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Practicing Quality Medicine Instead of Defensive Medicine:

Three Interprofessional Solutions to Balancing the

Certainty, Caution, and Cost Concerns

Lying at the Heart of Our Defensive Medicine Crisis

Defensive medicine is a graveyard of ideas. The evidence is as substantial as it is clear that American physicians are ordering clinically-excessive tests, procedures, and treatments not to treat their patients but to lower malpractice liability.[1] There is an inescapable chance that a seemingly unnecessary test can discover a serious problem. Failing to discover that problem can lead to malpractice suits, so physicians are increasingly exercising caution in the face of uncertainty by overusing certain (often costly) tests.[2] The logic of defensive medicine practices is understandable on an individual basis, because these extra tests, procedures, and treatments cost the physician nothing while potentially sparing him or her from a lawsuit.[3] But on a societal scale, the growing reliance of physicians on overtreatment has resulted in an increasingly wasteful, excessive, and inefficient provision of medical services across the United States.[4] Even after the past decade's malpractice awards have been halved on average,[5] American health

[1] *See, e.g.*, U.S. Congress, OTA, Defensive Medicine and Medical Malpractice, ota-h-602 at 13 ("Defensive medicine occurs when doctors order tests, procedures, or visits … primarily (but not necessarily solely) to reduce their exposure to malpractice liability."); David M. Studdert et al., *Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment*, 293 J. AM. MED. ASS'N 2609, 2609-10 (2005) (defining "defensive medicine" as a "deviation from sound medical practice that is induced primarily by a threat of liability.").

[2] *See* Sumi Sexton, *How Should We Manage Incidentalomas?*, 90 AM. FAM. PHYSICIAN 11 (Dec. 2014).

[3] *See* Michael Daly, *Attacking Defensive Medicine Through the Utilization of Practice Parameters: Panacea or Placebo for the Health Care Reform Movement*, 16 J. LEGAL MED. 101, 105 (1995) (noting that physicians are often "more likely to be penalized for ordering too few tests or for not performing medical procedures than they are for utilizing 'medically unnecessary' procedures [and] are therefore given strong incentives to utilize health care resources that are not medically necessary to reduce their perceived risk of malpractice liability to as close to zero as possible.")

[4] *See, e.g.*, *id.* at 102 (finding that over the next five years alone, the avoidable costs of defensive medicine could total $ 35.8 billion); Office of Disability, Aging, and Long-Term Care Policy, U.S. Department of Health and Human Services, ADDRESSING THE NEW HEALTH CARE CRISIS: REFORMING THE MEDICAL LITIGATION SYSTEM TO IMPROVE THE QUALITY OF HEALTH CARE 7 (2003) (describing the overwhelming number of providers who admitted to using unnecessary services to avoid malpractice liability).

[5] *See* United States - NPDB Report and Compliance Statistics by State, Table 3, National Practitioner Data Bank, http://www.npdb-

expenditures are the highest per capita in the developed world.[6] At a cost of $6,697 per person per year, American health expenditures account for about a seventh of the US economy.

Scholars have proposed and legislatures have implemented a wide range of solutions to the defensive medicine crisis, but it continues unabated. Despite the important roles that certainty, caution, and costs have in the analysis of defensive medicine practices, mainstream scholarship has focused on these factors to the marginalization of what should truly be at the discussion's forefront, namely the patient's health. It is taken for granted that extra diligence is in line with the physician's responsibilities, as there is always a possibility that a clinically excessive test could discover an unforeseen, if unrelated, malady. But every test, procedure, and treatment could also have the opposite effect of harming a patient, in violation of *nil nocere*, the physicians' ancient ethic to do no harm.[7] Harming a patient for no reason but to reduce malpractice liability may, ironically, also lead a jury to find for an injured plaintiff.[8] Through consultations, mediation, and alternative dispute resolution contracts, attorneys can collaborate with physicians to help them return to practicing quality medicine instead of defensive medicine.

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hipdb.hrsa.gov/servlet/DataTablesByStateServlet?selectedTab=Tabular&stateName=UNITEDSTATES (last visited Dec. 29, 2014) (noting that about 8,500 medical malpractice payments were made in 2011, while almost 16,000 such payments were made in 2001).

[6] *See* The Henry J. Kaiser Family Foundation, HEALTH CARE COSTS: A PRIMER 2 (2007).

