Does medical negligence litigation improve safety?

By David Hirsch

The incidence of iatrogenic injury is alarmingly high, yet the number of patients who seek legal advice – let alone receive compensation for these injuries – is surprisingly low. Despite the 'disconnect' in the numbers, however, there is considerable interest in the question of whether litigation against doctors and hospitals improves patient safety.

The capacity of litigation to improve patient safety turns on whether litigation, and more specifically tort law, promotes better practice or deters bad practice.

Early studies into this question were mostly anecdotal and of dubious quality. They were used selectively by the opposing medical and legal protagonists during the 'medical indemnity crises' years to argue for or against tort reform. But there is an increasing body of more rigorous scholarly literature that suggests that litigation can and does improve patient safety.[1]

Two main arguments support this conclusion.

First, the standard of reasonable care is often determined by guidelines and protocols developed by the medical profession and hospitals themselves. These documents abound, and medical negligence lawyers need to know where to find them. A good place to start is the department of health website in each state. Various medical and nursing colleges also publish their 'best practice' guidelines. Hospitals should also have protocols and guidelines and, in many cases, are mandated to do so by state departments of health.

When these guidelines and protocols are relied upon in litigation as evidence of the standard of reasonable care, it is clear that litigation puts 'teeth' into what healthcare professionals already believe is proper practice. In this way, litigation assists in promoting patient safety.

Second, and more contentious, is the argument that litigation acts as a deterrent that encourages proper practice by sanctioning bad practice.

It is accepted that some errors are inevitable in medicine but many if not most are attributable to systems, training and communication errors that may be avoidable with improved systems, more rigorous training and better communication.

The *deterrent signal* of litigation is thought to be achieved by creating economic incentives to improve patient care. The more mistakes that are made, the more compensation will need to be paid so, on the assumption that everyone wants to save money, people will modify their behaviours to make fewer mistakes, thus increasing patient safety.

This economically driven patient safety strategy makes sense for large enterprises, like hospitals and area health services, which are well placed to implement systems (computer generated reminders, colour coding of drugs, double-checking of orders, control of staffing levels, etc) to reduce medical errors.

Further, if these enterprises are to be held directly responsible for paying compensation claims, they are forced to 'internalise' the costs of medical errors rather than shunt them off to an outside insurer. Direct funding of compensation from an enterprise's limited budget can be a strong incentive to improve systems in a way that overall increases in insurance premiums may not be.

But the economic analysis does not fit well at the individual doctor level. First, doctors in private practice do not normally have the means to implement the kind of systems controls that enterprises can. Second, they are insulated from the economic pain of compensation because their medical indemnity insurers pay for their mistakes on their behalf.

Even if most people would be expected to do anything to save money, most doctors are not solely (or even mostly) driven by economic considerations. Their primary interests are the wellbeing of their patients and the preservation of their professional reputations. Doctors want to deliver quality care and avoid litigation. A strong incentive to maintaining high standards is therefore the *possibility* of a legal claim being made if they are not sufficiently careful.

The disconnect in numbers between those who could sue for negligent medical care and those who actually do also applies to the number of cases against doctors, and doctors' perception of that number. Doctors believe that their risk of being sued is very much larger than it is. This belief can be expected to exert a strong pressure on individual doctors to improve or maintain the highest standards of care in managing their patients.

It is encouraging to think that the anti-lawyer rhetoric of the last ten years, which has seriously undermined the rights of most injured people to compensation, is being overtaken by more rigorous analysis. Litigation is being considered more positively as a way of encouraging behaviour change at an enterprise and individual doctor level. The evidence supports the view that litigation can and does improve patient safety. ■

Note: 1 Mello, 'Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform', *Texas Law Review* (2002) Vol 80:1595; Mello, 'Disease Prevention and Health Outcomes', *Georgetown Law Journal* Jan 2008; 96, 2; Bloche and Studdert, 'A Quiet Revolution: Law As An Agent Of Health System Change', *Health Affairs*, 23, no. 2 (2004): 29-42.

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