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IN THIS ISSUE

■ Resolving conflicts:

Mediation enables family members and care team to discuss issues cover

■ Workplace intimidation:

Survey finds workplace intimidation at fault for many medication errors 76

■ Health care quality:

National health analysis finds poor quality of care a national problem 78

■ Tort reform:

AMA and consumer group differ on liability reform efforts 80

■ Assisted reproductive technology:

Pro-choice advocates support new recommendations from President's Council on Bioethics 82

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Mediation offers strategy for ethical conflicts

Process stimulates discussions and levels the playing field

Mediation long has been known as an alternative way of resolving civil legal disputes. But as the following case study illustrates, it is emerging as a new way to help resolve conflicts in medical settings.

Mr. D is an 82-year-old patient who has been admitted to a hospital's cardiac care unit and has recently undergone quadruple bypass surgery to open four occluded blood vessels. Due to uncontrolled diabetes, advanced age, and other health factors, he was a poor candidate for surgery. However, surgery was his only chance for survival.

Unfortunately, Mr. D did not recover from the operation. Instead, he has an open surgical wound that will not heal and has developed an infection. Despite Mr. D's prior statements to intensive care personnel that he did not wish to be "kept alive on machines," his wife insists that all available measures be used.

The intensive care unit personnel have tried to gently indicate to Mrs. D that her husband's condition is terminal, but they have not been blunt. Mrs. D is clinging to the belief that her husband will recover. Her insistence on invasive care interventions, and the emotional conflict this is causing among the care team, has led the nursing supervisor to request an ethics consultation.

Instead of convening an ethics committee, however, the hospital asks a hospital-employed mediator to talk to all parties and attempt to negotiate a resolution.

As a first step, the mediator meets with Mr. D's care team to get their assessment of his condition and his prognosis. Then, she asks three representatives of the team to meet with her and with Mrs. D.

At the meeting, the mediator explains to Mrs. D that she is employed by the hospital and is called in when there is a disagreement between caregivers or caregivers and family members about the care of a particular patient. She tells Ms. D that her role is to ensure everyone's voice is heard and to see if a resolution can be achieved.

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The mediator then explains to Mrs. D that her husband is dying — and his death is likely to occur within the next 24-48 hours. She describes the nature of his condition and the attempts that have been made to treat him.

The mediator then elicits information about Mrs. D, discovering that she has no surviving children, no involved family, and few close friends. After a discussion between the care

team and Mrs. D, facilitated by the mediator, Mrs. D requests the support of her rabbi. She then agrees that her husband would not want invasive measures, and asks to pursue a course of only palliative care.

The above case study is featured in a new book, *Bioethics Mediation: A Guide to Shaping Shared Solutions*, written by **Nancy Neveloff Dubler, LLB**, director of the division of bioethics in the department of epidemiology and population Health at Montefiore Medical Center in New York City, and **Carol B. Liebman, JD**, director of the Columbia Law School Mediation Clinic and an instructor in professional ethics.

Mediation is a process that allows all parties in a dispute to come together on a level playing field and feel assured that their positions will be heard and treated with respect, Dubler says.

“What mediation does is help people who are in strained circumstances and very inarticulate, confused, and frightened. It helps them to mobilize their thoughts and their values,” she explains. “It gives them an opportunity to present them. That is really critical for me.”

As in traditional mediation, bioethics mediation involves a single “mediator” meeting with all parties in a dispute, helping them clearly articulate their positions and then guiding the parties in attempts to reach a decision that they can all accept.

Frequently, family members in crisis may not be able to articulate how they really feel or what they believe the patient might want, either because they are under such stress, or because they feel intimidated in the health care setting, Dubler says.

When a mediator is introduced, the family is able to talk about the situation with someone completely outside the existing dispute — someone who has not been a part of prior decisions the family may or may not be happy with. The mediator becomes a person they perceive as willing to consider their wishes equally with the interests of the hospital and health care team.

“It is having someone in charge who is committed to hearing all of the different positions, and, because [the mediator] is committed to hearing them, [he or she] makes it possible for them to happen,” Dubler says.

Ethics mediation largely differs from ethics consultations in that the goal is an agreement between the parties — not a determination that one party’s decision “wins,” says **Autumn M. Fiester, PhD**, director of graduate studies in the

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Editorial Questions

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department of medical ethics at the University of Pennsylvania School of Medicine in Philadelphia, which recently sponsored a public panel discussion on the use of mediation in bioethics disputes.

