The Forgotten Hysteria Over Malpractice

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Abstract This article explores the origins of the medical “malpractice crisis,” and describes the basic social, economic, and political transformations that led to its emergence and the reasons for its rise. An understanding of these dynamics explains the gap in awareness about what the doctor/patient relationship is and what it should be, and its correlation to the upsurge in medical malpractice lawsuits and patient safety programs. The author recommends managing for and conserving the doctor/patient relationship as the key priority to be tackled in order to put an end to the “crisis” and prevent circumstances that further encourage it.

Keywords Health reform · Malpractice · Managed care · Physician · Patient · Quality improvement

In the summer of 2009, the Obama administration announced that \$25 million in government grants would be made available for programs to increase patient safety and reduce the number of medical malpractice lawsuits. But why did barely anyone notice? Was it a matter of poorly timing the news cycle? Was it that the funding was “pocket change” in the context of the multi-billion dollar health care industry? Was it that the funding would be oriented toward programs that everyone thought existed already, and only the latest attempt to do something about medical error and the “malpractice crisis?” Or was it that there was little connection made between the purpose of the grants and the commotion over health care reform?

The confusion about patient safety and medical malpractice is extensive, and has had a significant impact on health care.

Most specific and concerning, it has had an impact on the doctor/patient relationship. There is a gap in awareness between what the relationship is and what it should be. Yet there is as little understanding about the development of the gap as there is about its correlation to the upsurge in medical malpractice lawsuits and patient safety programs.

A Need for Protection

The practice of medicine is not too much different today than in the times of Hippocrates, Galen, Maimonides, Lister, or Salk. Yet during none of these periods—perhaps not even combined—were there so many and far-reaching advancements in the tools of medical science and technology as there have been in the past 50 years. The speed-up in scientific and technological change has permitted us to live longer; it has also divorced us from the reality that physicians are human and therefore fallible, and deprived us of the psychological bearings that fortify the doctor/patient relationship. So, too, has “managed care.”

For more than 100 years, both employer- and government-funded health insurance coverage have become the channels through which health care in the United States is organized and delivered. The notion of health coverage as a benefit was established through the early 20th century introduction of policies that could protect laborers’ financial well-being in the event of workplace accidents. It became perceived as a right with the passage of Medicare in 1965 and the Health Maintenance Organization Act less than 10 years later, which together provided a bedrock for managed care.

The concept of managed care is, in effect, a form of protection for both patient and physician. Through its programs and plans, it is protection-through-alliance. No less a practice was seen across feudal Europe, when

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weakened commoners and kings resorted to their stronger neighbors to provide protection from hostile forces in exchange for services and holdings. These arrangements of dependence and responsibility required a willingness of those who were less powerful to abdicate certain ownerships and freedoms to those with more power. They are what comprised feudal society and stabilized it. In health care, however, the similar exchange of power disintegrated the doctor/patient relationship and destabilized the entire system, for it required both patient and physician to willingly abdicate ownership and freedom over healthcare decisions to powerful proprietary health care organizations.

As patients sought protection in the plans, programs, and proxies of managed care, and the cost of health care increased and health insurance provisions became more restrictive and complex, physicians, in turn, sought their own means of protection. For centuries, diffuse numbers of physicians with soft ties to one another contributed to the overall functionality of their profession. Within that order they provided a high-demand service at a price that both physician and patient could agree was just; to solicit any amount beyond that would have disrupted the trusted relationship, if not also the relative economy. But approaching the end of the millennium, this is precisely what took place. As a result, the medical profession began to suffer from intrusions like those that dislocated and eventually destroyed its forebear, the guild of the Middle Ages.

Until the modern era of managed care, the majority of physicians had been solo practitioners in private practice. But when patients increasingly tethered themselves to managed care plans, a good many physicians began to find protection for themselves by securing arrangements under which their services were offered to small practice groups. Each of these groups, in search of their own protection, inevitably made an arrangement with a larger, conceivably stronger group. This exponential need for protection was conveniently satisfied by managed care organizations.

The result of these activities is encased in the popular complaint that the health care system is increasingly predicated by administrative function and formula which undermines the delivery of care and vitiates the pledge to safeguard the patient's standard of care. To what extent this is actually true is irrelevant, for it is the going belief. But irrespective of the extent to which the patient's health care needs are organized and overseen, it is by now well-documented that contracting with select networks of providers and requiring preauthorization for visits to specialists as means of cost control are corrosive actions. Most patients and medical professionals have resigned themselves to this over time. Meanwhile, the advancement of such conditions under the organizational, financial, political, and ideological girth of the public and private models of managed care has disrupted the old order of

health care, shaped the present one, and is already making that of tomorrow.

