Tort Reform and the Patient Safety Movement Seeking Common Ground

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According to Sage,1 “doctors hate malpractice suits . . . passionately and continuously . . . Eliminating malpractice suits takes precedence over every other political objective. . . . No contradictory belief, however well-reasoned, empirically based, or sincerely held, succeeds in crowding out antipathy toward malpractice from physicians’ minds. Not the large number of patients who die unnecessarily each year from medical errors; not the desirability of allowing patients to sue [health maintenance organizations] HMOs for improper care.” Sage’s vivid depiction of the profession’s bilious antagonism toward medical malpractice provides important context for drawing lessons from 2 articles in this issue of JAMA that explore the behavior of physicians in specialties that pay the highest malpractice insurance premiums and have the greatest risk of being sued. The study by Studdert et al2 reveals the extraordinary extent to which physicians report going against their own clinical judgment in the hope of minimizing their malpractice exposure. The study by Kessler et al3 finds evidence that certain tort reforms enhance the likelihood of high-risk physicians practicing in states enacting those reforms. Each study provides insight into attitudes toward malpractice and even toward practicing medicine, and underscores the need for new approaches to both tort reform and the patient safety movement.

In a survey of Pennsylvania physicians in specialties considered at high risk of lawsuits, Studdert and colleagues found a staggering 93% reported that they deviate from sound medical practice (ie, engage in defensive medicine) to lower that risk. One caveat of the authors is that these physicians have a strong vested interest and they suggest that “self-reports of defensive medicine may be biased toward giving a socially desirable response or achieving political goals.” Assuming, however, that the findings reflect actual behavior, important observations and ironies emerge. First, the physicians deviating from sound medical practice may not actually be the ones at high risk of liability claims; in this study, “as in previous ones, objective measures of physicians’ liability experience and exposure were not associated with individual physicians’ propensity to practice defensively.” Second, the most common defensive practices—ordering diagnostic tests or making referrals against one’s clinical judgment and not caring for high-risk patients—may sometimes represent good medical practices. The authors note that “[d]efensive medicine may reduce or improve quality, depending on the circumstances.” Similarly, at least some of the physicians who acknowledge avoiding high-risk patients or procedures may be behaving appropriately because they demonstrated advanced years in practice or were solo practitioners, factors that might justifiably be associated with such avoidance behaviors.

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themselves potentially serious violations of the standard of care and could be the basis for malpractice litigation.

To appreciate the implications of this study requires asking why such an extraordinary proportion of physicians behave in a manner different than their own clinical judgment would dictate. And, how is it even possible for them to do so with impunity? The answer to the first question lies in Sage’s observation about the tenacity of physician antipathy to malpractice. Some physicians apparently deviate from accepted practice reflexively, with no evidence that they serve their own purposes and substantial possibility that they are increasing their malpractice liability. The perceived burden of their malpractice premiums may overwhelm objective evidence of potential effects of “defensive” actions on malpractice exposure for these physicians.

The second question cuts even deeper. Despite the profession’s inherent orientation toward doing only what is necessary for patients, medicine’s self-regulatory controls apparently permit many physicians to deviate readily from accepted medical practice. The medical profession mounted vigorous resistance to financially driven controls imposed under managed care without clinical justification, but is still in the initial stages of adopting scientifically based practice guidelines and effective accountability measures.

The study by Kessler et al examines a different aspect of the malpractice issue. In their exploration of physician supply in relation to state malpractice laws, the authors found evidence that tort reforms enacted between 1986 and 2001 affect physician supply. For example, they report that the number of physicians in “high-risk” specialties increased in states that enacted legislation to “directly” limit malpractice awards through “caps” on damage awards or other measures. Furthermore, this increase in physician supply resulted from reduced retirements and increased entries into practice, not emigration from states without reform. In their complex analysis, the authors attempted to account for factors other than malpractice law changes that could influence the choice of physician practice location. One limitation of their approach is that they used indirect evidence rather than directly assessing whether changes in liability laws affected a physician’s decision to enter or stay in practice in a given state.

