Malpractice

The Christian Medical & Dental Associations affirm the following:

We are committed to providing excellent care to our patients and we hold ourselves to the highest possible standard.

We recognize that neither medicine nor dentistry is an exact science, and that all clinicians are subject to error. We further recognize that it is likely that we have all unintentionally practiced below the standard of care* at some time. We believe that the excellent practice of medicine and dentistry requires a willingness to recognize and learn from our professional mistakes and mal-occurrences.

We should take responsibility for bad outcomes that have been caused by our provision of substandard care. We lament that the climate of our culture discourages us from following biblical mandate of confessing, seeking forgiveness, and pursuing reconciliation. We believe that a patient who has been injured by substandard care may be entitled to restitution.

We oppose harassment or frivolous cases filed for vindictive or monetary reasons. We oppose the settlement of any case without the full involvement and informed consent of the doctor.

We recognize that a judicial judgment of professional liability does not necessarily mean that the clinician is incompetent or deserving of practice restriction. Nor does it suggest that we should withhold our compassion and love from that colleague. We should judge neither ourselves nor others too harshly because of an adverse malpractice judgment.

A malpractice suit can cause significant suffering to the individual professional. It may adversely affect his or her physical and emotional health, family and spiritual life, and Christian witness. We should protect our own physical, emotional, and spiritual health through Scripture, prayer, and appropriate counsel from others. In turn, we should volunteer our support and help to our colleagues when they are in need. Compassion and empathetic guidance from others may have a profound influence on the outcome. The manner in which Christian clinicians handle this difficult professional problem can be a unique opportunity to be a distinctive witness for Christ.

*The "standard of care" refers to those acts which a reasonable physician of like training or skill would do in the same or similar situation. The standard of care is not the optimal or best care possible when viewed with the knowledge of an adverse outcome, nor does it take account of less than perfect acts or results.

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Explanation of Statement

Background

The scientific approach to medical and dental care has increasingly led to an expectation, by both laypersons and professionals that everything will turn out well - and often it does. Sometimes, however, things do not turn out well. Bad outcomes may occur because the disease held the upper hand; or because the professionals involved made an error, avoidable or unavoidable. But sometimes it is because the healthcare professionals just plain did not perform up to standard.

Claims of professional liability for malpractice by physicians and dentists use the tort system to seek recompense. This system involves an adversarial court proceeding in which the plaintiff's attorney must prove 4 things: (1) the practitioner had a professional obligation; (2) the practitioner did not perform up to the standard of care; (3) the plaintiff suffered harm, and (4) there is a causal relationship between the practitioner's failure and the harm suffered.

Claims of professional malpractice against healthcare professionals have increased in recent decades, as have the monetary amount of awards given when the court finds professional liability. This has resulted in major increases in costs in several areas, including an increase in the cost of professional overhead, an increase in the cost of medical care because of extra testing that is done ("defensive medicine"), as well as the actual cost of the litigation.

In addition to the financial cost, there has been a significant increase in the emotional cost to healthcare professionals. The potential, the threat, and the actual lawsuit can all bring emotional turmoil to clinicians, their staff, and their families.

Secular Perspective

There has been much discussion, some research, and multiple proposals to improve this uncomfortable situation. "Tort reform" has been considered, but with little actual change occurring.

While there is a very appropriate concern about the frequency of "medical mistakes", there is often confusion and conflation of error, claims of malpractice, and actual professional liability. Many errors occur which are not the result of malpractice and/or which do not result in patient harm. Many claims are made which do not represent instances of malpractice. But unfortunately, it is likely that considerable malpractice occurs which does not result in claims or compensation.

Changes in healthcare finance and delivery have exacerbated this entire area of concern. Many forms of managed care lead to diminished professional autonomy about specific treatment decisions. It is feared that this may lead to diminished quality of care, and potentially to increased malpractice, actual or perceived.

Healthcare professionals have responded in different ways to the increased stress of practice brought about by these changes. Some have ignored the issue and have continued to practice patient-centered care. Some have changed to a less risk-prone specialty or retired earlier than they might have. Others have succumbed to the stress with depression, chemical abuse, or other potentially destructive things.

