Dear Dr. Jeff:

Do you think that medical liability reform would affect the way we care for our residents in nursing homes? Should the average long-term care physician support tort reform or should we see liability as a way to police some of our colleagues who we know are doing a poor job?

Dr. Jeff responds:

The topic of liability or malpractice reform is all about anger, peppered with a small amount of greed. Patients sue doctors primarily because they are angry over the care they received – angry at the doctors and angry at the outcome.

Physicians are angry at the reality that every medical decision, however trivial or well-intentioned, might have to be defended in court and carry the potential of devastating financial loss and public humiliation.

Rightly or wrongly, our medical system spends billions of dollars for tests and consultations that are ordered in defense against potential liability suits rather than to advance the patient’s best interest. This too makes everyone angry, sometimes including the patient who is asked to pay in whole or part for a test that everyone at heart knows is unnecessary.

The argument sometimes made that the threat of lawsuits helps to prevent poor performance by physicians or to limit bad outcomes for patients has always seemed particularly weak to me. Effective deterrents need to be clear, fair, and predictable.

For example, laws against driving while intoxicated set clear and measurable standards for blood-alcohol levels, punish irresponsible behavior by the driver, and are invariably enforced with penalties that are appropriate to the offense. Although DWI hasn’t been totally eliminated, there seems little doubt that current laws do significantly decrease its frequency and the number of associated traffic injuries and fatalities.

By contrast, malpractice suits are often unpredictable, measure performance against an extremely vague standard of community practice, frequently reflect poor outcomes rather than poor patient care, rather than poor performance by the health care professional, and ultimately punish the entire medical community, rather than the occasional genuine offender, through higher malpractice insurance rates.

The simple existence of malpractice insurance exposes the irrationality of the system. Insurance policies are intended to provide protection against events that are essentially unpredictable and random, such as fire, theft, or unexpected death. They extend protection to the broad population against the lighting bolt which strikes an individual. Unfortunately, that is the category into which most malpractice suits fall.

If we really believed that most of the events that lead to legal actions represented unacceptable behavior on the part of the individual practitioner, we would expect that individual to pay for his or her acts, either financially or criminally, rather than permitting coverage through an insurance carrier. One might expect that the highest premiums would be charged to those with the least training and expertise, rather than to surgical subspecialists with years of extra training.

The irrationality of the current system is also exposed by the common practice of naming multiple physicians and institutions as defendants in legal claims. Is it really possible that several hospitals, multiple physicians, and a nursing home all committed malpractice against a single patient? Or is it obvious that the law is being used to reimburse a patient who has suffered a bad outcome for which no one is clearly at fault?

The Liability of Liability

Statistics suggest that most of the physicians who are reading this article have, at some time in their careers, been served with a malpractice claim. Any physician who has ever been named in a lawsuit knows that simply being sued is a punishment in itself, regardless of the eventual outcome. It makes for self-doubt and reflection on whether it makes sense to spend a life trying to care for the sick. This is clearly not an effective way to police a profession.

Most proposals for “tort reform” concentrate on capping awards for pain and suffering. While this may, indeed, be a small and reasonable step, it fails to deal with the reality that the entire system doesn’t work. Juries want to give money to people who have suffered poor outcomes, regardless of whether any “tort” (literally, a wrong) occurred.

Those juries are right to do so. A family with an injured child needs help with the medical and personal-care costs of raising the child. But it should not be the obstetrician who pays. Patients who are chronically disabled after unsuccessful neurosurgery need help with their chronic care – but not from the neurosurgeon.

Many of these liability claims are driven by the irrational separation between acute care, which is generally covered by health insurance, and chronic care, which generally is not. Because an acute-care patient has developed chronic needs that are not covered by health insurance, the person needs some other source of funds. Malpractice is a cumbersome, inefficient, and essentially unjust mechanism to provide for such needs.

Unfortunately, even if the entire concept of malpractice were swept away, two large problems would remain. The first is that smart lawyers don’t sue long-term care physicians for malpractice. They sue the institutions for negligence. Unlike the primary care physician caring for an elderly patient, who might be a sympathetic figure to many juries, nursing homes are generally proprietary institutions and often members of large chains listed on the stock exchange. They are perceived to have “deep pockets.”

And the legal standard of proof for negligence is much lower than that for malpractice, since the former is based on what should have been done rather than on what everyone else might do.

Since federal regulations seem to adopt an absolutist standard (suggesting for example that the resident must be kept free of unavoidable pressure ulcers or weight loss), it allows the plaintiff’s attorney to assert in many cases that a facility failed to meet its legal requirements and that the patient suffered as a result. When a care plan is added with the asserted goal that the resident will “be kept free of ...” it suggests that any bad outcome must be the result of botched care.

With survey results hanging in the lobby of every long-term care facility, the combination of a cited code deficiency with a resident with a bad outcome is blood in the water for some opportunistic attorneys.

For many bad outcomes – such as pressure ulcers or falls with injury – where no clear blame can be attached to any individual, the facility can still be held liable. Thus, malpractice reform alone is unlikely to change the current legal environment in long-term care, although it would certainly brighten the lives of many physicians who worry about the threat of lawsuits.

The Reality of Reform

Ironically, our institutions are partly protected from liability suits by the legal and economic reality that our patients are not considered valuable. They have no future earnings to lose, no sexual desire to provide to their partners, no extra medical costs beyond what are covered by insurance.

In a legal system that attempts to measure every injury with money, their future survival is only a cause of further expense rather than a loss. Premature death saves a family money. The resident’s pain and suffering is all a lawyer has to work with. Tort reform limiting the value of this last item would make residents financially worthless in the eyes of the law.

However, poor care really does occur in many instances. Too many physicians are frankly ignorant about the needs of frail seniors. Polypharmacy is the rule rather than the exception in many facilities, with practitioners simply throwing pills at symptoms rather than spending time with residents and thinking through rational diagnoses. Far too many physicians are too rushed or too insecure to listen to valuable suggestions from other members of the interdisciplinary team.

Although many possible sources to learn about better care are available, including AMDA clinical practice guidelines and conferences, their penetration into the ranks of physicians has not been very deep. The medical profession has done a poor job of policing its own, as have the law, the ministry, accountants, and many others. Medical directors should not expect the courts to improve the performance of the members of medical staffs. That, in the end, is our job.

Careful credentialing should be a vehicle to weed out some of the worst performers before they cause a problem. Where genuine fraud or abuse is observed, it is our obligation to report it to proper authorities. Good policies and procedures, evidence-based care systems, useful forms with reminders, and education of the medical staff can promote better care.

Every health care professional who practices in your building should understand the facility’s expectations regarding attendance, collaboration with the rest of the interdisciplinary team, return of telephone calls, and standards of care. Poor performers need to be monitored, educated, documented, and, if necessary, eliminated, whether they have been sued or not. That would be true tort reform, the elimination of wrongful actions before they occur.

By Jeffrey Nichols, MD

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He invites your questions for possible discussion in this column. Please submit them by e-mail to caring@elsevier.com.