Patient Safety and the Malpractice System

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KEYWORDS

• Tort system • Risk management • Informed consent • Patient safety

KEY POINTS

- The cost of health care in the United States and malpractice insurance has escalated greatly over the past 30 years.
- In an ideal world, the goals of the tort system would be aligned with efforts at improving safety.
- There is little evidence that the tort system and the processes of risk management and informed consent have improved patient safety.

The cost of health care in the United States has increased dramatically over the past few decades. There are many explanations offered as to why this has occurred, including the use and implementation of newly designed and costly devices and implants; the introduction of novel pharmaceutical agents that are expensive to develop, test, and bring to market; and the costs of health care education and health care delivery infrastructure.

One frequent cited and significant contributing factor is the cost associated with the malpractice epidemic, which has developed, persisted, and escalated largely over the past 30 years. Although malpractice insurance premiums across the board have stabilized in the past decade, and frequency and severity of claims have leveled, the cost of the entire enterprise is stifling. According to Hilary Clinton and Barack Obama, "high premiums are forcing physicians to give up performing certain high risk procedures leaving patients without access to a full range of medical services."[1] They also claim that "the tort system must achieve four goals: reduce the rates of preventable patient injuries, promote open communication between physicians and patient, ensure patients access to fair compensation for legitimate medical injuries and reduce liability insurance premiums for health care providers."[1] There is little, if any, objective evidence that the tort system has even scratched the surface in achieving these lofty and largely unachievable objectives. The cost of defensive medicine also adds to the cost. Examples include prescribing antibiotics when not indicated to supplant the risk of an unlikely occurrence of a serious infection, exposing patients to the cost and risk of loss of bacterial susceptibility to a therapeutic medication. Another example is exposure of a patient to a preoperative cone beam CT scan for fear that if a complication occurs, an expert witness may allege that the standard of care was violated when that study was not ordered. Several examples occur in medicine. One is the recommended frequency of mammograms for evaluation for potential breast cancer. If a national agency or body determines that the frequency between mammograms be expanded as a general rule, a patient who experiences breast cancer within the extended interval may feel that the frequency of evaluation should have been greater. And if an expert can be located who agrees, a lawsuit may be filed.

The tort system has been labeled adversarial, promoting a behavior of defensiveness, denial, and blame. The concept of error disclosure has been aligned by some people with the patient

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safety movement, described as a culture of error disclosure, apology, and no blame, a supposed contradiction to torts.

There are others who have opined that the threat of torts (malpractice system) is good for patient safety. The concept is that the fear of being sued due to the ever-present possibility that an adverse outcome and/or patient dissatisfaction would result in an allegation of malpractice with the accompanying embarrassment and guilt plus a potential large monetary award would entice a practicing oral and maxillofacial surgeon (OMS) to use safe practice meeting the standard of care. Others claim that the tort system punishes OMSs who have a disregard for practice within the standard of care and the publication of those sanctions and punishments will dissuade any potential patients from seeking care from the identified surgeons. There are little data to prove that the publication of sanctions and punishments will affect the number of patients seeking services from the exposed surgeon.

OMSs are repeatedly reminded during training and in practice to first "do no harm." In many situations, surgical and/or treatment outcomes may be less favorable than desired. When this occurs, there are some people who infer that any unfavorable outcome is in some way, shape, or form an error that is the result of malpractice, a breach of the standard of care, and the fault of the surgeon.

The National Practitioner Data Bank (NPDB) was formed by the US government decades ago. Some of the rationalization for this entity included the concept of patient safety by limitation of privileges and licensure of health care providers being sued, stipulated, or restricted or making a payment to a patient in response to a complaint or claim. Some state licensing/regulatory agencies publish actions taken against licensees for transparency purposes, supposedly to inform potential patients/consumers that the health care provided by the OMS had an adverse action, situation, or result. Again, in theory, potential patients can avoid the clinicians sanctioned, thereby experiencing safer care or management by seeking out or being treated by a health care provider who has not been similarly sanctioned.

Advocates for the tort system of civil liability may make the same allegation. If a health care provider is confronted by an attorney representing a client who is a patient of that provider, he/she may be asked to settle the matter, generally by paying an amount demanded by the attorney. If and when this action is reported to a regulatory agency (licensing board or data bank) and those actions become public, a potential patient may decide to avoid that individual so sanctioned, thereby increasing safety of care for that individual or for the population as a whole.

If a civil lawsuit is filed, there may be public disclosure of the action. In times past, legal counsel may have demanded a large settlement or suit value, into the millions or tens of millions of dollars, generally making the headlines in the press. As the prospective patient population becomes aware of the litigation, they may choose to avoid treatment by the individual named as the defendant.

There are few, if any, data that prove that the tort system, the court of public opinion, the NPDB, the regulatory/licensing agencies, or any other mechanism influenced by these reports results in safer patient care. It may be argued that, when comparing early reports of medical error contributing to from 44,000 to 98,000 deaths in the United States in the 1990s[2] with recent reports of more than 250,000 deaths in the United States due to medical error,[3] we have in fact suffered more deaths in spite of all the patient safety initiatives that have been proposed and integrated over the past 15 years. A confirmation of this suggestion is found in the annual public report of adverse health events in Minnesota, with the number of overall adverse events remaining relatively unchanged over the past 8 years.[4]

RISK MANAGEMENT AND IMPACT ON PATIENT SAFETY

Risk Management

Risk management associated with medical professional liability insurance providers is understood to mean reduction of risk of a claim or lawsuit against a health care provider. It does not generally refer to reduction of the risk of oral and maxillofacial surgical care to the patient being treated.

Many professional liability insurers offer or require participation in courses, seminars, online modules, office inspections, and other mechanisms to manage risk associated with rendering oral and maxillofacial surgical care. The objective of these courses is primarily to manage or reduce the risks associated with OMS care to avoid the possibility of a claim or lawsuit. They also provide information regarding what to do in situations when there may be adverse outcome.

Informed Consent

A highlight and heavily referenced component of risk management is the informed consent process. Required by most regulatory agencies, informed consent is required for most surgical procedures performed by OMSs. The process includes but is not limited to the doctor informing the patient regarding the planned surgical procedures,