When an ethics committee or ethics consult is called, frequently the parties will state their positions. Then the consultant or the committee will weigh the options and — using their own levels of education, knowledge, and values — make a recommendation.

“But who is to say that the committee’s values and decision-making process is more valid?” Fiester asks.

The committee process also may be compromised because the physicians often have prior relationships with committee members. This can create the impression with the family — real or just perceived — that their wishes are not given the same value or weight.

During mediation, the parties openly discuss the issue with a mediator whose stated goal is to remain independent and help the parties arrive at a decision. The mediator does not make the decision, she notes.

“I think this process uniquely fits bioethics disputes well because we are talking about individual patients and their families, and those are the values and beliefs that — within certain limits — we should honor,” Fiester says.

Bioethics and legal mediation not the same

Mediation is based on three core principles: party autonomy, informed decision making, and confidentiality. Mediators usually convene meetings on neutral turf, with ensured confidentiality. This enables all parties to feel that they can speak freely, without concern that something they say can be used against them later.

While bioethics mediation shares many characteristics with legal mediation, there are important differences, Dubler notes.

In bioethics mediation:

- The mediator is generally employed by the hospital.
- The mediator and the members of the treatment team are repeat players.
- The mediator provides information, enforces norms, and ensures that resolutions fall within medical best-practice guidelines.
- Deciding not to reach a resolution is not an option.
- The playing field is usually uneven for patients and their families.

- Confidentiality is limited to information not relevant to patient care.
- Time is of the essence.
- Mediations involve life or death issues.
- Facts play a different role.
- The person with the most at stake — the patient — is frequently not at the table.
- There may be a sequence of separate meetings prior to the group meeting.

If an independent mediator were to be used, he or she would likely not have the appropriate background in medical ethics, nor a sense of institutional policies and values, Dubler says. Thus, the mediator is most often employed by the hospital, which may detract somewhat from the patient or family member’s sense that this person is independent. However, this issue can be openly acknowledged and dealt with early on.

The mediator should disclose that he or she works for the hospital, and explain that his or her job is to facilitate an agreement — not protect the wishes or interests of the medical establishment.

Facts also play a different role because, in ethics mediation, it is not the mediator’s job to determine whose version of “the truth” is accurate, but only to help the parties reach agreement.

Deciding to agree to disagree is also not an option, Dubler adds. In most legal disputes, the parties in mediation can meet several times to work toward a decision. In bioethics, decisions frequently need to be made very quickly. And they must be made. Unlike the traditional settings, the parties cannot agree to do nothing. A solution must be pursued in some fashion.

“Bioethics mediation is a hybrid,” Dubler says. “It combines the clinical elements of bioethics with the process of mediation.”

Mediation not always the answer

Mediation may not be appropriate in all disputes, Dubler says. For mediation to work, all parties involved have to want to achieve a resolution. If one of the parties is holding steadfastly to his or her position, unwilling to compromise, and unwilling to hear others’ positions, then the process will not help. This is rarely the case in medical ethical disputes, but it can occur, she notes.

Even when mediation is pursued, it is a difficult process in a health care setting, especially when the decision — as it often is — is extremely time-sensitive.

Dubler and Fiester’s book also contains examples of attempts at mediation that either did not

work or the outcome was not optimal, Dubler says.

"This was not a Pollyanna document we were creating," she says of the book. "We wanted to pull cases that showed both the process and the problems."

Many good ethics consultants already use a form of mediation when they work with providers, patients, and families, Dubler adds. When she and Liebman sent copies of the book to several colleagues, many responded back that the already used mediation, but that the process had never been so clearly outlined.

"I think a lot of good, sensitive bioethics consultation people instinctively do mediation, [and] instinctively try to reach consensus. What we tried to do with this book is to try to make all of that articulate," she notes. "We have not rediscovered the wheel, but I think we have described it in a way that helps you roll it in a different way."

Future of bioethics mediation

In the future, Fiester says, mediation may be used for more than dispute resolution. She hopes it will provide ways for hospitals to help patients and families feel empowered and will encourage their participation in making decisions about their care.