Christian Perspective

It is tempting to think that Christian healthcare professionals will be somewhat immune to the devastation of malpractice because they will all continue to conscientiously do what is in the patient's best interest. But even excellent dedicated physicians, believers or not, can be affected by this dark cloud of malpractice. And some believers will respond with the same feelings of fear, devastation, shame, isolation, and self-destruction as do non-believers. But this needn't be so. Believers have a Comforter to help them in any sort of trouble. And believers have a community who can be supportive.

The Christian Medical and Dental Associations deliberated for some time in the development of the above position statement, hoping and praying that it will be of benefit to their Christian colleagues, and to themselves.

Abstracted Articles

Morreim, E. Haavi. "Cost Constraints as a Malpractice Defense." Hastings Center Report Feb/Mar 1988; 18 (1): 5-10.

"Cost containment pressures impose fiscal responsibilities upon physicians that can conflict with their fiduciary commitment to patients. Should the law permit health care providers to adjust standards of care according to patients' financial resources?" The author addresses this question by bringing the reader through the conflict between fiscal and fiduciary responsibilities and the inadequacies of current law, and then introduces the concept of "rebuttable presumption." She concludes, "To exonerate those physicians whose inadequate care was economically unavoidable is not necessarily to endorse inferior care for the poor. It may instead encourage physicians to make maximal use of existing resources, since the cost-constraints defense applies only where there is no alternative to substandard care. Further, the defense may help to shift the entire issue to the level at which it belongs. Society as a whole must reconcile compelling and competing values: equality, freedom, beneficence, and fiscal prudence. The conflicts are stubborn, yet scarcity renders difficult choices inevitable."

Hall, Mark A. "The Malpractice Standard under Health Care Cost Containment." Law, Medicine and Health Care Winter 1989; 17 (4): 347-55.

In this article, the author responds to the position put forth by E. Haavi Morreim in her essay entitled, "Cost Containment and the Standard of Medical Care" (published in the California Law Review, however, a condensed version appeared in the Feb/Mar 1988 issue of the Hastings Center Report and is abstracted above.) He rebutts Morreim's main argument, that the law is too rigid to accommodate a reduced standard of care and thus should be changed, and concludes, "radical reform of the law is not required to accommodate cost containment incentives in an appropriate fashion. The law is fully capable in present theory and application of recognizing the gradual (or abrupt) emergence of cost incentives. Any dramatically different approach, such as that proposed by Morreim, would likely create more problems than it would solve."

Lee, S. B. "The Stress of Medico-Legal Litigation." The Canadian Medical Protective Association Information Letter Spring 1991; 6 (2): 1-3.

In response to an inquiry as to whether the Canadian Medical Protective Association (CMPA) should provide psychological support for physicians involved in lengthy legal proceedings, the author wrote to 788 physicians involved in 424 lawsuits regarding stressors associated with a lawsuit, such as a sense of betrayal at being sued despite one's best efforts and the maze of the legal system, and what, if any, beneficiary services could be provided. After evaluating the responses, the author concluded, "It seems to me that...CMPA's members will likely be better served not by the development of a new approach, but rather by better use of what we already have."

Hickson, Gerald B. et al. "Factors That Prompted Families to File Medical Malpractice Claims Following Perinatal Injuries." JAMA 11 Mar. 1992; 267 (10): 1359-63.

In this study, the authors identified the self-reported factors that prompted families to sue following a perinatal injury by interviewing mothers of infants who had experienced permanent injuries or deaths. From the most frequently given to the least, they are: advised by others, needed money, realized there was a cover-up, child would have no future, wanted information, wanted revenge or to protect others. They found that "families give many reasons for filing a claim. Obtaining money may not be the only goal for some families who file suit."

Weiler, Paul C., Joseph P. Newhouse, and Howard H. Hiatt. "Proposal for Medical Liability Reform." JAMA 6 May, 1992; 267 (17): 2355-58.

