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Not the Last Word

Malpractice: Problems and Solutions

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The American malpractice system is a mess, and in orthopaedic surgery, it is messier still. One problem is frivolous lawsuits. The Harvard Medical Practice Study [5] reviewed the hospitalization records of more than 30,000 patients and determined for each case whether negligence was committed and a suit was filed. The researchers found most of the events for which claims were made did not involve negligence.

It is small consolation that physicians usually prevail at trial. Even when a doctor wins the case, defending a malpractice claim is a losing proposition. At best, the physician is portrayed by the plaintiff's counsel as a bumbling incompetent. Also, malpractice insurance (which routinely exceeds USD 100,000 per year in some states) indemnifies against only financial damages; the losses of time, reputation, and serenity are for the physician alone to bear. The net drain on happiness probably exceeds what one experiences in contracting appendicitis or breaking an ankle.

In response, the orthopaedic surgery community has pressed for change. The hallmark of the orthopaedic approach is limits on noneconomic damages. These so-called "caps" would mandate that while all medical expenses and lost wages caused by malpractice are compensable, no more than a given amount, say USD 250,000, can be awarded for "pain and suffering."

Caps are an appeal to logic and fairness. For one thing, the argument goes, it is impossible to place a precise dollar value on pain and suffering, and if any amount is to be arbitrary, why not keep the dollar values modest? In addition, limits on noneconomic damages mitigate the harm caused by "runaway" juries, making the system less volatile and therefore less expensive for all.

But let's face it: the real appeal of caps is that they limit the number of suits. Most cases are brought forward on a contingency basis; the lawyers get paid only if they win. If the payoff of a case is limited, its attractiveness to an attorney is, likewise, limited.

Caps work. In general, malpractice premiums are much lower in those states (such as California) that have caps in place [10]. But the problem with caps is that they solve the wrong problem. While there is plenty amiss with the American medical malpractice system, the largest flaw is not having too many lawsuits. If anything, there are too few. The Harvard Medical Practice Study cited above, for example, reported only eight of the 280 patients (2.9%) who were the victims of medical negligence actually filed malpractice claims. As such, if we can agree a central purpose of a

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Note from the Editor-in-Chief: We are pleased to introduce readers of Clinical Orthopaedics and Related Research® to Not the Last Word, a new quarterly column. The goal of this section is to explore timely and controversial issues that affect how orthopaedic surgery is taught, learned, and practiced. We welcome reader feedback on all of our columns and articles; please send your comments to eic@clinOrthop.org.

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malpractice system is to compensate victims of negligence, we can also agree caps, which discourage litigation across the board, and not just the frivolous cases, undermine that purpose. And, if another central purpose of a malpractice system is to deter errors, then we might also agree any method that discourages litigation in general, benefiting bad physicians as well as good ones, similarly undermines deterrence.

Orthopaedic surgeons should favor a system that minimizes physician pain yet allows victims of error unfettered access to fair compensation. Abraham and Weiler [1] have proposed such a system. They call it "enterprise liability." Under this approach, it is the organization, not the physician, that is named as the defendant in a suit. The rationale is simple: because many medical errors are, in fact, systems failures, it stands to reason that the enterprise should bear primary responsibility for compensation and deterrence. Local enterprises, when held accountable in this way, should likewise do a better job of policing practice and eliminating bad practitioners, as opposed to the current approach to malpractice, which indiscriminately lumps (and punishes) many good surgeons along with the few bad players.

There are, of course, impediments to applying enterprise liability. For one thing, even for procedure-oriented specialties like orthopaedic surgery, much health care is not delivered within the confines of a single enterprise. Also, it is not assured that enterprises themselves will avoid hunting for scapegoats. Even so, the advent of Accountable Care Organizations (as promoted by the 2010 Patient Protection and Affordable Care Act) and the heightened political awareness among physicians regarding liability rules will, respectively, mitigate those concerns. Enterprise liability is a practical option moving forward.

We orthopaedic surgeons, as advocates for our patients, should favor a system that limits error and compensates victims when errors occur. As human beings, we can't help but hate attacks on our competence and character. Thus, we are also right to favor a system that minimizes finger pointing. A system of enterprise liability meets all of those standards. Enterprise liability, not caps on noneconomic damages, should be our favored approach.

Commentary

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Dr. Bernstein has raised an important issue: the use of a method of professional liability reform called enterprise liability. The US medicolegal system has not accepted it in the past, and it will be difficult to implement such a major culture change in the future. However, Dr. Bernstein raised this method of compensating injured patients because he sees a new opportunity for change under the Patient Protection and Affordable Care Act, with the new development of Accountable Care Organizations. I agree with him on this point and would argue it is also a desired method in the new practice model in which physicians are increasingly becoming paid employees of a hospital or hospital system.

