Innovative Solutions to the Medical Liability Crisis

by Marion Dinitz

Just as multiple factors have contributed to the medical malpractice crisis in this country, multiple solutions are being instituted in cancer programs across the country.

SPONSORED PHYSICIAN LIABILITY COVERAGE

Forming risk-retention groups and captive insurance companies are just two ways hospitals are cooperating to address the physician malpractice insurance crisis. Other options range from subsidizing premiums to sponsoring formation of new hospital association- or state-sponsored mutual insurance companies to hiring physicians needed to maintain threatened services.[1]

For the last three years, Grand View Hospital in Sellersville, Pa., has been offering liability coverage to voluntary staff physicians through a risk-retention group it operates with eight other Pennsylvania hospitals outside Philadelphia. Several thousand staff physicians, residents, and former residents are now covered.[1]

Hospitals and other providers are finding that sponsoring liability coverage for oncologists can pay off. Many are using such sponsorship to engage physicians in comprehensive risk management programs designed to improve both patient care processes and documentation—keys to reducing malpractice exposure.

Regardless of how it is done, sponsoring physician liability coverage exposes hospitals to significant financial and legal risk. Risk retention or captive insurance arrangements must be adequately funded and rigorously managed to remain solvent. And any support for physician liability coverage must be carefully structured to comply with federal anti-kickback and tax laws.[1]

RISK-MANAGEMENT PROGRAMS

Florida has developed its own risk-management program to provide uniform reporting throughout the state. Florida requires physicians, nurses, and any healthcare professional licensed by the state to take risk-management education, also called reducing medical errors. A two-hour continuing education class is required for relicensure of healthcare practitioners every other year.

Florida hospitals often add their own strategies for risk management. For example, at Jupiter Medical Center in Jupiter, Florida, the radiation department takes a digital photograph of the patient. The photo is placed on the patient's computerized treatment plan before the patient is placed on the table to assure the correct patient is being treated.

Jupiter Medical Center regularly reviews and updates its risk management programs to help avoid possible malpractice suits.

"Risk management becomes even more important in these litigiousness times, when you don't want to be faced with a lawsuit," said Terri Freeman, risk manager at Jupiter Medical Center. To date, the hospital's cancer program has never had a malpractice claim. Even so, Freeman points out that Jupiter Medical Center is increasing its number of seminars on risk management.

Since the University of Florida Shands Cancer Center in Gainesville, Florida and several of the hospitals affiliated with the Shands Health Care system are self-insured for malpractice, the health system also has a rigorous risk-management program in place.

"The advantage we have is that our insurance company and our risk managers are part of our core team. When a malpractice claim is filed alleging a bad outcome, then our insurance company is right on site and works very closely with our operations staff. If there's an opportunity to improve our processes, our insurer helps us do that," said Marvin Dewar, MD, JD, vice president of Affiliations and Medical Affairs at Shands. "Most people's insurance companies just defend claims and pay the losses, they don't help design solutions to the problems."

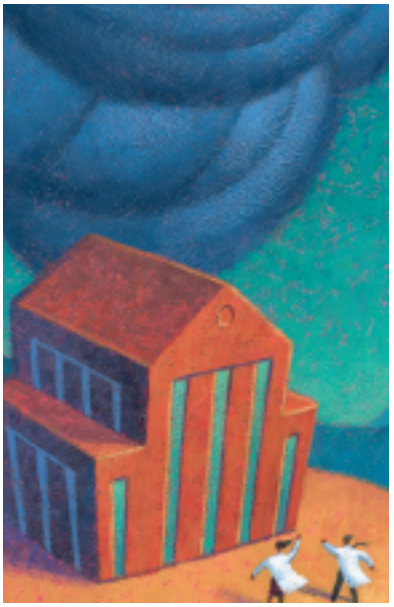
The University of Pittsburgh Medical Center, a multi-facility healthcare system with 20 hospitals, has developed a comprehensive risk management-patient safety program throughout each facility. Karen Hartley, MBA, vice president for risk management services at UPMC, is responsible for oversight and coordination of the patient safety-risk management initiative and collaborates with many others in the healthcare system to implement an effective program.

"We are proud of the patient safety risk management program we have built. We have leadership support and a clinical/administrative staff that is engaged in quality opportunities derived from actual experiences to facilitate proactive change across the system. Leadership from the top down and bottom up is essential to get the information and support to actually make change," said Hartley.

