PREVENTION SHOULD BE THE PREFERRED INSURANCE PROGRAM FOR ALL PHYSICIANS

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In Brief • En bref

Recent fee increases announced by the Canadian Medical Protective Association (CMPA) and the Ontario government's plan to stop its CMPA-rebate program for the province's physicians have put the spotlight on medical liability insurance. In this examination of the role played by the CMPA, Ottawa lawyer Karen Capen notes that quality service and attention to physician–patient communication will in most cases ensure a litigation-free professional life.

Les hausses récentes des frais annoncés par l'Association canadienne de protection médicale (ACPM) et le plan du gouvernement de l'Ontario de mettre fin à son programme de remboursement de primes ACPM aux médecins de la province ont attiré l'attention sur l'assurance responsabilité médicale. Dans cette analyse du rôle joué par l'ACPM, Karen Capen, avocate d'Ottawa, signale que le service de qualité et l'attention portée à la communication médecin–patient garantiront dans la plupart des cas une vie professionnelle sans litige.

Practice liability is an important consideration for Canadian physicians. This was highlighted recently when the Ontario government announced it would stop the Canadian Medical Protective Association (CMPA) dues-rebate program for physicians. (Eight provinces have separate rebate programs, while Saskatchewan has never had one. In Alberta, the Alberta Medical Association will now decide on the allocation of funds in its global budget.)

The original arrangement in Ontario was negotiated in 1987 by the Ontario Medical Association (OMA) and the Ministry of Health. At the time the OMA created a fund comprising the government's contribution and a matching amount from the global physician budget. Since 1991, the OMA-administered fund has reimbursed physicians for 100% of the CMPA fee difference from the years 1986 to 1991.

Under the new proposal the government said it will consider helping physicians who pay the highest annual fees. Assistance might include short-term exemptions or partial subsidies for those who provide certain specialty services.

The Ministry of Health said it was substantially reducing its funding in order to:

- ensure that CMPA premiums are reasonable and reflect actual costs;
- make physicians and the CMPA directly accountable to one another;
- lessen the difficulties for physicians who perform procedures that require high fees; and
- ensure that CMPA fees do not adversely affect practice patterns and professional specialty preferences.

A recently announced increase in CMPA membership fees has also brought practice-liability issues to the forefront. Last fall, the CMPA informed physicians that there would be substantial increases in membership dues in 1996, particularly within some specialties; the average increase would be 20%. It said the increase was necessary because its reserve-for-claims target is a fully funded position; there had been no increase in 1994 and only a partial increase in 1995 because of the economic difficulties many members were facing.

Most physicians know that the CMPA is a physician-owned and operated mutual-defence organization, and not an insurance company. It was incorporated in 1913 and for many years has included more than 90% of practising physicians in its ranks. Membership benefits include advice on general legal matters affecting medical practice and legal counsel during lawsuits, coroners' inquests, complaints and disciplinary proceedings, billing disputes and other inquiries, as well as the pay-

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ment of legal fees, settlements, awards and costs in legal actions.

The CMPA helps physicians on an "occurrence basis," which means that in order to be eligible the physician must have been a member of the CMPA at the time the professional work that is being questioned occurred. Neither a retired physician nor the estate of a deceased physician is required to maintain membership in order to benefit from the CMPA's services.

The CMPA fee schedule for 1996 ranges from annual fees of $900 for clinical fellows, interns and residents to $23 340 for obstetricians and $22 440 for neurosurgeons and orthopedic surgeons. Of 63 categories within the fee schedule, only 13 specialty groups are required to pay more than $5000 per year: anesthetists, obstetricians, otolaryngologists, neurosurgeons and urologists, as well as cardiovascular, general, gynecologic, orthopedic, pediatric, plastic, thoracic and vascular surgeons.

Last fall, the CMPA explained the fee increases in a newsletter: "The volume of work . . . about which members seek assistance has increased significantly, and the cost of providing that help has risen substantially. . . . By its increasingly frequent use of structured settlements the Association seeks to take advantage of sometimes quite significant savings. By its participation in a court-initiated Alternate Dispute Resolution Pilot Project [we hope] that at least some legal actions can be brought to a conclusion well short of trial.

"However, there are elements of court awards and settlements over which the CMPA has no direct control. Items such as the cost of future care over the lifetime of a very seriously disabled patient can account for millions of dollars, especially when a court determines that a patient requires care in a specially constructed and equipped home [from] highly trained personnel employed around the clock."

The CMPA has been facing more claims — the number has risen from 908 claims in 1990 to 1208 in 1994, an increase of 33%.