"Many problems in health care institutions will not ever rise to the level that an ethics consult is called," she notes. "These patients and families may leave unhappy with the course of treatment, unhappy with their experience, and we will never know because they don't know how to tell us."

As an example, Fiester notes the issue of expanded visitation in critical care units. Family members may want to be present for longer periods with a loved one who is dying — and providers may be OK with this — but the family never asks because they don't know that they can.

In other instances, they may be unhappy with certain aspects of the care they receive, but don't speak up because they assume "this is the way things are done."

An established hospital mediator also may allow patients and families and providers the opportunity to discuss options before disputes happen, Fiester says.

"There are many empowerment issues in health care settings," Dubler agrees. "I also do a lot of prison work. And I like to say a hospital is not a prison, but they take away your clothes, put a number on your arm, and stop you at the door

SOURCES

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if you try to leave."

Dubler hopes the book will provide a guide for institutions interested in developing the use of mediation at their facility. Many hospitals already are doing a good job, but they aren't aware of the basic principles involved in mediation, and they aren't as aware of some of the problems that can occur and why. "With the book, we hope you have some clarity about what your role is and what techniques might be useful." ■

Workplace intimidation affects patient safety

Poll reveals intimidation of most health care staff

According to newly released survey data from the Huntington Valley, PA-based Institute for Safe Medication Practices (ISMP), intimidating behavior is a common element of many health care practice settings, and such behavior is a factor in the occurrence of many medication errors.

More than 2,000 health care professionals, including nurses, pharmacists, and other providers, responded to ISMP's November 2003 survey. Seven percent of the respondents indicated they were involved in a medication error during the past year in which intimidation clearly played a role.

"It is not an easy thing to talk about. No one likes to admit that they've been intimidated at work, or that they've been intimidated into changing their decisions," says **Judy Smetzer**, vice president of ISMP and author of the survey's report.

"One of the surprising results is that it is not just physicians — health care workers intimidate each other," she adds. "It is not just one or two physicians in a hospital that everyone knows [and] no one likes to interact with. It is a pretty pervasive problem."

ISMP is a nonprofit organization that works with health care practitioners and institutions,

regulatory agencies, consumers, and professional organizations to provide education about medication errors and their prevention. The organization administers a voluntary medication error database and also does consulting for health care organizations on ways to improve procedures to prevent medication errors.

It was during several consultation visits, that ISMP officials noticed that cultures of intimidation were common in many health care settings, but they were rarely consciously acknowledged, she says.

When asked, health care personnel would claim to have “wonderful” working relationships with their supervisors and other providers. However, they also created complex processes for communicating with certain intimidating people, Smetzer says.

For example, some staff asked more experienced nurses to call particular physicians with questions about a medication order. Or pharmacists often asked nurses to call a provider known to be unwilling to return their calls.

A common thread that ran through several reports to the ISMP volunteer database revealed that members of the health care team often had a feeling that something was not right, but were too afraid to speak up. The result was a preventable error.

“One of the things we see over and over again, and we were starting to pick up on, is that somebody knew something was wrong or had a feeling that something was wrong, but they proceeded,” Smetzer says. “They were easily convinced that they were wrong. Or they followed unsafe practices because they didn’t want to appear to be difficult or to be stupid. And it is sad.”

ISMP decided to publish a survey in two of its newsletters, asking health care personnel about their experiences with workplace intimidation. The organization has distributed several similar surveys in the past, each receiving about 300-500 responses.

They were shocked that 2,000 people responded to this one.

“We were amazed at the response we got,” she says. “It probably isn’t the greatest response rate when you realize our newsletter is probably read by millions. Our surveys are more or less straw polls, not something scientific we can hold up and say, ‘This reflects the population.’ But it really opened up a lot of issues and allowed people to start talking about things that they would not have talked about before.”

Almost half of the survey respondents (49%) indicated that past experiences with intimidation altered the way they handle order clarifications or questions about medication orders. About 40% of all respondents indicated that, at least once during the past year, they had concerns about the safety of a medication error and assumed it was correct rather than interact with an intimidating prescriber. Even when the prescriber was questioned about safety, almost half (49%) of respondents felt pressured into dispensing a product or administering a medication despite their concerns.

According to the respondents, physician-prescribers used condescending language or were impatient with questions twice as often as other health care providers. Sixty-nine percent said a prescriber had at least once in the last year responded, “Just give what I ordered,” when faced with a question, while 34% of respondents encountered similar pressure from other practitioners.

