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Recommended Citation

Orentlicher, David, "Medical Malpractice: Treating the Causes Instead of the Symptoms" (2000). *Scholarly Works*. 1160.

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Medical Malpractice Treating the Causes Instead of the Symptoms

DAVID ORENTLICHER, MD, JD

The 2 reports on medical malpractice in this month's issue deliver 2 messages.^{1,2} In their study linking negligent care and malpractice claims,¹ Studdert et al found that for all of the academic debate and legislative activity in the past 20 years, some things have not changed very much with medical malpractice and the law. Eighteen years after landmark California data and 8 years after equally important New York data, malpractice occurrence and malpractice claims data from Colorado and Utah in 1992 paint essentially the same picture as the earlier results: a small percentage of injured patients actually sue, and when claims are brought, a high percentage of them do not involve malpractice. In other words, the tort system includes many false-positives (patients who sue in the absence of negligence) and even more false-negatives (patients who do not sue despite having been harmed by negligence).³ As a result, the law often subjects the wrong physicians to legal process, it generally does not hold physicians accountable for their negligence, and it fails to ensure adequate compensation for injured patients.¹

See p 250 and p 261

In contrast, Thomas et al,² from the same group of researchers, suggest considerable progress in the second study in this issue. Although the likelihood of negligent care appears to have been fairly stable over time, ranging from 0.79% of hospitalized patients in 1974 (California) to 1.00% of hospitalized patients in 1984 (New York) to 0.90% and 0.80% of hospitalized patients in 1992

(Utah and Colorado; see Table 2 in Reference 1), the likelihood of death from negligent care may have declined substantially. In California in 1974 and New York in 1984, 1 in 4 negligent events resulted in death (Reference 2 and Table 2.2 in Reference 4); in Colorado and Utah in 1992, 1 in 11 negligent events led to the patient's death.²

If the data on patient mortality were the only evidence of progress in malpractice, we could not be confident in drawing conclusions. The better results over time could simply reflect regional variation or empirical inaccuracy. The researchers have been cautious about the significance of their mortality data,² and readers should also be careful not to put too much stock in the exact magnitude of the numbers from 1992 or earlier. Extrapolations from the New York study yielded an estimate of 180,000 deaths each year in the United States from all kinds of iatrogenic injury, whereas a similar extrapolation of the Colorado and Utah study suggests 65,000 deaths a year.² (Extrapolating the California data would yield an estimate of 150,000 deaths a year.⁴(pp20,22))

Nevertheless, it would be incorrect to conclude that little improvement has occurred. Recent shifts in public policy suggest that we are witnessing a welcome sea change in society's response to problems in medical malpractice.

Public policy used to emphasize reforms that would protect physicians from the vagaries of the legal system.⁵ Led by California and Indiana, state legislatures capped the amount of money that patients could recover for their injuries, required patients to bring their lawsuits within 2 or 3 years

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after suffering harm, and forced patients to file their claims with medical review panels before pursuing their claims in court.⁶

Public policy today emphasizes reforms that will protect patients from the vagaries of the health care system. Indeed, in the final weeks of 1999, after the release of an Institute of Medicine report on medical negligence,^{7,8} President Clinton,⁹ health care organizations,¹⁰ and large employers¹⁰ called for major efforts to reduce the incidence of medical malpractice.

The focus is where it should be: on the causes rather than the symptoms of negligence by physicians. Experts in malpractice are drawing on lessons from other industries to implement changes in health care that will prevent unnecessary harms. For example, attention to system-wide defects instead of to the practices of individual practitioners has led to important changes.^{2,11} Computer programs now flag dangerous interactions among different drugs taken by a patient, and they identify situations when the planned dose seems inappropriately high.¹² Having physicians type, rather than write, their prescriptions reduces the likelihood that the pharmacy will deliver the wrong drug to the patient. Systems reforms also include procedures to prevent physicians from operating on the wrong patient or the wrong part of the body.