Oregon Hematology Oncology Associates, PC, a

physician practice in Portland, Oregon, does not have a specific risk manager but rather has in place a decentralized management structure. If an issue comes to the attention of any of the group's departments regarding, for instance, patient dissatisfaction or an incident issue, it is brought to the attention of either the manager on site or to the manager of the department in which the person is working.

The practice also may turn to the Oregon Medical Association's (OMA) attorney as a consultant for incidents. As part of orientation, the practice requires staff to read and be familiar with the OMA Loss Prevention Medical-Legal Handbook. The practice sends its physicians and nurse practitioners to the OMA Loss Prevention Program, an annual educational seminar, which subsequently gives the practice a discount on its premiums, said Pat Cosgrove, MSN, OCN®, the practice's chief operating officer.



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TORT REFORM

In some states, tort reform laws have been shown to limit award sizes, and a recent survey showed that medical liability insurance premiums are 17.1 percent lower in states that have capped court awards.[2] A number of states are trying to "fix" the malpractice crisis through legislative channels, such as what has been accomplished in California (see page 32).

In September 2003 the Texas legislature passed Proposition 12, which is an amendment to the constitution and limits non-economic damages in medical malpractice cases to $250,000.

"We have been notified in writing by Texas Medical Liability Trust, our malpractice carrier, that upon next year's renewal we'll see a 12 percent *decrease* in our malpractice premiums," said Jack Brown, administrator at SW Regional Cancer Center in Austin. However, "at renewal the decrease turned out to be 2 percent based on certain factors such as group size, claims experience, and length of time in coverage by TMLT," he added.

Generally, the premiums for the practice's medical oncologists are in the range of $13,500 per year. The physicians in the practice also carry medical liability insurance for the clinical staff (i.e., nurses, phlebotomists, physicians assistant, nurse practitioners) and the cost is less than physician liability coverage.

In August 2003, the Florida legislature passed a bill that included a $500,000 cap on non-economic damages against individual physicians in most cases and a $1 million non-economic damages cap that one or more plaintiffs can collect against multiple physicians. The law took effect September 15, 2003. While Florida physicians are now protected by a $500,000 limit on non-economic damages, no matter how many plaintiffs join the lawsuit, several situations exist in which the cap can be pierced.[3]

Florida joins Arkansas, Georgia, Mississippi, Nevada, Ohio, and Pennsylvania as states that have passed tort reform packages with no cap or one higher than $250,000. Nevada's and Ohio's reforms include $350,000 caps; Mississippi enacted a $500,000 limit. Georgia, Arkansas, and Pennsylvania did not include any cap. Both Arkansas's and Pennsylvania's constitutions prohibit award limits; and legislation has failed in the Pennsylvania legislature that would provide for a state referendum in May 2005 to decide whether the state's constitutional prohibition against non-economic damage caps in medical liability cases should be removed. It could take at least another four or five years to move such legislation in Pennsylvania again, said Richard Shadduck, MD, deputy director of the West Penn Allegheny Health System Oncology Program in Pittsburgh and president of the Pennsylvania Society of Oncology/ Hematology.

In Pennsylvania, said Shadduck, "assuming that you could convince the legislature to pass tort reform, which is a big assumption, it would be a few years until you could do it because you have to change the state's constitution. A more immediate response would be a ruling by the state supreme court, which can overrule the legislature or enact ruling on its own."

Grand View Hospital's CEO noted that while the Pennsylvania law does not include a cap on damages, it does allow hospitals and physicians to appeal if paying those damages would force a doctor out of business or force a hospital to cut services, thereby affecting access to care in the community. In addition, Pennsylvania law allows judgments for future medical costs to be spread out over time.

In Oregon, the cap on non-economic damages was lifted by the Oregon Supreme Court, which ruled the cap was unconstitutional.

DEFENSIVE MEDICINE

One last method for surviving the medical malpractice crisis is for oncology programs to practice what is commonly known as "defensive medicine."

Fear of litigation and possible massive jury awards in Pennsylvania has caused oncologists in this state to adopt such a practice. Shadduck points out that when he makes rounds with his fellows who are treating patients, he periodically brings up the issue that "you have to consider some less likely medical possibilities and do additional tests to protect yourself."

