EDITORIAL

Malpractice Liability and Quality of Care
Clear Answer, Remaining Questions

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In this issue of *JAMA*, Mello and colleagues[1] report findings from a review of 37 studies and conclude that increased liability exposure (such as numbers of malpractice claims, dollar amounts of liability insurance premiums, or changes to state malpractice laws) was not associated with improvement in the quality of patient care. Their review draws effectively from databases of peer-reviewed medical literature, economics scholarship, and legal publications, and presents a thorough, necessary, and rigorous analysis of recent research.

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The review also highlights limitations of prior work. Apart from obstetrical care, studies relating malpractice liability to the quality of medical care have provided few insights about specific practice areas, and there is scant research involving outpatient settings or no-liability control groups. Exposure types, controls, and outcomes were variable, which limited the inferences that could be drawn. Given heterogeneity among the studies, the authors appropriately refrained from conducting a meta-analysis.[2]

The relationship between malpractice liability and quality of care presents a legitimate and important research question, which Mello et al[1] answered convincingly. The studies the authors reviewed, however, were the product of a specific political conversation. In the mid-1970s, the mid-1980s, and the early 2000s, the United States experienced problems with the availability or affordability of third-party insurance sold to individual physicians in private practice. At such times, many medical professional societies and their insurers declared that physicians would relocate or leave the most affected practice areas unless lawsuits were curtailed through tort reform (new state laws that made malpractice claims more difficult to bring, more challenging to prove, or worth less in damages). Quality (or, more properly, safety) has always been the principal political counterargument to tort reform, with the claim being that reduced legal accountability will let "bad" physicians harm more patients.

Future forms of health care financing, care delivery, and liability insurance may be different, and studies of malpractice liability will need to engage quality accordingly. Individual physicians working as small businesspeople who purchase their own malpractice insurance is a fading model for good reason. That model fails the basic tests of financial sustainability, responsible governance, and health system science. The Physician Insurers Association of America has renamed itself the Medical Professional Liability Association, broadening its reach to include new types of risk bearing such as captive insurers, risk retention groups, and institutional self-funding. The studies that Mello et al[1] evaluated had examined the medical liability and health care systems that have been in place, not the liability and care systems that are needed going forward.

As Mello et al[1] suggest, the goals of tort law are not limited to deterring negligence. They include compensating financial losses consequent to injury and requiring transfers from those who have caused harm to those who have been harmed (corrective justice). Ideally, tort law also provides voice and dignity to injured patients whose harms society should acknowledge, and independent courts enable individuals to hold accountable even large and powerful institutions (a social recourse function). Tort law communicates that people have duties to behave with care toward each other (an expressive or cultural function), and the discovery process in a lawsuit can reveal facts about why someone was injured (an information function).[3] These purposes echo interpersonal and social aspects of health care quality that matter in addition to technical safety.

Liability will not change physicians' behavior for the better, and it may make things worse, unless physicians believe that providing good care avoids lawsuits. As Mello et al[1] describe, deterrence depends on the ratio of the signal (liability follows from actual negligence) to the noise (liability is randomly imposed). Studies predating those on which Mello et al[1] focused tended to show that malpractice suits were both underinclusive and overinclusive in that negligently injured patients often failed to sue, whereas some patients filed unmerited claims.[4] Yet physicians' beliefs about tort liability are seldom based on empirical evidence. More salient are rumors and anecdotes circulating in practice settings and at social gatherings, trends conveyed by malpractice insurance premiums and political messaging by organized interest groups.

Even with a clear relationship between actual negligence and tort claims, the deterrent influence of tort reform will make little difference if physicians do not know the law in their states or how the law may have changed. Physicians' understanding of the law tends to be incomplete and unresponsive to actual differences in exposure to liability.[5] The decision by Mello et al[1] to pool studies of legal changes (including subtle state tort reforms) together with other types of exposure variables, such as claims and premiums, may have biased their findings toward the null.

Evaluation of the relationship between malpractice liability and quality of care requires consideration of the direction of the causal arrow. By analogy, when consumers seek advice or information about a product or service, they may hesitate

if they find online complaints, and reading that a company has been sued may lead them to forgo the purchase. In other words, these consumers view lawsuits as reflections of poor quality, not as a spur to improvement. While acknowledging this, Mello et al[1] reverse the causal arrow to ask only how liability influenced quality in the studies reviewed. This is partly because the underlying research was prompted largely by malpractice politics: tort reform constituted the experiment and posed the testable hypothesis. But positing this causal pathway also reinforces the notion that malpractice liability is an external force on medical practice, not the consequence of the intrinsic characteristics of medicine.