On the other hand, respondents made it clear that intimidating behaviors were not limited to just physician-prescribers. They encountered a surprising degree of intimidation among other providers as well.

Intimidation takes many forms

Methods of intimidation ranged from subtle questioning of judgment to more explicit threatening behavior. Nearly a quarter of respondents often encountered condescending language or voice (21%) or impatience with questions (19%). And almost half of the respondents reported were the recipients of strong verbal abuse (48%) or threatening body language (43%) at least once during the last year.

Furthermore, Smetzer says, repeated occurrences of intimidating behavior did not arise from a single, menacing individual. Thirty-eight percent reported that three to five individuals were involved, and 19% reported repeat occurrences with more than five individuals during the past year.

These findings suggest that the problem cannot just be chalked up to “one or two bad apples” in an organization, but a prevailing culture that permits intimidation, Smetzer says.

“When almost half of your respondents can name three to five individuals and repeated instances in the last year alone, that’s a pretty big problem,” she notes.

Although pharmacists and nurses reported encountering about the same frequency of intimidating behaviors by physician-prescribers,

SOURCE

- **Judy Smetzer**, Institute for Safe Medication Practices, 1800 Byberry Road, Suite 810, Huntington Valley, PA 19006.

pharmacists reported more frequent intimidating behaviors by other providers, especially strong verbal abuse (encountered by 50% of pharmacists, and 38% of nurses) and a reluctance to answer questions or return phone calls (83% of pharmacists and 69% of nurses). They also reported more frequent effects from intimidation than nurses.

Pharmacists (49%) had also asked another professional to talk to an intimidating prescriber about an order more frequently than nurses (38%). While more nurses than pharmacists felt that their organizations had defined an effective process for handling disagreements about the safety of an order, both reported equal dissatisfaction with their organizations' ability to deal effectively with intimidation (61% dissatisfied).

Defining bad behaviors

Not much information is available in the professional literature about workplace intimidation in health care settings, says Smetzer, so it is hard to make definite recommendations.

However, an important first step is to acknowledge the problem and work toward talking about it openly, instead of remaining in denial, she adds.

Smetzer also recommends that health care organizations develop clear policies stating that intimidating behavior will not be tolerated and establish procedures that allow health care workers to freely report intimidating behavior.

"It's important that providers who exhibit intimidating behaviors be dealt with constructively and not in a purely punitive manner because this will be counterproductive in the long term," she says. "We need to have ways of demonstrating and supporting effective and appropriate modes of communication."

It's also important, Smetzer contends, to spend significant time developing clear definitions of intimidating behavior.

While verbal abuse and threatening behavior are obvious modes of intimidation, there are other modes that more subtle. For example, several pharmacists reported asking nurses to call

prescribing physicians because the physicians did not return pharmacists' calls. "Now, that is intimidation too, when they decide you are not important enough to call you back, you are going to start doubting the importance of calling," says Smetzer.

ISMP recommends that health care organizations develop codes of conduct and values that encourage behaviors that safeguard team cohesion and staff morale, sense of self-worth, and safety. The institute also suggests establishing a conflict resolution process that ensures effective communication, protects patients, and strictly enforces a zero-tolerance policy for intimidation, regardless of the offender's status in the organization.

More information on the survey is available on the institute's web site at www.ismp.org/Survey0311.htm/ ■

Poor health care quality is a national problem

Study shows only 50%-60% get recommended care

A recent analysis of data collected by the RAND Corp, a Santa Monica, CA-based health policy think tank, indicates that people in all parts of the nation are at risk for receiving poor health care.

A previous report from RAND's Community Quality Index (CQI) study focused on the quality of care delivered nationally, but provided no information about whether the problems observed were consistent across communities or based on exceptionally poor performance in a few communities, researchers reported in the May 4 edition of the journal *Health Affairs*.¹

The new analysis from the study by RAND Health, the corporation's research division, is the first comprehensive community-based assessment of health care quality in the United States.

"What we now know is that it really doesn't matter where you live — only about 50% of the time are you getting the recommended care," says lead study author **Eve A. Kerr**, MD, MPH of the Veterans Affairs Ann Arbor Health Care System and the University of Michigan. "The lack of community level variation in overall quality should serve as a wake-up call to all communities to examine their own quality of care and determine how they can do a better job."