In defensive medicine, he explains, "you're ruling out five or six other possibilities, even though you don't think the patient has them, because you could be held accountable for not having excluded them. For example, you do extra lab tests instead of just doing blood count and bone marrow to find out what's wrong with the patient. You might do extra flow cytometry looking for other conditions to rule out five diseases instead of honing in on one; you do extra X-rays, extra CT scans to exclude other conceivable diseases that might be present."

In addition, Shadduck said, "for outpatients, you need to get referrals from primary care physicians to do

certain tests. Then you need to call insurers to get permission to do certain tests such as scans. All this creates a backlog of work for staff." And practicing such defensive medicine further drives up the cost of healthcare.

A Florida oncologist concurs that "we are ordering so many more tests" to avoid malpractice suits. He points out that radiologists are "over reading like crazy" and as a result patients are confused, exposed to more studies being ordered by their providers because of diagnostic studies reporting questionable and marginal abnormalities that in the past would have been ignored. "Practicing such defensive medicine drastically increases the cost of health care and most certainly increases anxiety and fear in the patients who are afraid of their cancer coming back or getting worse," he added.

THE PATIENT EFFECT

In the end, the innovative solutions detailed above will only protect a hospital or practice so far. The healthcare community is spending considerable resources and time on the medical malpractice crisis, which, in the long run, is certain to have a negative impact on patient care. Many in the healthcare industry believe this is already happening. A 2003 Congressional study reports that the medical malpractice system *has* taken a toll on healthcare by eroding physician morale and damaging the doctor-patient relationship.[4] In addition, growing malpractice fears tend to make doctor-patient relationships more adversarial. More than one doctor in this study reported that excessive litigation has fostered a sense of viewing each patient as a potential malpractice lawsuit rather than a patient in need of help.[4]

David Herold, MD, a radiation oncologist who practices at Jupiter Medical Center in Florida, has seen his medical liability rates climb from over $4,000 per year in 1999 to over $40,000 per year in 2003 for $1 million per incident, and $3 million total coverage from an "A" rated carrier.

Still, Herold maintains that the medical malpractice crisis in Florida has not altered how he cares for his patients. This physician has never turned away patients. Nevertheless, the crisis does directly impact the care his patients are receiving since it is becoming more and more difficult for his patients to be seen by specialists, particularly in emergency situations.

"Many surgeons and specialists (particularly neurosurgeons or orthopedic surgeons) are faced with the malpractice crisis, consequently, many of my patients cannot be evaluated in consultation. Some South Florida surgeons have stopped practicing altogether (such as brain surgery) and I have had to send several of my patients to the University of Miami (two hours away) to have procedures. This entire malpractice crisis has a snowball effect on care. Patients are ultimately suffering."

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THE US ONCOLOGY PERSPECTIVE

The largest oncology practice management organization in the country, US Oncology, has more than one malpractice carrier for its 850 network physicians. "Because of the state of the malpractice market, there is no one vendor, in our opinion, who could service all of our sites and give us the stability that is required," said Mark Yarmolich, AIC, ARM, CWCP, director of risk management, US Oncology in Houston, Texas.

Fortunately, US Oncology has not experienced a large increase in premium dollars over the last few years due to its effective loss prevention, recognition, and training program, said Yarmolich. US Oncology practices have an internal Risk Management Committee whose physicians are trained to review malpractice claims, work with legal counsel, and research alternative programs and causation.

"We're trying to provide this risk management program to our smaller practices in order to get them to recognize the causation," Yarmolich added.

In addition, US Oncology practices have access to an online reporting system used to look at malpractice claim trends and potential causation.

"We are fighting for tort reform and reduction of premiums, but we recognize [those actions come] after the horse is out of the barn," said Yarmolich. "We want to get on the front end and reduce medical errors. If you reduce medical errors, that's ultimately going to lead to a reduction in claims and dollars paid and verdicts. US Oncology is trying to move from reactive to proactive."

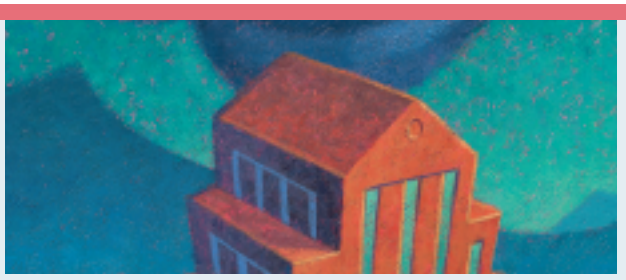
For all physicians in the US Oncology network nationwide, medical malpractice premiums range from $5,000 to $28,000 per physician, said Yarmolich. The highest rates are in Illinois, Florida, and even some groups in Texas, he noted, adding that in some jurisdictions rates are high because of claims and it's very expensive to get high-level coverage. On average, he points out, for an oncologist with claims-made coverage, premiums range between $10,000 and $15,000 per year for $1 million/$3 million coverage.