Although the principal finding from the study by Kessler and colleagues is that tort law changes appear to influence physician choices about where to enter practice or whether to retire, the most compelling lesson is that the tort reform climate has a “relatively modest impact” on physician supply. Influencing physician supply is not a reason to pursue liability changes, nor is it necessary. Kessler et al documented that physician numbers are increasing inexorably throughout the United States regardless of the status of medical malpractice law, which exerts its effects on the margin of high overall growth rates. Holding other factors constant, Kessler et al found that compared with states without reforms, direct tort reforms could account for expanding overall physician supply by an increment of 3.3%, 3 years after adoption; overall physician supply, however, increased by 61% even in states without reforms. Similarly, increases in physician supply among the high-premium specialties in states without reforms ranged from about 46% to nearly 120%, except for surgery which increased at much lower rates everywhere.

Perhaps the foremost lesson emerging from the work of Studdert et al and Kessler et al is that medicine’s 30-year pursuit of piecemeal tort reform has had some results, but not all the consequences have been positive and serious problems with the quality of medical care have not been ameliorated. While some physicians apparently prefer to practice in states that have enacted certain liability law changes, the tort system still seems to engender perverse behaviors such as widespread, sometimes serious, and often costly deviations from accepted medical practice, and internal self-monitoring by the medical profession evidently permits such behavior to occur on a large scale. Most important, the pattern of tort reforms pursued to date has not led to innovative legal approaches that serve both the profession and patients by tying liability law restructuring to systemic, evidence-based changes in medical practice that ensure adherence to not deviation from good medical care.

A path toward a new approach could emerge from the evolving patient safety movement, but will require substantial interaction among currently disparate groups. Leape and Berwick have identified many recent initiatives to improve patient safety, which suggest that as the evidence base for safe and effective practices expands, health care may be more open to implementing measures to encourage and even enforce such practices systematically. This could provide real tort relief through a corollary to the previously discussed irony that defensive practices may actually increase liability risk by codifying unnecessary measures as the legal standard of care. That is, systematic incorporation of evidence-based medical guidelines could reconcile the legal and medical standards and provide a measure of tort relief.

The tort reform and patient safety movements interface at many points, but efforts to relate them to one another mainly have been narrowly focused. Within the medical community, some patient safety proponents argue that a systems approach to protecting patients is inhibited by current law and call for removing the risk of liability from reporting medical errors. Others express doubt that removal of liability exposure would accomplish a general acceptance of effective monitoring and feedback mechanisms to ensure quality. At the same time, some traditionalists in organized medicine, who are not necessarily involved in patient safety efforts, wage periodic battles with personal injury lawyers over now-standard tort law changes in state legislatures and in the US Congress as malpractice premiums wax.

These contrary positions cannot be reconciled as long as the patient safety movement and tort reform initiatives proceed along separate tracks. What is needed is to link new approaches to legal accountability with mandatory active par-
Women's Health: A Call for Papers

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The March 21, 2001, issue of JAMA1 was devoted to women's health and featured articles on physical activity and coronary heart disease, hormone therapy and cognition, risk of dementia in postmenopausal women, estrogen therapy and ovarian cancer mortality, the treatment of postmenopausal osteoporosis, depressive symptoms among HIV-seropositive women, enhanced surveillance for pregnancy-associated mortality, and cervical cytology and histologic interpretations. Since then, a number of important studies, including several from the Women's Health Initiative2,3 and the Heart and Estrogen/progestin Replacement Study,4,5 have been published. Studies already published and many currently under way can provide important information to improve the health of women. To assist and enhance this initiative, the editors of JAMA will devote a theme issue in March 2006 to articles pertaining to women's health.

We invite manuscripts reporting the results of original research, especially randomized clinical trials and systematic reviews, including meta-analyses. While special communications and commentaries will be evaluated, evidence-based articles will be given priority.

Topics of particular interest are women's health aspects of diseases with major public health impact including cardiovascular disease, cancer, infectious diseases, musculoskeletal diseases, endocrinological diseases, alcoholism and other drug abuse, and psychiatric disorders; sex differences in treatment effects, including drug effects and pharmacokinetics; normal and abnormal growth and development through the life cycle; health aspects of exercise and sports medicine; psychosocial and cultural issues affecting women's health; studies of pregnancy, infertility, prenatal care, and childbirth; eating disorders, including anorexia and bulimia; menstrual disorders; and complications of menopause.

Manuscripts received by December 1, 2005, will have the best chance for consideration for this theme issue. All manuscripts will undergo our usual rigorous editorial review process with no advance promise of acceptance for publication. High-quality submissions not accepted for this theme issue may be considered for other issues of JAMA or for referral for consideration by one of the Archives specialty journals. Please follow JAMA's Instructions for Authors6 regarding authorship, submission, and formatting requirements.

REFERENCES

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