The best example of enterprise liability in practice that I know of involves the aviation industry. As in medicine, system errors can occur, but also individuals make mistakes. In the case of an airplane crash, the airline company is responsible for all damages. The pilots are not personally liable because their profession has agreed to full transparency and reporting of individual errors. However, the pilot does bear individual responsibility under two circumstances: when he or she is under the influence of drugs or alcohol at the time of the crash or if he or she did not follow the required checklist for flying the aircraft. This model seems perfect for surgeons and hospital systems to adopt.

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But I am pessimistic that it will happen. In the past, trial lawyers have mounted strong opposition to any professional liability reform; the courts and our legislators (most of whom are lawyers) likewise have not favored such change. There is too much money at stake. Also, I am pessimistic that even our own profession would support enterprise liability. For just as pilots have to admit and disclose their individual errors, so would surgeons under this approach. Physicians fear the loss of reputation, the resultant loss of income, and the difficulty of admitting to colleagues and patients that we erred and caused harm. I believe our profession would accept individual responsibility for errors committed while under the influence of drugs or alcohol, but the challenge for many surgeons will be the acceptance and use of required checklists before, during, and after surgery.

Most changes in past attempts at healthcare reform have been at the margins: a small fix or BAND-AID® here, a small change there. It would be wonderful if leaders of the professions of medicine, law, and politics, along with our patients, would come together and implement enterprise liability in health care as it is used in the airline industry. Such are quixotic dreams. Only if state and federal leaders, along with physicians, agreed such reform was necessary because of the continued rise in healthcare costs, the continued threat of adverse events, and the importance of shared decision making, would such reform become a possibility. Even then, though, it would be but a small one.

Commentary

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> "It isn't what we don't know that gives us trouble, it's what we know that ain't so."
>
> Will Rogers

It is becoming more and more difficult to engage physicians and lawyers who represent patients in a productive dialogue about fixing what ails the medical liability system. Each group views the other with suspicion and distrust. Nonetheless, to have a productive dialogue, the participants must first agree about the nature of reality.

Evidence-based liability reform, like evidence-based medicine, must look at the facts as they are, not as we assume them to be. The arguments in favor of medical liability reform are more faith-based than fact-driven.

The author begins by rounding up the usual suspects: "frivolous lawsuits," caps on "pain and suffering," discouraging lawyers from bringing cases. These are driven by fears. The fears of plaintiff's counsel, loss of reputation, rising liability insurance premiums, loss of time, loss of peace and enjoyment of life, runaway juries. Fears, although real, do not make the thing feared a reality.

Truth should matter, especially when it comes to changing our laws to deny a person his or her right to full and fair compensation. That person would surely be awarded compensation if only he or she had been injured in a road wreck caused by driver error, rather than violation of the standard of medical care by a physician who commits medical errors.

Review of the relevant literature shows the arguments made in support of so-called reform proposals are simply untrue [3]. An ambitious project of the nonprofit Center for Justice & Democracy at New York Law School [3] is an updated survey of the data every orthopaedic surgeon should read. This freely downloadable, heavily footnoted book leads to the conclusion that whatever the infirmities of the current system, they cannot be laid at the feet of the injured patients and their advocates. Rather, we learn the inconvenient truth: We are not inundated with frivolous

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medical lawsuits. "[P]ortraits of a malpractice system that is stricken with frivolous litigation are overblown" [7]. Capping pain and suffering damages does not reduce malpractice insurance premiums [9] and does not affect physician supply, but it does prevent legitimate cases from being filed [3]. Legitimate cases actually improve the cause of patient safety [3].

Dr. Bernstein's contention that too few malpractice cases are being filed is also borne out by the literature [2]. Medical errors occur at an alarming number and are, largely, system failures [4]. Recently, there have been small steps in increasing acceptance for physicians to admit medical mistakes as part of the healing process. Most notable was the recent Technology, Entertainment, Design (TED) talk of Canadian emergency physician Brian Goldman MD [8]. This is also good for the overall cause of improving patient safety.

In place of the current system, Dr. Bernstein advances the idea of enterprise liability. Enterprise liability has several advantages as a method of bearing the costs of medical errors, obtaining coverage in a pool, holding the system responsible for system failures, and making system wide improvements in the interest of patient safety. Additionally, the enterprise is in a better position to police the few bad, serial malpracticing physicians who create most of the medical negligence payouts and who receive shockingly little discipline from state medical boards [6]. An enterprise liability system would also have the benefit of depersonalizing the effects of litigation. Unfortunately, as of now, this is not the law anywhere in America.

A reasonable, workable alternative is the Wisconsin system, The Injured Patients and Families Compensation Fund. Doctors in Wisconsin have unlimited coverage since every healthcare provider has that type of coverage. The fund has nearly USD 1 billion in assets and pays out only a small portion of that every year and is financed through assessments on healthcare providers.