[7] *See, e.g.*, U.S. Congress, *supra* note 1, at 23 ("The malpractice system may also encourage physicians to order risky tests or procedures that both raise health care costs and on balance do more harm than good for patients."); The T. J. Hooper, 60 F.2d 737, 740 (2d Cir. 1932) (…"there are precautions so imperative that even their universal disregard will not excuse their omission.")

[8] *See* Alan G. Williams, PHYSICIAN, PROTECT THYSELF 34, 59-60 (2007).

The Impracticability of Large-Scale Solutions

The graveyard of ideas to resolving the rise in defensive medicine practices is stacked high with alluring but unfeasible large-scale solutions. One of the more intuitive ideas took hold in the early 1990s, and encouraged designated professional medical associations to define the appropriate standard of care through guidelines.[9] These guidelines would help an uninformed jury or judge decide a medical malpractice case, while also forming "safe harbors" whose irrebutable evidence would cut down on meritless suits.[10] But because certainty is a clinically unattainable goal at this point in history, the guidelines failed to insulate physicians from malpractice liability.[11] The Obama Administration has resurfaced this initiative and hopes to strengthen it with "evidence-based" guidelines, but the guideline initiative's renewal is likely doomed because patients and their ailments are typically too unique for a checklist to always work.[12]

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[9] *See* Institute of Medicine, National Academies of Science, CLINICAL PRACTICE GUIDELINES: DIRECTIONS FOR A NEW PROGRAM 38 (M. J. Field & K. N. Lohr eds., 1990) (defining the guidelines as "systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances.")

[10] *See* C. C. Havighurst, *Practice Guidelines for Medical Care: Policy Rationale*, ST. LOUIS UNIV. L. J. 34 (Summer 1990), *in* "Effect of Medical Practice Policies in Malpractice Litigation," LAW AND CONTEMPORARY PROBLEMS 54, at 131 (1991) (referring to the effect of the guidelines as having a "pre-emptive effect that precludes opposing testimony about the applicable standard of care.")

[11] *See* Comm. to Advise the Pub. Health Serv. on Clinical Practice Guidelines, Inst. of Med., CLINICAL PRACTICE GUIDELINES: DIRECTIONS FOR A NEW PROGRAM 15 (Marilyn J. Field & Kathleen N. Lohr eds., 1990) (stating that the guidelines initiative "suffers from imperfect and incomplete scientific knowledge as well as imperfect and uneven means of applying that knowledge.")

[12] *See, e.g.*, Obama's Health Care Speech to Congress, September 9, 2009, *available at* <http://www.nytimes.com/2009/09/10/us/politics/10obama.text.html?pagewanted=1&%2360;!Undefined%20dynamic%20function%20data_ sanitationlib::sanitize_string:l%20called -&%2362;> (last visited December 28, 2014); M. C. Weinstein & J. A. Skinner, *Comparative Effectiveness and Health Care Spending: Implications for Reform*, N.E. J. OF MED. 362, no. 5

Legislation is another popular solution. Tort reform, the creation of health courts, and the modification of American malpractice doctrine to fit its European counterpart are all solutions as outstanding as they are unfeasible. Congress, now suffering from one of its most unproductive and partisan bouts in American history, will not enact such legislation with broad bipartisan support anytime soon. If national reform occurs, it could save 70 to 126 billion dollars in healthcare costs.[13] But in an era when even groundbreaking healthcare legislation fails to include substantive tort reform, that is simply a very large "if."[14]

Legal Consultation

In stark contrast to the infeasibility of large-scale solutions, interprofessional medical-legal collaboration can reduce defensive medicine practices and encourage quality medicine practices in their wake more economically, quickly, and feasibly. Counsel from a medically competent attorney can substantially reduce the waste and inefficiency beginning to characterize the provision of medical services in the US. Just as the physician plays a critical role in keeping his or her patients informed of their medically advisable options, so too can an attorney play a critical role in keeping physicians informed of what tests, procedures, and treatments are legally advisable. Indeed, the breadth of large-scale solutions is part of the problem in the clinical context, when every body and ailment is so unique. Dispensing advice on a case-for-case basis is perhaps the only reliable option.

