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Medical Litigation and Its Influence on the Quality of Medical Care

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Improvements in the quality of medical care are one of the main arguments made in the support of the current medico-legal infrastructure. Put simply, a greater risk of malpractice liability will lead to safer clinical practice[1]. The continued year-on-year increase in the frequency of claims, however, would suggest that the hypothesis is not working. In Ireland the number of high court cases taken for medical negligence increased from 566 (2007) to 1001 (2016). In the UK, the NHS receives more than 10,000 new claims annually. It is clear that the mechanisms that underpin medical error are more complex than previously thought.

We need a new approach. The practice of defensive medicine should not be confused with improvement in medical care. Evidence of defensive medicine is common. It is costly and it provides no clinical benefit. Data that demonstrates that tort actually improves clinical outcomes is more difficult to demonstrate.

The case put forward in favour of the deterrence tort model is that a litigious environment works in a number of effective ways. The psychological fear of litigation urges doctors to practice to a higher and safer standard. Adverse clinical practices are highlighted. Financial sanctions place a further impetus on individuals and on institutions to take more care. It is a means of ensuring higher standards.

Mello et al[2] have recently reported a study that has examined the relationship between malpractice claims and its impact on the quality of medical care. It was a systematic review of 37 studies related to malpractice, liability, tort, negligence and measures of health related outcomes including quality, safety, care and the patient. The studies spanned the time interval 1994-2019.

Papers that examined the relationship between liability risk and measures that more reflective of costs than quality were excluded. For these reasons, studies focusing on caesarean deliveries and most types of diagnostic tests were not included. Such measures are over-used due in part to the practice of defensive medicine. They do equate with improved patient outcomes.

In the study design, the findings were deemed to be in the direction of deterrence if greater liability risk was associated with better outcomes. Reported findings were in an anti-deterrence direction if greater liability was associated with a worse outcome.

The key conclusion is that greater tort liability was not associated with improved quality of care. Fifteen out of 20 studies showed no relationship between liability risk and patient mortality. The other studies had equivocal findings. Hospital readmission rates did not show any association with liability risk. All 6 studies that had examined the readmission rates found no patterns. The postoperative complication rates did not show any relationship with liability deterrence.

There were 16 obstetric papers in the study. Nine of them showed no relationship with liability risk. There were no associations with APGAR scores, low birth weight, preterm birth weight or birth injury, 5-day neonatal mortality or death/disability at 5 years. Obstetricians with a history of malpractice claims were not associated with changes in the quality of care.

There are valid reasons to explain why tort is ineffective in the delivery of better medical care. Some errors are due to inadvertent and unpredictable lapses. Other errors are not amenable to the current precautionary put in place by institutions.

Doctors frequently don't know the standards expected of them until they are faced with a legal claim. It is very challenging to know what the law demands in every clinical situation. This area of confusion blunts the professional's ability to respond appropriately each time and every time.

Litigation rates can be a poor surrogate marker for medical care standards. Trivial or equivocal medical events can lead to a legal case while more serious examples of medical negligence may not.

The unintended consequence of a healthcare service with a high litigation rate is that excessive numbers of highly competent, experienced personnel will seek retirement at the earliest opportunity. They perceive law suits as a bit of a lottery. A common stated sentiment is 'I'm stepping down before my luck runs out'. An imbalance in the ratio between an inexperienced and experienced workforce is counter-productive to good healthcare.

Liability will not change doctors' behavior for the better and it may make it things worse unless physicians are convinced that providing good care helps to avoid lawsuits.

Blame and shame lead many doctors to regard malpractice claims as quasi-criminal accusations. As a result there is a reduction in transparency. In the current climate there is a psychological burden placed on both the doctors and their patients.

Efforts to improve patient care should take a new direction. The reduction of inequalities of healthcare within communities is necessary. The barriers to good healthcare range from lack of education, lack of access, and late presentation for clinical care. The remedies are systems that build trust, share information, address social and medical needs, and ensure that malpractice fears do not act as a barrier to clinical care. There are societal implications. We need to decide whether we really want vast sums to be paid out in claims, when the money would be better spent on the service itself. The IMO has argued that the current system of litigation following an adverse event is not in the interests of patients, doctors, or the State.

The conclusion is that there is no association between malpractice liability risk and outcomes. A greater tort threat does not improve clinical care. We need to constantly remind ourselves that quality improvement is based on the principles of scientific knowledge and evidence based practice and not on the courts.

References:

1. Sage WM, Underhill K. Malpractice liability and quality care. Clear answer, remaining questions. JAMA 2020;323:215-317
2. Mello MM, Frakes MD, Blumenkranz E, Studdert DM. Malpractice liability and health care quality: a review. JAMA 2020;323:352-366.