From the Outside, In

It is not coincidence that just after managed care took hold, there was an increase in the number of malpractice claims against physicians whose performance resulted in less-than-optimal-outcomes. Nor is it any less coincidence that this happened around the time the impact of the first Title VII lawsuits alleging workplace discrimination on grounds of race, sex, or handicap was being felt. For the majority of malpractice lawsuits do not even allege that the physician has performed some improper or negligent professional activity; they almost never claim the physician has done something illegal. They instead allege a violation of the patient's safety and well-being. In this way, the advancement of a malpractice claim is the patient's weapon of choice for protective assault not against *malpractice* but against *malpractitioner*.

The malpractice claim is a symptom of the degradation of the old order of health care. The loss of the traditional order created a fear of being abandoned in a world the patient neither knew nor understood, and produced a vacuum that led to engagement of a search for some responsible force. It would have been satisfactory to attribute the infirmities of the health care system to managed care organizations, health insurance companies, pharmaceutical companies or government agencies, or some combination thereof. These are the organs through which patients had come to protect themselves against illness and injury. But each has been too faceless, too unwieldy, and too distant to be demonized. Not one of them satisfies the requirement that such conditions call for: a loosely-knit, though highly-visible opposition force.

Patients personify this form. Yet the human tendency toward self-preservation—to say nothing of the decreasing amount of personal responsibility in our society—means most patients would have a near-impossible time pointing the finger at themselves. Thus, physicians remain the lone entity available for persecution and are, individually and collectively, a perfect scapegoat for the broad failure to deal with the grave problems in and of the health care system.

That the response to fixing the problems with the health care system has been milder than the rhetoric about them makes clear why anti-physician sentiment remains respectable. It is because persecution through legal actions against physicians has nothing to do with the qualities of the physicians themselves. They instead have everything to do with the tensions of the health care system.

Accordingly, the belief that the malpractice claim and some associated monetary award will mitigate “pain and

suffering” is only a means. The claim stems from the failure of health care professionals to replace the traditional order and concept of the doctor/patient relationship with a contemporary construct. Consider that there is not yet available any provable means by which to place an absolute value on human life or limb; there is only what psychologists and behavioral economists call *coherent arbitrariness*, or the relative valuations that appear to be sensible and undeniable but are actually random. So even if the counsel to fight on the artifice of money—and not for one’s rights or to repel an invasion of one’s well-being—could make the claim purposeful and justified, it provides no real palliative.

Yet physicians have been generally reluctant to point this out or to in other ways concertedly defend themselves in courts of law. Whether they do so to uphold the professional oath “to knowingly do no harm” unto the patient or because they fear some form of backlash by other patients and colleagues is compliance mistaken for cowardice. It is a stance that has left every physician open to attack. Concretely and inevitably, it diminishes the status and function of the profession, and could only make its professionals decreasingly able to wield the authority they have traditionally possessed. At the same time, however, the profession and its people will be expected to maintain every bit of accountability.

The Herald and the Thief

Even the staunchest critics of the health care system agree that physicians are necessary to make health care perform. Yet they also agree that health care is no longer the domain of physicians—or of patients. It has become the stuff of “providers,” “consumers,” and “third parties.” It has become pluralist. It has become depersonalized. It has grown into the dimensions perceived by Oreschenkov, “the old doctor” of Alexander Solzhenitsyn’s *The Cancer Ward*. So it is understandable that the present realization of this change in the structure of health care delivery has evoked angry calls, from all corners, for “tough reform” to “overhaul the system.” But this is the wrong response.

Our society is not willing to do without the services that the health care system has come to provide. Those most vocal about the deficiencies of the system are even less able to do without it than are the majority, as witness the continued invocation of the nearly decade-old findings of the Institute of Medicine’s *To Err Is Human* that “perhaps as many as 98,000 people ... die in hospitals each year as a result of medical errors that could have been prevented.” Numberless single-cause interest groups—personified in the mid-2000s during the hysteria over Terri Schiavo—have been oriented toward pressuring, paralyzing, and manipulating the debate by building on an outlier case in

which there is a less-than-optimal outcome. Though small in number, their highly predictable and intense behaviors tend to penalize and impede the work of the decent, competent majority of medical professionals. Yet they are still the only available checks on professionals and institutions of medicine and health care, which have not taken collective hold of performing in accordance with this responsibility.

For more than a quarter century, a good many of the professionals and institutions of medicine and health care have attempted to check themselves through quality improvement formulas and tools. But they are slowly awakening to the realization that these devices cannot single-handedly measure “quality.” Their focus on quantitative models expresses the incidence of positive and negative outcomes, which is data much too narrow to provide the necessary answers. They have not eliminated malpractice claims or in other ways provided the autonomy and community that gives a chance for fulfillment of the doctor/patient relationship. Nor have they overcome the persistent, underlying belief that physicians are motivated to run patients through the full range of diagnostic tests and procedures in order to make money.