(2010): 460-65 (noting that the American Recovery and Reinvestment Act of 2009 authorized a billion dollar investment into guideline-oriented research comparing "clinical outcomes, effectiveness, and appropriateness of items, services, and procedures that are used to prevent, diagnose, or treat diseases, disorders, and other health conditions.")

[13] *See* Office of Disability, Aging, and Long-Term Care Policy, U.S. Department Of Health And Human Services, ADDRESSING THE NEW HEALTH CARE CRISIS: REFORMING THE MEDICAL LITIGATION SYSTEM TO IMPROVE THE QUALITY OF HEALTH CARE 11 (2003).

[14] *See* Patient Protection and Affordable Care Act § 10607 (2010).

Helpfully, the trend of increasing attorney specialization coincides well with the increasing need for collaboration between attorneys and physicians. An attorney can advise physicians that a test, procedure, or treatment is legally unnecessary only if the attorney has the malpractice experience it takes to recognize when a test is clinically excessive. Despite the difficulty of obtaining such specialized advice, advice of this nature offers precisely the kind of protection against unwarranted malpractice suits that "are needed to decrease the unnecessary use of diagnostic tests."[15]

The need to purchase malpractice insurance is another important area of advice that can substantially reduce waste and inefficiency in the provision of American medical services. Physicians working in high-risk practice areas see the highest annual premiums, sometimes approaching a quarter of a million dollars or more.[16] While those physicians undoubtedly need insurance to balance the risk of injury inherent to their practice, their counterparts who work in low-risk practice areas may be in a position to avoid purchasing malpractice insurance altogether. Patients who conflate bad outcomes with malpractice would be less likely to sue in the hope that their jury might be inclined to award large damages because the defendant's insurance provider boasts "deep pockets."[17] But if a physician mistakenly sees no need for malpractice insurance, then that physician may lose everything in order to compensate a seriously injured patient – and even then, the patient might not be fairly compensated. Counsel

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[15] *See* Tara F. Bishop et. al., *Physicians' Views on Defensive Medicine: A National Survey*, 170 ARCHIVES OF INTERNAL MED. 1081, 1083 (2010).

[16] *See, e.g.*, American Medical Association, America's Medical Liability Crisis Backgrounder on Florida, *available at* http://www.ama-assn.org/ama/pub/category/12384.html (last visited Dec. 30, 2014) (finding that obstetricians and gynecologists pay premiums up to $250,000 in Florida); American Medical Association, America's Medical Liability Crisis Backgrounder on Illinois, *available at* http://www.ama-assn.org/ama/pub/category/12384.html (last visited Jan. 1, 2015) (finding that Illinois neurosurgeons pay premiums of about $300,000).

[17] *See* Mark A. Behrens et. al., *The Constitutional Foundation for Federal Medical Liability Reform*, 15 J. HEALTH CARE L. & POL'Y 173, 174 n.6 (2012).

from an attorney can help physicians determine whether to purchase medical malpractice insurance, thus sparing the court system from meritless cases and preventing disaster for otherwise uninsured physicians and their patients.

Mediation

Mediation offers another promising area of medical-legal interprofessional collaboration. Mediators act as a neutral third party by helping both the physician and patient confidentially negotiate a mutually acceptable solution. Mediations generally offer three advantages over litigation: in mediation, the parties control the outcome and are spared the expense and stress of preparing for trial and sifting through pre-trial discovery, litigation is still possible if either party prefers at some point to resolve the issue through the court system, and the dispute quickly achieves resolution.[18] Time is an important factor not only for reasons of convenience, but also cost. Litigation typically costs the injured plaintiff between $25,000 to $250,000.[19]

In addition to the general advantages that mediation holds over litigation, medical malpractice is a type of dispute whose resolution would be especially conducive to the mediation process. Firstly, the emphasis on cooperation between the parties helps repair, maintain, and potentially strengthen the patient-physician relationship.[20] Such a delicate relationship, based on trust and communication, is less likely to survive the kind of antagonism and hostility that characterize the adverse nature of trial. A continuing relationship is key to helping the physician understand, for future reference, what actions to take and what to avoid in the treatment of his or

[18] *See* Florence Yee, *Mandatory Mediation: The Extra Dose Needed to Cure The Medical Malpractice Crisis*, 7 CARDOZO J. CONFLICT RESOL. 393, 416 (2006).
[19] *See id.* at 407.
[20] *See id.* at 417.

her patients. While this trial by error is not the ideal kind of solution, at least mediation allows the physician to gain some understanding instead of yielding to the prerogative to remain silent and ignorant of real and perceived errors.