In this article, the authors, an economist, a lawyer and a physician, discuss replacing the current malpractice tort system with a no-fault compensation system. They begin by citing the Harvard Medical Practice Study, undertaken by the authors and several of their colleagues (this study is also abstracted and dated 13 May, 1992 in JAMA), which demonstrated that while only one-sixth of claims filed are paid, "the tort litigation/insurance system paid one claim for every 15 tort incidents." The conclusion of this study was that while there were numerous false positives (meritless claims filed), there were many more false negatives- "negligent injuries that did not lead to tort claims." If a no-fault compensation system were

adopted, "victims of medical injuries, both negligent and nonnegligent, are compensated." The authors then cover the financial aspects and benefits of a no-fault system and implementation strategies.

Johnson, William G. et al. "The Economic Consequences of Medical Injuries: Implications for a No-fault Insurance Plan." JAMA 13 May, 1992; 267 (18): 2487-92.

This study, the basis of an article published in the 6 May, 1992 issue of JAMA (also abstracted) analyzes the "actual economic consequences of medical injuries" in order to open a discussion on alternatives to malpractice litigation. The authors interviewed patients who had suffered adverse events in New York hospitals and then "estimated the costs of a simulated no-fault insurance program that would operate as a second payer to direct insurance sources and would compensate for all financial losses attributed to medical injury." They conclude that the study "indicates that a no-fault program would not be notably costlier than the more than $1 billion New York physicians now spend annually on malpractice insurance."

Sage, William M., Kathleen E. Hastings, and Robert A. Berenson. "Enterprise Liability for Medical Malpractice and Health Care Quality Improvement." American Journal of Law and Medicine 1994; XX (1&2): 1-28.

"[Assumptions about quality in health care and its defense] are rooted in the past, a past in which the doctor ruled. Strangely, those assumptions have survived the revolutions that now deny the doctor the sole authority to judge and guide care. The doctor no longer really controls health care, as in the days of solo practice, but, when it comes to quality, the doctor is still held accountable. When the researchers study quality, they focus on the behavior of the physician. When the Quality Assurance Committee meets, it reviews the performance of the physician. When the payers and the regulators turn on their searchlights, they want doctors in their glare. Control is shifting, structure is shifting, the pattern of care is shifting; but accountability is not."

Harris, Curtis E. "Malpractice Fear." Today's Christian Doctor Winter 1996; XXVII (6): 8-11.

In an litigious society, fear of being named in a malpractice suit can adversely change how a Christian physician conducts his practice. However, according to the author, "with few exceptions, the threat of malpractice often appears to be more significant than it actually is." This is not to undermine the serious nature of malpractice, but "few treat it today as if it is a public crisis." To illustrate his point, the author states, "the average physician can commit 500-600 acts of malpractice before suffering an adverse jury decision." The author concludes that these facts are not "intended to encourage poor standards of care, nor is it intended to imply that significant unrecognized malpractice is rampant. Rather...it is important not to allow the fear or malpractice to dominate the practice of medicine to the extent that it interferes with our Christian witness or causes emotional injury to ourselves and our families." This article is first in a series of three by the same author.

Harris, Curtis E. "Understanding Malpractice." Today's Christian Doctor Spring 1997: XXVIII (1): 22-27.

In this second of three articles on malpractice, the author explains what frequently causes law suits and important legal terms that ones needs to be familiar with. He also informs on "the best ways to prevent lawsuits" including clear documentation and having rapport with the patient. He concludes, "Even the finest Christian physician will be sued, and even the most competent doctor will malpractice. Fortunately, the joy of Christianity is the realization that perfection is neither attainable nor expected. But if we understand what prompts malpractice suits and what we can do to avoid them, we will mitigate the change of litigation."

Harris, Curtis E. "The Journey: A Spiritual View of Malpractice." Today's Christian Doctor Summer 1997; XXVIII (2): 30-34.