Surely anybody who chooses medicine as a profession places a higher value on maintaining and improving the health of others than on making money. The educational and practical commitment is anyway inconsistent with making money; it is more proportionate to earning income. Were the case otherwise, there would be many more than 27,000 new physicians trained each year in the U.S. and no prospect of the estimated shortage of more than 125,000 physicians in the next 15 years.

With incomes in the six-figure range, medicine remains one of the highest paid professions in the U.S. But physicians have had to see more patients, increase the price of their services, or both, in an effort to keep pace with rising operational costs and the rate of inflation. This development has generally held true despite the relative disparity in income between specialists and primary care physicians and the implications of managed care, government reform, and the economy in general. Yet it runs in line with a public perception that physicians seek a “target income” most easily accomplished through their increasing the volume of services. It is therefore an unhappy accident that for the past century the symbol of the medical profession has been the caduceus, the staff wielded by Hermes, the god of Greek mythology who doubles as the deliverer of information and the patron of thieves.

In the discussion over physicians’ income, which includes a seemingly logical extension to pay-for-performance schemes, little credence is given to the results of study upon study that show real income rises less over time the more skill and knowledge a job requires. Nor has there been much attention given to the research that concludes most people

rank respect and dignity above anything else on the list of factors that contribute to increased productivity at work. And there is even less given to the convergence of a number of separate though dependent developments of the past 30 years or so, which include:

- rising operational costs and rates of inflation;
- rising costs and decreasing availability of professional liability insurance;
- the phenomena of “going bare”;
- the practice of “defensive medicine”;
- a continuous exodus of insurers from markets that have subsequently become cost-prohibitive;
- the dividing line between a patient case that results in a “negative outcome” versus “malpractice”; and
- a failure to adopt tort reform that includes caps on non-economic damages.

These factors, especially taken together, have contributed to more and more rules and regulations, which have in turn raised costs rather than cut them. But these rules and regulations are not a reaction to economic or technological advancements. They are a reaction to a small number of extreme cases that had a big impact during a period of sharp change.

Reform or Reorganization?

Medical malpractice legislation and litigation first materialized in the U.S. during the 19th century to safeguard and equitably compensate a population frequently exposed to sham medical practices. Despite the medical profession having become more regulated over time, the physician has been gradually treated with the contempt once reserved for the snake oil huckster for whom the laws were designed.

The healthcare system cannot forever function effectively under this atmosphere. But it is necessary that this tension be asserted anew, with increasing intensity at decreasing intervals, lest the belief in managed care become vulnerable to sudden collapse. Still, a collapse is imminent and will come as soon as there is belief in a new order of healthcare.

Yet the new order cannot be seen until there is first belief in an alternative to the reliance on the health care blocs that define the integrated units of modern medicine. This means an investment in the creation of new institutions throughout health care and society based on the principles of Hippocratic medicine, in which care favors the person over the disease and policy fits the patient rather than the bureaucracy. Until then, there can be no doubt that the malpractice claim will continue to be a salve for the despair over the sickness of the health care system.

But what is the starting point for resolution? Up to now and into the foreseeable future, the tendency rests on an to

attempt to fix everything at once. The result is a focus on processes, checklists and outcomes, and not nearly enough attention paid to the delivery of care.

For more than 20 years, there has been a growing demand for examination and revamping of the standards of “quality care.” The hope had been that those within the profession would be willing, able, and disciplined enough to see-through this effort. But they were not. And because they did not show themselves to be responsible, the American public has been increasingly doing it for them.

During this span of time, talk of a “malpractice crisis” has been relegated mostly to the latter paragraphs of policy speeches and opinion columns. When it is mentioned there is only talk of resolution through “tough reform.” But it is naïve of policymakers and trial lawyers to believe that reform will prevent medical errors. It is equally naïve of medical professionals to believe that reform will overcome malpractice litigation, the per-person costs of which are higher in the United States than in any other country in the world. Reform cannot bond the fissure of the doctor/patient relationship. Nor can it overcome the reality that most of what is called “medical error” actually consists of organizational breakdown by way of management dysfunction.

The correlation between medical error, medical malpractice and patient safety is rather clear on its surface. But it is often soon-forgotten that lapses in the delivery of quality care are not so much a failure of medicine than a failure of management’s task to efficiently and effectively place the right people where they need to be at a particular time. By extension, physicians who become preoccupied with the prevention of malpractice suits cannot concentrate fully on the tasks and activities in which they employ their strengths, which means their skills become less and less organized. This, in due course, disrupts the doctor/patient relationship. For better and worse, so too do the snowflakes of information available on the World Wide Web that have emboldened patients to perform self-diagnosis and self-treatment, as do the television dramas that examine the medical decisions and procedures made by physicians and lay bare their personal life decisions and activities.

When all is said and done, sustaining the doctor/patient relationship remains one of a small handful of real priorities we know of and know how to manage effectively. It is the sort of underlying priority—perhaps the primary one—that needs to be tackled if there is going to truly be an increase in patient safety and reduction in the number of medical malpractice lawsuits.

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