In the end, Yarmolich and others still believe that oncology malpractice claims tend to run at the lower end of the spectrum compared to all types of medical practice claims.

Heads Up!

A risk management expert talks about some "hot" issues in medical malpractice

by Janine Fiesta, JD, BSN



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Most malpractice cases come from the inpatient hospital setting; however, the number of cases that come from physician offices and outpatient clinics is on the rise. Today's cancer care professional needs to be aware of a number of risk management issues that are on the healthcare radar screen.

Medical errors. The healthcare community should get away from what risk management calls "tombstone regulations," which means reacting to a situation and piecemealing a solution/approach *after* a problem has occurred. Experience has taught us that complex systems with multiple checks and balances do not always alleviate medical errors. In fact, in some instances, we've actually seen the opposite effect—when multiple providers are accountable instead of one person, everyone may assume that the other individuals have performed the safety check. A proactive approach to risk management emphasizes the evaluation of "near misses" *prior* to an injury occurring, which is a more productive method of protecting patients from medical errors.

Inadequate pain management. In 2002 a California patient successfully sued a physician for failure to provide adequate pain medication. The $1.5 million award against the physician was at least partly based on information in the patient's medical record, which documented that the patient had communicated the severity of the pain to the physician.

In 1999 the Oregon state medical board disciplined a doctor for failing to relieve the pain of his sick patients. While he was using acetaminophen for terminal cancer patients, he was refusing to prescribe any pain medication for others.

Currently, a number of other state medical boards around the country are reviewing physicians and disciplining for failure to provide adequate pain medication.

Failure to follow advance directives. A few years back, an interesting case occurred outside of Philadelphia in which a physician (who was a patient) sued his physician colleague for failing to follow the patient's advance directive. The patient was in his early 70s and had suffered a stroke and knew what the next stroke might mean in terms of his quality of life. He wrote a very detailed advance directive, a living will, and a durable power of attorney for healthcare that clearly stated his wishes. He communicated those wishes to his physician, who did not follow them when the next stroke occurred. Instead, the physician resuscitated him, put him on life support, and was very aggressive in his treatment. The patient physician survived the stroke, but with very severe complications. He pursued litigation against his own physician and the jury found liability.

There are several similar cases around the country where physicians are being sued for failing to follow specific, expressed wishes of competent patients.

Failure to diagnose or delay in diagnosis. In 2002 a Florida healthcare entity was sued when it failed to follow-up on a mammogram report. The patient never received a card from the hospital about the results of her mammogram, although the physician said he tried to reach her and initialed that he had read the report. Ten months later, the patient felt the lump, but by that time she had metastatic disease and died shortly thereafter. However, the $7 million verdict that was awarded was shared in thirds between the patient, the physician, and the hospital. The patient's liability was related to family testimony that the patient had always received a card from the hospital previously, wondered why she had not received any information about her last mammogram, but chose not to pursue the matter. So, the patient was found to have one-third liability for failing to contact her physician for the results of her mammogram. One-third of the accountability was assigned to the physician for failing to make sure he contacted the patient and for not documenting that he had attempted to get in touch with the patient. The hospital also shared one-third of the liability because the hospital could not prove that it had sent a letter indicating that the patient had a problem and should call or return to the hospital.

In other legal cases, patients have also shared in the legal accountability because of their own non-compliance with their responsibilities as patients.

SO, WHAT CAN YOU DO?

Keep in mind the importance of standards of care. In any malpractice suit, it is the failure to follow a reasonable standard of care that determines whether you're going to be held liable. While a number of physicians view such standards as "cookbook" medicine, the use of standard procedures have actually been helpful from the standpoint of consistency and defending malpractice cases. Today, standards and protocols can be admitted as evidence and understood by judges and juries.

In the end, sound legal advice is to always practice safe and good patient care. From a malpractice and risk management point of view, a practitioner can be defended if his or her decision was based on the safety of the patient and the quality of care given to the patient. Always err on the side of the patient when making any healthcare decisions.

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