The change in focus is a welcome shift from unproductive and unfair criticisms of patients and their attorneys. Although it is likely true that most lawsuits are filed in the absence of negligence,^{1,13} that fact probably reflects the relatively low rate of negligence, not the arbitrariness of personal injury lawyers.⁵ The following example will illustrate. Probably no more than 1 in 10 people who come to a lawyer because of suspected malpractice are actually harmed by negligent care (personal communication with Michael S. Miller, JD, Miller, Muller, Mendelson & Kennedy, Indianapolis, Ind, January 4, 2000). If lawyers are accurate 90% of the time in distinguishing cases of negligence from cases in which negligence was not involved (ie, 90% sensitivity and 90% specificity), then half of all malpractice suits will be based on cases in which no negligence took place.

The critical change in focus from the symptoms to the causes of malpractice could not have occurred without research like that presented in this issue.^{1,2} During the 1970s and 1980s, most people shared the perception that ambulance-chasing lawyers and litigious patients were harassing competent and careful

physicians, thereby pushing insurance premiums to unaffordable levels and driving doctors out of high-risk specialties like obstetrics and gynecology. In the popular view, problems in malpractice would be solved if it became more difficult for patients to sue their physicians.

As the data accumulated, however, it became clear what the Colorado and Utah experiences confirm: patients and their lawyers are not too likely to sue; if anything, they are too unlikely to sue. When physicians face only a few percent chance of being charged with malpractice,^{1,14} they may not be adequately deterred from negligence. In addition, patients are not being adequately compensated for their injuries if only 2% or 3% of them bring claims. And, as the studies demonstrate, many patients who have the greatest need for compensation—the indigent—are the least likely to sue.^{1,15}

With better data, then, it became clear that the problem with malpractice was not in its litigation. The primary need is to reduce the frequency of malpractice, not to reduce the frequency of lawsuits. Although different studies have yielded different rates of negligence and different rates of mortality from negligence,^{2,7} they all indicate that medical malpractice is a leading cause of illness and death in the United States.⁷

Important advances have already occurred in the medical profession's efforts to prevent the occurrence of malpractice. As mentioned, procedures have been implemented to reduce adverse events from the use of prescription drugs. In addition, the development of specific and detailed standards for patient monitoring during surgery has apparently contributed to reductions in the number of severe injuries from the maladministration of general anesthesia.¹⁶ There is, then, good reason to conclude that the improvements in data are at least in part real.

We might also consider whether some of the improvement reflects greater efforts at cost containment. As insurers have restricted reimbursement, hospitalization rates have declined, and patients are being discharged more quickly. Fewer admissions and fewer days once admitted mean fewer opportunities for iatrogenic injury. If physicians reduce unnecessary admissions, for example, patients are spared unnecessary procedures. To be sure, cutbacks on hospital care may jeopardize patient care, but the studies in this issue took into account negligent care that occurred before the patient's admission to the hospital,² and other studies do not provide much

support for the view that cost containment has worsened the quality of care.¹⁷

Where do we go from here? Continued focus on preventing malpractice is the most important policy. Patient welfare is the ultimate goal, and the interests of patients and physicians alike will be best served if patients escape harm. One of the studies in this issue demonstrates again the areas where the most harm occurs from negligence: surgery and other procedures, drug administration, and faulty diagnoses by primary care providers.² Preventive measures should emphasize those areas, as they already have to a large extent.

As to additional reforms of tort law, it is difficult to be optimistic. The most promising reforms, those that would ensure better compensation of injured patients, have commanded little political support.¹ Alternative reforms, those that would further impede patient access to the courts, may be more popular in state legislatures. However, they would only exacerbate the existing problems of physicians receiving weak signals of deterrence from the legal system and patients having trouble recovering compensation for their injuries. Diluting the deterrence of tort law would be especially troublesome in the current era of managed care. When physicians practiced under fee-for-service reimbursement, tort liability arguably aggravated the financial incentive to provide too much care by inducing defensive medicine. Under managed care, financial incentives encourage physicians to provide too little care, so tort liability can help ensure that physicians do not respond to their financial incentives by withholding necessary treatment.¹⁸

Acknowledgment

I am grateful for the contributions of Judith L. Failer, PhD, and Michael S. Miller, JD, and the financial support of the Program in Medical Ethics, Indiana University School of Medicine.

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