Prediction 2009: Tort Reform Within Reach

by Jeff Segal, MD, JD, FACS

By the time this editorial goes to press, Congressional legislation on healthcare reform will have gone through countless rewrites.

Conventional wisdom, especially among physicians, argues that any action of tort reform just will not happen. The first iterations of bills from the House and Senate prove that thesis. Nonetheless, I believe that conventional wisdom is wrong. Action will be taken, even if in the 11th hour. There. I am on the record.

Let me explain. In August, I attended our medical society meeting in North Carolina to listen to Senator Kay Hagan's presentation. After the presentation, several physicians asked about tort reform – including caps on pain and suffering, and the like. Senator Hagan's position was similar to the majority in the Senate. No caps. I then asked the audience how many physicians practice defensively. Virtually all of the 150 physicians at the meeting raised their hands. I then asked the Senator whether she could rally behind safe harbor provisions for doctors who follow guidelines developed by physician specialty societies. Answer: "That's an interesting idea. Yes."

I posed the same question to Former Senate Majority Leader Tom Daschle in June. His answer: "Yes." Further, Senator Daschle suggested President Obama is no less supportive.

How are Democratic leaders able to buck the traditional party line of being pro-plaintiff? The reason is that safe harbor provisions are both pro-doctor and pro-patient. In other words, it is a common sense idea that smart people of all political persuasions can and should support. Further, if defensive medicine can be curtailed, a large sum of money would be freed and redeployed for more useful purposes – such as purchasing health insurance policies for the uninsured, paying for health information technology, and more. How much money? Some estimate that defensive medicine costs our country upwards of $200B per year. Admittedly, some defensive medicine keeps patients safe. But, the vast majority of defensive procedures provide zero benefit to the patient. And, paradoxically, some patients are actually harmed by such practices.

Relevant to the field of phlebology, a more insidious type of defensive medicine dominates - tests, referrals, and procedures that practitioners will NOT do because of fear of litigation. This inaction often creates a cascade of events creating predictable problems for patients and logarithmic costs for the system. Defensive medicine is illustrated by the following representative case study.

An elderly woman with coronary disease, hypertension, and diabetes had symptomatic venous insufficiency for years. For two years, she had a circumferential ulceration around one ankle. Leg edema was managed with diuretics. She was admitted to a hospital to work up the ulceration. A diagnosis of venous insufficiency was firmly established. Her doctors believed the patient's advanced age and comorbidities made the surgical treatment of the venous insufficiency "too risky." While the patient understood risk as" her risk", it was just as likely the doctors meant "their risk."

The patient's ankle ulcer morphed into sepsis. The primary actor now was MRSA. She was hospitalized for over a month; much of the time spent in the ICU. The costs were exorbitant. At discharge, she left with her original complaint unchanged, the venous-stasis ulceration.

One month later, a phlebologist performed an independent work-up. Diagnosis: Severe venous insufficiency including great saphenous and small saphenous veins, with large calf perforators. The rest of work up suggested the patient's heart and lungs were strong enough to undergo procedures which could keep her out of the ICU for another one month stint. Over two months, the phlebologist performed endovenous laser ablation of all diseased veins and ambulatory phlebectomy of larger varicosities.

Result: The long standing ulceration healed completely. Pain improved. She regained her ability to walk. Most importantly, the risk of another septic episode putting the patient's life at risk evaporated.

One phlebologist temporarily forgot about the spectre of litigation - demonstrating how patient care improves and costs decrease when the right treatment is offered to the right patient. Contrast that conclusion with patient's experience with her other doctors.

Five thousand physicians were recently polled by Sermo. The question was whether health reform could be achieved without tort reform. Over 90% of respondents believed that the two issues were inextricably linked. Health reform legislation that ignores the medico-legal system's impact on physician behavior is doomed to a slow start if it can even leave the starting gate.

So, what is the answer? Simple. Any legislation must recognize the reality that most professional liability cases end with no payment to the plaintiff. That means that most cases should not have been filed. Nonetheless, physicians have no choice but to defend. And defending will be emotionally painful, long, and expensive. And, from the day the case is filed, a doctor with a previously clean record will dramatically change the way he or she practices. Physicians respond predictably to the disincentives imposed by the tort system. We become ordering machines. As one ER physician delicately put it: "If it keeps me out of a courtroom, I will scan patients until they glow."

Legislators have an opportunity to embed a different type of predictability into the system. Let physicians dictate what should qualify as immunity from litigation. Let physicians define what really are best practices. And allow physicians to comfortably deviate from clinical guidelines when doctors believe it is in an individual patient's best interest in a particular clinical situation. This will sidestep the charge that best practices are little more than cookbook medicine, allowing clinicians the latitude to do what is right for each individual patient. Here, a doctor would need to do little more than document why clinical guidelines were reviewed but rejected in this particular case. Patients and doctors will both benefit from such an approach.

Physicians have never had more leverage on the topic of tort reform. I recognize this is a counterintuitive conclusion. The reforms may not be recognizable as what we doctors have presented over the past two decades. Nevertheless, some reforms will save a great deal of money without putting patients in harm's way. Finding a hundred billion dollars for more positive initiatives is rarely a bad thing. Phlebologists should assume a leadership role in advancing this cause. Many phlebologists have adopted new practice models and fully embraced a 21st Century system of healthcare delivery. This is no time to sit on the sidelines. Tell your politicians what you have been doing to effect change. Then tell them why embracing these new models should keep you out of a courtroom. I stand by my prediction, that if physicians make their voice heard, tort reform will be passed.

Jeff Segal, MD, JD, FACS is founder and CEO of Medical Justice, a membership-based organization that offers patented services to protect physicians from frivolous lawsuits, demands for refunds and Internet defamation. For more information, contact Dr. Segal at jsegal@medicaljustice.com or logon to www.MedicalJustice.com.

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