware of inherent biases in medical decision-making, which helps to maintain mindfulness in the routine practice of emergency medicine (EM);
- Make sure departmental policies and procedures are designed to identify and address all late resulting laboratory results, radiology reading discrepancies and culture results in a timely and uniform manner; and
- Provide clear and concise at-home care instructions to patients—prior to discharge—and in a manner the patient can understand.

Part 2 will discuss each of these recommendations in detail and will consider recent trends in medical malpractice as they relate to EM, explore areas of risk, and discuss strategies to reduce medical malpractice risk in the ED.

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