Many of the studies examined by Mello et al[1] were causally ambiguous; they may have shown how tort claims influenced clinicians' behavior or they may have shown how clinicians' behavior influenced tort claims. Of the 37 studies, 21 used an exposure measure that included the frequency of malpractice claims, the cost of claims, or the cost of insurance. Mello et al[1] considered these to be independent variables indicating liability risk, although these factors also can be dependent variables that arise when physician negligence increases. Thus, care quality might be lower, not higher, among physicians who experience more claims. The primary studies that evaluated changes to the tort system are less vulnerable to this critique, although they still have the signal to noise problem described above.

The work by Mello et al[1] offers insights into the role tort liability might have in promoting quality within the nested ecosystems of future health care relating to patients, physicians, hospitals, and communities. Some patients, especially older adults, retain a trusted physician at the center of their self-defined medical universe. The physician-focused liability insurance model studied in the research that Mello et al[1] reviewed comports with this orientation. Many younger patients, however, see themselves as performing the key roles of symptom recognition, care coordination, and evaluation of outcomes. For them, medical liability should offer a functional warranty against unsafe or substandard episodes of complex care, centering on the organized settings in which such care occurs. If something goes wrong, the liability system should ensure transparency and promote reconciliation rather than assuming an adversarial posture. The liability system should reinforce the quality and reliability of informational resources and safeguard patient privacy, which are challenges similar to those affecting the general online economy. With respect to the trust reposed in physicians, medical liability should support fiduciary obligation but not generate cycles of defensive practice among consultants, such as the iterated referrals from general gynecologists to radiologists for mammograms to surgeons for biopsies and back to gynecologists that often characterize breast cancer detection and management.[6]

For individual physicians, standard economics predicts that tort law deters errors by making negligence expensive and therefore physicians will be motivated to avoid damages, higher premiums, and the time spent defending claims. Lack of external motivation may not be a root cause of most errors. Moreover, as with other financial incentives, tort liability may crowd out important internal motivators of quality.[7,8] Physicians have additional reasons to practice quality medicine: they care about their patients, enjoy mastering their field, appreciate their autonomy, and want to help their health care organizations or teams.[9,10] They also value their reputations, both for intrinsic reasons and for future business.[11] Medical liability should reinforce sound ethics, teamwork, and information exchange rather than undercutting them. Liability practices directed at corrective justice can be especially counterproductive. Blame and shame lead many physicians to regard malpractice claims as quasi-criminal accusations, which reduces transparency and imposes high psychic costs on both them and their patients.

The review by Mello et al[1] primarily relates to hospitals and inpatient settings, where most serious errors of predominantly clinical origin tend to occur. Within these complex care systems, several decades of research on medical errors has elevated organizational issues over individual inattention or malfeasance as root causes.[12] With a majority of US physicians now employed by hospitals and large groups, individual liability is even less likely to promote quality than in the studies Mello et al[1] evaluated. Instead, remaking organizational liability is likely a more effective means of directing both hospitals' and physicians' attention to quality assurance and improvement. In their discussion, Mello et al[1] support "enterprise liability," ie, holding the hospital rather than individual physicians primarily accountable for malpractice that occurs within the hospital setting. Even without an explicit shift in responsibility, replacing individual malpractice insurance coverage with more stable organizational risk management sharpens the connection between liability and quality. As Mello et al[1] observe, hospitals are also well suited to design and implement communication and resolution programs that respond promptly and compassionately to patient harm, while incorporating lessons learned into safety improvement.

New insights into population health suggest that an important part of improving quality of care is reducing inequality of care within communities. Medical errors may be compounded for communities that experience socioeconomic marginalization due to poverty, race, language, age, location, gender identity, and other sources of vulnerability. In particular, mistrust of the health care system may be exacerbated by lack of transparency and recourse should an error occur.[13] Moreover, care that fails to account for the social determinants of health can cause substantial avoidable harm, much of which occurs outside the hospital or practice setting but to which less than optimal clinical processes may contribute.[14] A liability system that promotes quality in vulnerable communities would be oriented toward building trust, sharing information, facilitating timely redress of errors, anticipating and preventing injuries associated with unmet social needs, and ensuring that concerns about malpractice liability do not adversely affect access to care.

Although Mello et al[1] model malpractice exposure as an external force, much of the liability system in operation is driven by physicians' professional norms regarding matters such as expert testimony to the standard of care, honesty

with respect to errors, and responsibility to deliver socially competent services. As understanding broadens of how medical care relates to health, a parallel construct of health justice is emerging that examines clinical care through the lens of social equity.[15] Applying health justice principles to medical liability could offer a new path to both quality and access that runs not through courtrooms and state legislatures, but through professionalism.

ARTICLE INFORMATION

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