In this last article in a series of three, the author addresses a very important issue of malpractice to Christian physicians- that of the spiritual and emotional trauma felt while in the midst of a lawsuit. He states, "Very little attention has been paid to the emotional and spiritual impact of a suit on the life of the physician who is sued. If there is a 'conspiracy of silence' in medicine, it is surely the silence of shame, fear, and isolation felt by the physician blamed by others for the severe injury or death of a patient...however, in the litigious society in which we practice, there is no opportunity to share our feelings, and certainly no opportunity to admit our guilt." He then introduces the Medical Malpractice

Ministry or 3M, a ministry developed for the Christian physician for the purposes of healing and support. 3M includes personal counseling by physicians who have been sued and this article contains excerpts from these physicians as they recount their experiences. The author concludes, "In the end, it is not the malpractice suit that matters, but rather what we do with the pain we experience, what we learn from the 'fire' God uses to refine our faith...What an opportunity we have!"

Michael, Janet E. "The Impact of Managed Care on Malpractice." in The Changing Face of Health Care. Grand Rapids, MI: William B.Eerdsmans Publishing Company, 1998. pp. 214-224.

The rise of managed care has brought many changes in the way doctors carry out their practices. The threat of decreased autonomy coupled with increased responsibility has made malpractice once again the hot topic. In this article, the author details major managed care malpractice cases, addresses professional liability issues, and discusses the impact of managed care on health care standards. She finishes by naming new challenges that now face physicians and concludes, "Health care professionals today have the power to make decisions, lobby in a political sense, and act as advocates for patients. What each health care professional does with that power, and what he or she does to avoid professional liability, is an individual choice. May God grant each clinician the wisdom needed to meet the clinical, ethical, and legal challenges that will continue with the growth of managed care."

Studdert, David M. and Troyen A. Brennan. "The Problems With Punitive Damages In Lawsuits Against Managed-Care Organizations." The New England Journal of Medicine 27 Jan, 2000; 342 (4): 280-83.

Two recent verdicts, Fox vs. Health Net and Goodrich vs. Aetna, in which 89 million and 120 million were respectively awarded to the plaintiff indicate that "many of the barriers to managed-care litigation that appeared firm in 1993 are today under siege." In this article, the authors discuss punitive damage awards, changes in the law that support managed care organization (MCO) suits, and "how physicians, insurers, employers, attorneys and patients may be affected by a rash or verdicts in which punitive damages are awarded." The authors conclude, "Whatever its net effect, a crisis in the litigation of cases involving managed care, should it come, will be ugly and costly….Attention to the far-reaching implications of a surge in managed-care litigation should highlight the attractiveness of a more sophisticated approach-namely, carefully crafted regulatory oversight that is responsive to the need to reconcile the protection of patients and quality assurance, on one hand, with the cost containment that consumers demand from managed care, on the other."

Mohr, James C. "American Medical Malpractice Litigation in Historical Perspective." JAMA 5 April, 2000; 283 (13): 1731-37.

"Medical malpractice and the problems associated with it remain an important issue in the US medical community. Yet relatively little information regarding the long-term history of malpractice litigation can be found in the literature. This article addresses 2 questions: (1) when and why did medical malpractice litigation originate in the United States and (2) what historical factors best explain its subsequent perpetuation and growth?

Medical malpractice litigation appeared in the United States around 1840 for reasons specific to that period. Those reasons are discussed in the context of marketplace professionalism, an environment that provided few quality controls over medical practitioners. Medical malpractice litigation has since been sustained for a century and a half by an interacting combination of 6 principal factors. Three of these factors are medical: the innovative pressures on American medicine, the spread of uniform standards, and the advent of medical malpractice liability insurance. Three are legal factors: contingent fees, citizen juries, and the nature of tort pleading in the United States. Knowledge of these historical factors may prove useful to those seeking to reform the current medical malpractice litigation system."

Bibliography

Ely, John W. et al. "Malpractice Claims Against Family Physicians: Are the Best Doctors Sued More?" The Journal of Family Practice Jan 1999; 48 (1): 23-4.

Typically, multiple malpractice suits against a doctor raises flags of incompetence and carelessness. However, this study concludes, "Among Florida family physicians, the frequency of malpractice claims increased with evidence of greater medical knowledge."