Law and the Public's Health

MEDICAL ERRORS, MEDICAL NEGLIGENCE, AND PROFESSIONAL MEDICAL LIABILITY REFORM

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The role of individual states in the protection of the quality of health care is paramount under the principles of public health law.[1] One of the most complex issues in health care quality law concerns which remedies should be available when patients suffer death or injury as a result of the alleged negligence of a health care professional or corporation. In public health policy and practice, the question of liability is part of the continuum of issues that arise in public health oversight of health care quality. In this issue, *Law and the Public's Health* examines the law of professional medical liability, as well as prospects for federal reform and their implications for public health practice and policy.

THE EVOLUTION OF PROFESSIONAL LIABILITY LAW

For several hundred years, courts have recognized the concept of legal liability for professional medical negligence. In *Slater v Baker and Stapelton* (an English common law, or judge-made law, case from the 18th century), a court articulated the standard of care against which the conduct of physicians would be measured in such an action as "the usage and law of surgeons" and "the rule of the profession as testified to by surgeons themselves."[2] This standard, which came to be known as the "professional standard," was adopted by U.S. state courts. It was a highly deferential standard that shielded physicians from professional liability in two ways. First, the professional standard meant that even if a physician's conduct fell below even the most reasonable expectations, he could not be found liable if other physicians testified that his conduct was within the professional standard of care.[3] In other words, only another physician's testimony would be considered relevant to a determination of negligence. Second, courts adopted the "locality rule," which held physicians to a standard of care no higher than that found in their practice locale, thereby precluding evidence of a higher standard of care offered by outside experts.[4]

Beyond physician liability, the courts also immunized hospitals against liability under other doctrines. One such doctrine was the charitable immunity doctrine, which exempted charitable corporations from liability in order to preserve their assets for community benefit.[5] Another was the "captain of the ship" doctrine, which ascribed the negligence of hospital staff to the attending physician, perceived as the actual person in charge.[2] The underlying theory of this doctrine was that hospitals were mere physician workshops and could not be held accountable for errors of their staffs. Subsequent state legislation establishing anti-corporate practice of medicine prohibitions perpetuated this view of hospitals as mere physician workplaces.

By the middle of the 20th century, this protective legal shield began to give way to medical advances and a concomitant broad diffusion of knowledge through improved medical training, as well as the resulting adoption of nationally recognized licensure and accreditation standards for professionals and institutions. Physicians—particularly specialists—began to be judged in accordance with a national standard of care that essentially laid the locality standard to rest and made it possible to introduce the testimony of national experts.[6] Hospital liability—for both acts of corporate medical negligence[7] as well as the negligence of staff (through vicarious liability)[8]—was also recognized and the principles of direct and vicarious liability in health corporations was extended to other corporations as well, including managed care organizations.[2]

Thus, as medicine evolved, so did judicial standards, and as the potential for liability grew, so did the recoveries. Recovery included both compensation for measurable economic losses resulting from death and injury, and non-economic awards, including punitive damages. Insurers began to predict major malpractice premium increases, and rates skyrocketed in the 1970s. As these events unfolded, state legislatures began to intervene through legislation to temper the potential outcome of a major expansion of common law liability. Even though the leading malpractice study shows that for every eight instances of negligence, only one claim is filed,[9] 45 states and the District of Columbia have enacted reforms since 1985 to limit recovery in a wide variety of personal injury actions, including medical liability claims.[10] Malpractice reform legislation—the best known of which is California's 1975 enact-

ment, known as MICRA—tends to operate in two ways: 1) it imposes caps on damages (in some states both economic and noneconomic); and 2) it imposes procedural barriers to make litigation harder to bring. Studies suggest that California's legislation reduced the potential for litigation but did not lower premium rates until 1988, when a subsequent law imposed direct price controls on malpractice liability insurers.[11]

THE CURRENT SITUATION

The reasons underlying the most recent spike in medical malpractice premiums led to a new wave of concern. A widely disseminated report prepared in 2002 for the Department of Health and Human Services (DHHS) Assistant Secretary of Planning and Evaluation documented widespread problems and identified excessive damages awards as a leading factor.[12] Other studies suggest that insurers have boosted premiums to offset economic losses from a declining stock market.[13] Whatever the underlying reasons, daily news accounts report on the impact of rising premiums on physicians and the resulting impact on communities, as well as the perceived impact on the federal budget. A 2002 report by the U.S. Congressional Budget Office (CBO) estimated that tort reform could save billions of dollars in federal health programs, since many programs, such as Medicare and Medicaid, include malpractice premiums in their provider payment calculations.[14]

Federal discussions have centered on two basic approaches. The first, favored by members who view quality of care matters as within state purview, is a "go-slow" approach that turns on modest assistance to states to support their own tort reform or regulatory activities. The second, favored by the Bush Administration, favors a federalization of tort reform through the establishment of national standards that, like MICRA, would limit the frequency of litigation as well as the size of allowable non-economic damages recoveries. As of March 2003, the leading measure is H.R. 5—Help, Efficient, Accessible, Lowcost, Timely Healthcare (HEALTH) Act—introduced by Congressman James Greenwood of Pennsylvania. However, long-term health care quality improvements are not under consideration in a malpractice reform context presumably because such initiatives would have virtually no immediate effect on rates.

Some of the medical liability legislation issues of particular interest to the public health community are:

- Will the federal measure expand or limit state authority to fashion reforms? For example, would the legislation preempt state efforts to encourage quality of care reforms by conditioning more stringent non-economic damages caps on the adoption of certain reforms by health care providers? For example, should a defendant be covered by a lower cap if he/she can demonstrate the use of relevant quality safeguards or the adoption of a voluntary error disclosure policy with patients? Such disclosures appear to reduce litigation.[15]
- Does the legislation preempt alternative state approaches to reform such as rate regulation?
- Is the legislation confined to medical liability claims, or does it preempt state law remedies for all types of claims against health care providers? For example, H.R. 5 affects the available remedies for all claims against health care corporations, not just medical malpractice. The bill covers corporate violations of consumer fraud laws, state antitrust statutes, and state environmental and occupational health laws.
- Will the federal legislation require improvements in medical errors reporting by health care providers as a condition of coverage under the caps?
- Will insurers be required to report financial data on rate increases and will rate cuts that flow from the reforms be covered by a provider rebate provision?

Legislation to federalize malpractice liability standards is anticipated to pass the House of Representatives by the spring of 2003, but it is too early to predict when Senate action will occur.

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