The 1996 fee increase and the Ontario government's proposed action called attention to a serious problem, since physicians' overall incomes are limited and cannot necessarily rise at a comparable rate. Still, no physician would want to practise without CMPA membership or comparable commercial coverage.

Professional liability and compensation issues have been widely studied since the 1980s, when there were indications that Canadians would begin to see a marked increase in the frequency and severity of medical malpractice claims. The Prichard Commission's 1990 report, *Liability and Compensation in Health Care*, contained seven main findings:

- There had been a significant rise in malpractice claims in the 15 years preceding the report.
- The increase occurred even though there were no changes in laws governing liability.
- The increase was accompanied by increased "insurance" costs for physicians and health care institutions.
- Medical malpractice litigation is expensive, with more than 50% of expenditures going to legal expenses, not compensation for the injured party.
- A higher quality of health care services was being provided than would have occurred without the threat of litigation.
- Despite the increase in litigation, less than 10% of persons who have viable claims receive compensation.
- Without policy changes, claims would increase over the next decade.

Two of the Prichard Commission's 79 specific recommendations are particularly relevant in light of current concern about Ontario's plan to eliminate the rebate program. The commission said the main source of medical liability "insurance" should be noncommercial to ensure that premiums or fees reflect Canadian law and costs, and that governments should be prepared to negotiate shared responsibility for the increased costs of "insurance" premiums or fees for physicians.

In fact, the CMPA's 1994 annual report states that "while it is to be expected that there will be an increase in the number of legal actions each year, there is no evidence of a medical malpractice crisis, at least in the incidence of new legal actions."

According to the CMPA's analysis of claims handled in 1994, this means that the physician's average risk of being involved as a defendant in a legal action in 1994 was 1 in 27. The report added that "while the likelihood of being involved as a named defendant will vary according to the type of practice . . . the overall risk has remained relatively constant over the past 10 years and at a fairly low occurrence rate." [By comparison, litigation risks are much greater in many US states. In Montgomery Country, just north of Houston, 29.3% of physicians were sued in 1992. — Ed.]

In the 5 years prior to the 1994 report, the CMPA formally concluded more than 4000 legal actions. Approximately 27% were settled; of 359 legal actions that proceeded through trial, judgements favoured the physician in 69% of cases. The report notes that 64% of cases were dismissed or stopped before trial.

Significantly, the CMPA reports that many of the cases were commenced because of communication difficulties between patients and physicians. Generally, the clinical care provided met appropriate standards but insufficient time was set aside for explanations about why complications had occurred or the explanations were not understood.

A recent US study of why patients sue doctors and hospitals noted that not all adverse outcomes result in legal action, and threatened lawsuits do not always involve adverse outcomes. It found that 71% of problems involved physician–patient relationship issues (Beckman H, Markakis K, Suchman A et al: The doctor–patient relationship and malpractice: lessons from plaintiff depositions. *Arch Intern Med* 1994; 154: 1365–1370).

The four main themes behind the lawsuits were:

- desertion of the patient (physician sent a surrogate or was perceived as unavailable or too important, or patient felt abandoned), 32%;
- devaluation of the views of the patient or family (physician discounted the illness and suffering, attempts to advocate on the patient's behalf and the opinion of the patient or family, or failed to listen), 29%;
- delivering information poorly (physician failed to provide an explanation or to keep the family up to date, blamed the patient or family for a bad outcome and communicated insensitively), 26%; and
- failing to understand the patient or family perspective (physician did not pay attention to patient discomfort, failed to solicit opinion or failed to recognize the psychosocial impact of a medical problem), 13%.

The CMPA provides procedural guidelines for physicians to follow when it appears they may face litigation. Generally, the CMPA should be informed at once: it is much better to react unnecessarily than to leave a problem until it is has festered and can be sorted out only by litigation. Warning signs include awareness that a mistake has been made, an unexpectedly adverse outcome to a prescribed treatment, or negative comments from the patient or family.

Prevention is the preferred insurance program for all physicians. Paying attention to the physician–patient relationship represents the most effective form of risk management in a successful medical practice. Quality health care services and attention to good communications will in most cases ensure a litigation-free professional life.

A study of Canadian physicians' experiences with medical malpractice, conducted for the Canadian Federal/Provincial/Territorial Health Provider Liability Task Force (Coyte P, Dewees D, Trebilcock LL: Medical malpractice — the Canadian experience. *New Eng J Med* 1991; 321: 89–93) noted that Canadian physicians are only 20% as likely as their American counterparts to be sued for malpractice. Possible explanations for this discrepancy include the presence of universal health insurance, more generous social-welfare programs, limited use of contingency fees, limited awards for nonpecuniary damages such as pain and suffering, infrequent use of juries, a less litigious culture and "the effective defence work of the CMPA." ■