Secondly, mediation offers a forum through which the physician can explain and contextualize his or her conduct to the patient or the patient's family. In the highly technical world of medical practice, potential plaintiffs should understand clearly what happened before beginning the litigation process. A face-to-face meeting with the physician can achieve the same result as a lengthy discovery process, with the added benefit of helping quickly reach a settlement agreement.[21] With about one hundred thousand Americans dying annually from preventable medical errors[22] and up to 18% of hospital patients suffering some preventable injury,[23] surely there is room for mediated agreements to resolve malpractice issues in some disputes – particularly disputes in which there has been a bad outcome for the patient, but not as a result of malpractice. This is why physicians should not send an intermediary because of their demanding work schedule. In certain cases, after all, patients sue for malpractice simply to find out what really happened. Most importantly, allowing physicians to explain themselves are another way in which mediations help physicians understand, for future reference, what actions to take and what to avoid in the treatment of his or her patients.

Thirdly, the speed and productivity of mediation gathers extra weight by the fact that malpractice suits are an especially laborious and inefficient type of litigation. Underclaiming,

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[21] *See id.* at 419-20.

[22] *See* Committee on Quality of Health Care in America, Institute of Medicine, TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 1 (2000), *available at* http://www.iom.edu/~/media/Files/Report%20Files/1999/To-Err-is-Human/To%20Err%20is%20Human%201999%20%20report%20brief.pdf.

[23] *See* Jennifer Arlen, *Contracting Over Liability: Medical Malpractice and the Cost of Choice*, 158 U. PA. L. REV. 957, 971 (2010) ("Studies have found that between four and eighteen percent of hospital patients are the victims of medical errors, many of which cause serious injuries.")

undercompensation,[24] and years'-long delays are typical of malpractice litigation.[25] In mediation, by contrast, some form of quick compensation is virtually guaranteed if both sides can come to a mutual agreement. For example, a pre-suit mediation program in Florida required physicians to disclose any medical error and offer mediation to resolve any dispute.[26] The patients who agreed to mediate received the same, if not slightly more, compensation than patients who litigated, and they received compensation six times faster than those who litigated.[27] Mediation's efficiency will quickly clarify the boundary of what is and is not excessive treatment in a jurisdiction, which physicians can and should rely on for future patient treatment.

The "Hippocratic Contract"

Lastly, attorneys can help physicians draft a contract that enters patients into a health plan built on a regimen of alternative dispute resolution. Almost all American medical students swear to abide by the Hippocratic Oath or some variant of it, and the spirit of this oath reminds the aspiring physicians to use their knowledge "to further the public's and the patient's interests, rather than the professional's self-interest."[28] In line with that spirit, this contract will require the

[24] Univ. Tex. Law Sch., Law & Econ. Research Paper No. 99 (2008), *available at* http://lawweb.usc.edu/academics/assets/docs/black.pdf ("[T]he per-case efficiency of the system is a bit under 50%. Stated differently, it costs about a bit over a dollar in legal fees and expenses for the plaintiff to end up with $ 1 in his pocket.").
[25] *See* Catherine T. Struve, *Doctors, the Adversary System, and Procedural Reform in Medical Liability Litigation*, 72 FORDHAM L. REV. 943, 944 (2004).
[26] Interview with Randall Jenkins, Esq., UF-Shands Assoc. Dir. of Patient Safety Research & Educ., in University of Florida College of Medicine-Shands Hospital, Jacksonville (Feb. 23, 2011).
[27] *See id.*
[28] Clifford Perlis, et al., Role of Professional Organizations in Setting and Enforcing Ethical Norms, 30 CLINICS IN DERMATOLOGY 156, 157 (2012).

physician to notify his or her patient of any error, incentivizing physicians to exercise nothing less than their best judgment.[29]

In the event of an injury, the dispute (but, to maintain anonymity and avoid even the appearance of bias, not the parties) will be referred to a panel of three medical experts for arbitration. Arbitration requires less discovery and time than litigation; puts the complex, medical decision into the hands of a panel of medical experts; and forgoes the formality, antagonism, and publicity that can characterize the ordeal of formal litigation, all while maintaining the finality of a trial and the hard look that both parties deserve.