Commentary

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Our current tort system resolves disputes through litigation. Dr. Bernstein notes researchers found most events for which claims were made did not involve negligence. This suggests the current system works, since most malpractice suits find for the defendants.

Error is not the same thing as malpractice. Although malpractice litigation is demeaning, can be tedious, and certainly is expensive, the alternative—compensating those who allegedly suffer from medical misadventures—would be far worse. Prioritizing the business of medicine first and putting the patient with a bad result in charge are mistakes. Here's why: Among the patients whose treatment could have been better are other people who think they have been mistreated, and worse, individuals who believe they deserve compensation for actual or imagined dysfunction. Our society, our hospitals, and our prisons are loaded with folks who feel they are entitled. Compensation for situations that are judged by some flawed process to have been caused by medical care will provide a whole new apparatus for undeserved rewards. In real life, few patients tell the whole truth about what happened to them, what they have taken, or what they have done. Review of the discovery process of any lawsuit makes this clear enough.

Enterprise liability is a concept borrowed from manufacturing. If a part fails, the company issues a recall and fixes the problem. The underlying assumption is that there has been a flaw in the creation of the product somewhere from design to production and the process is at fault. This concept fits less well when applied to an unemployed motorcycle driver on

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alcohol and drugs who loses his leg in a high-speed injury that he or she caused. My wise accountant opined any audit will disclose discrepancies; similarly any chart review will find courses of action that might have led to better results.

Where will the funds come from to compensate patients for damages they allege? Government? Healthcare insurers? Doctors? Surely a torrent of preferred pathways, algorithms for treatment, and computer-driven systems to control losses will follow; these will, almost necessarily, stifle innovation.

We can develop a new system wherein a well-intentioned (though perhaps not well informed) someone will assert an adverse outcome could have been averted, and we even can compensate patients under such a system. But we will probably find ourselves with much more paperwork and in a much-less favorable atmosphere to treat patients as individuals and with dignity and kindness.

Commentary

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The claim that more tort liability could be a cure for our ailing system of medical malpractice liability will undoubtedly strike many physicians as preposterous. The logic of this proposed tort reform, however, is compellingly as laid out by Joseph Bernstein in this column on medical malpractice. Indeed, the case for enterprise liability—a system that shifts liability from physicians to the enterprises that supply health care—is even stronger than Dr. Bernstein shows. In sharp contrast to the current system, enterprise liability is triggered by the occurrence of medically caused injuries, regardless of fault. No-fault liability would result in more tort liability across the run of cases, but this expansion of tort liability could solve the malpractice problem by removing blame from the liability equation.

No one likes to be sued, especially when the allegation is one of professional malpractice. Rather than having one's competence impugned, many physicians understandably engage in defensive medicine or otherwise cover up their mistakes. These allegations can also be upsetting to patients who place faith in their physicians and feel grateful for the care that they have received, even when the physician ultimately is unable to provide a cure. These patients are often loath to sue their physicians, regardless of whether further investigation would support a malpractice claim, whereas others who feel their physicians have not been adequately sensitive can end up blaming the physician for the failure to provide a cure, even if malpractice is not involved. The resultant mismatch between the incidence of medical error and the incidence of malpractice claims is well described by Bernstein and more extensively documented by others [2].

To be sure, fault-based liability has a number of appealing attributes. It requires proof that the defendant was legally at fault for the plaintiff's injury, enabling risky actors to avoid tort liability by exercising reasonable care. The failure to exercise reasonable care constitutes legal fault, a conclusion that can be quite different from the colloquial attribution of fault. No one can be blamed for not being perfect. We all make mistakes, but any misstep, whether the result of professional incompetence or a simple lapse of attention, can be sufficient to establish negligence liability. The frequency of these mistakes can be reduced by procedures or the design of systems for delivering health care, but fault-based liability largely ignores these issues by instead placing blame

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on the provider whose inadvertent mistake directly caused the patient's harm. Requiring the patient to prove instead that the "fault" lies with the enterprise is no panacea because the optimal design of systems and procedures involves complexities that render such proof practically inaccessible to plaintiffs. Is the injured patient, or more precisely, the contingency-fee lawyer, really the party best able to identify the practices that ought to be utilized by the enterprise of health care?

By placing responsibility for all medically caused injuries on the enterprise itself, tort liability would create financial incentives for these institutions to adopt procedures and systems that would both reduce the incidence of inadvertent error and provide internal mechanisms for addressing instances of professional incompetence. Eliminating blame from the liability inquiry could be the best way to address the problem of medical error, but doing so requires an expansion and redirection of tort liability, a reform quite different from the reduction of tort liability often championed by medical professionals.

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