The panel's binding decision, based on their own clinical experience and common sense instead of an inherently imperfect guideline, will determine the patient's monetary award, if any. The panel's three experts will be drawn from the local medical board, which already has the funds to compensate injured patients,[30] the authority to discipline physicians, and the experience with neutral investigations of complaints against physicians. Fault plays no role in the panel's discussion. While fault typically deters misconduct and provides useful feedback for physicians, the notification requirement provides the deterrence and the panel's analysis provides the feedback, all while giving physicians the peace of mind to practice quality medicine instead of defensive medicine. If the physician exercised seriously poor judgment, then the panel is free to recommend that the local medical board open a formal investigation. Such investigations have penalized many physicians already, so there is no basis to believe that a medical board has any bias in favor of physicians. To the contrary, medical boards have a vested interest in removing

[29] *See generally* John Dorman, *The Hippocratic Oath*, 44 J. OF AM. COLL. OF HEALTH 2, 84–88 (1995).

[30] At the least, medical boards can gain access to the funds by increasing the dues that local physicians owe, then aggregating that increase into an injured patient compensation fund.

poor physicians from the field while juries have shown to be overly deferential to physicians.[31] Caps on non-economic damages also play no role in the discussion if state law provides no caps. Caps not imposed by the state should be avoided to award injured patients precisely what they deserve and to encourage patients to sign into this contract.[32]

Courts, physicians, and patients can find this contract appealing. An alternative dispute resolution agreement will face the close scrutiny of courts that may question whether it is unconscionable or runs afoul of certain constitutional guarantees, such as the 7th Amendment's right to a jury trial. To survive that scrutiny, the attorney drafting this contract must make a point of writing it in clear language. Patients should be free to take their time before signing, and certainly not be made to sign at the point of service. This contract, like its counterparts in California and Ohio, should also let those with "signer's remorse" void it within one month of signing.[33] Despite the fact that the contract prevents patients from bringing suit for medical malpractice in the civil court system, patients will see that the contract offers more opportunities than restrictions. Because physicians must notify patients of error, patients will know about any error from the outset and receive compensation far more quickly and with more likelihood than litigation can accomplish.

Physicians, meanwhile, will appreciate the opportunity to deepen their communications with patients and see fewer lawsuits. Adherence to the contract will not only incentivize the kind of excellence in which the medical profession takes pride, but also offer a marketing advantage to physicians. After all, physicians with the contract could advertise their practice as one that

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[31] *See* Philip G. Peters, Jr., *Doctors & Juries*, 105 MICH. L. REV. 1453, 1495 (2007) ("…juries treat physicians very fairly, perhaps with too much deference.")
[32] *See* Medical Liability/Medical Malpractice Laws, Nat'l Conference of State Legislatures, (Aug. 15, 2011) *available at* http://www.ncsl.org/issues-research/banking/medical-liability-medical-malpractice-laws.aspx (listing the states with caps).
[33] *See* Cal. Civ. Proc. Code § 1295(C) (2009); Ohio Rev. Code Ann. § 2711.23(B) (2009).

offers quality medicine. The arbitration's anonymity, privacy, and lack of participation from the parties fit most physicians' intense schedule. Physicians, as well as defense and plaintiff attorneys, should all find appeal in the arbitration's lowered discovery costs, lessened error rate (including fewer successes of meritless cases), and easier time of determining what cases have merit.

Conclusion

Through consultations, mediation, and the creation of a Hippocratic Contract, medical-legal interprofessional collaboration can reduce the number of medically excessive and legally unnecessary tests, procedures, and treatments. The Hippocratic Oath and its variants typically include the vow to avoid overtreatment, because, as Benjamin Franklin once said, "the best doctor gives the least medicines."[34] But overtreatment lies at the heart of defensive medicine practices, which are by definition the use of excessive care for legal purposes. The ethic of *nil nocere* certainly shuns the use of a test, procedure, or treatment that can unnecessarily harm the patient. Interprofessional collaboration between attorneys and physicians can enable physicians to stop jeopardizing that ancient medical ethic, and instead return to providing the kind of medicine they are eager to provide – quality medicine that will improve patient heath, not defensive medicine that will endanger it.

[34] *See* Christopher C. Evans, CANCER UNCENSORED at 29 (2012).