The study examined how effectively health

Quality-of-Care Ratings in the 12 Study Communities (as a Percent of Recommended Care Received — based on 100%)

Quality by Type of Care and Overall Care

City	Preventive	Acute	Chronic	Overall
Boston	57	58	55	57
Cleveland	55	59	58	57
Greenville, SC	52	50	57	53
Indianapolis	55	56	55	55
Lansing, MI	56	55	53	55
Little Rock, AR	51	51	52	51
Miami	55	48	57	54
Newark, NJ	50	53	57	52
Orange County, CA	51	50	52	51
Phoenix	56	53	55	55
Seattle	61	53	58	59
Syracuse, NY	56	55	58	56

Source: RAND Corp., Santa Monica, CA.

care is delivered in 12 metropolitan areas: Boston; Cleveland; Greenville, SC; Indianapolis; Lansing, MI; Little Rock, AR; Miami; Newark, NJ; Orange County, CA; Phoenix; Seattle; and Syracuse, NY.

To define and measure quality, the research team selected 30 clinical areas that represent the leading causes of death and disability, as well as the major reasons people seek health care. Then they developed a set of quality indicators within each clinical area based on a review of national guidelines and the medical literature.

Although the economic and health resource profiles of these communities are very different, there were few consistent differences in the quality of care received by people in the communities, the final analysis indicates.

The study found that on average:

- People in the 12 communities studied received only 50%-60% of recommended health care.
- There were very few significant variations in the quality of preventive, acute, and chronic care across communities nationwide.
- No single community consistently had the highest or lowest performance for all selected chronic conditions.
- Quality of health care varied substantially across conditions. In almost all communities, the poorest care was for diabetes.

The 12 communities in the CQI are representative of metropolitan areas with populations of 200,000 or more. The study was based on interviews with nearly 7,000 adults in these communities and a review of all of their medical records. It

assessed 439 clinical indicators of quality for 30 acute and chronic conditions such as urinary tract infections, diabetes, asthma, high blood pressure, and heart disease — along with preventive care.

(See table, above.)

The new analysis demonstrates that poor quality exists throughout the United States health care system and is not relegated to certain pockets of the country, researchers said.

Elizabeth A. McGlynn, PhD, associate director of RAND Health and a co-author of the study, noted that, while low levels of quality were previously reported for the nation, many people might have concluded that quality was better in their own community than in the nation as a whole.

“Even if you are minutes away from the best hospital in your community, you are still at risk for poor care,” she said. “We hope this study stimulates a dialogue among patients, doctors, employers, hospitals, and insurers in these 12 communities, and in other communities we did not study, about the best local solutions to these serious deficits.”

Researchers noted that some people might be surprised that performance was not better in areas with outstanding medical institutions. The analysis examined average care for adults from an entire metropolitan area, rather than care received from a specific facility, health care system, or doctor.

Although no one community fared significantly better than the others on the quality of preventive, acute, and chronic care, there were some differences. The findings revealed:

- All the communities demonstrated important deficits in the provision of basic care. People living in Little Rock received 51% of indicated care, compared with 59% among those living in Seattle.
- Residents in all communities were more likely to receive services to prevent chronic disease through screening (for example, measuring blood pressure) and immunizations than they were to receive other dimensions of preventive care, such as services to prevent sexually transmitted diseases and HIV, or substance abuse counseling.
- Quality of care for hypertension was among the best for the chronic conditions — residents in Cleveland received about 70% of indicated care.
- Quality of care for cardiac conditions (coronary artery disease, congestive heart failure and atrial fibrillation) was generally lower than care for hypertension, ranging from 52% in Indianapolis and Newark to 70% in Cleveland and Syracuse.
- Care for depression ranged from 47% in Newark to 63% in Seattle.

What can be done?

Although each community must grapple with how to improve the quality of care locally, the researchers note, the analysis clearly indicates that considerable room exists for improvement in health care delivery at the community level.

The researchers suggest that not all of the solutions should come from within the medical system alone. For example:

- Large employers could provide leadership to improve chronic disease care in outpatient settings as they have done to reduce medical errors in hospitals.
- Health care systems, with or without financial incentives, could initiate quality improvement initiatives in collaboration with the community to improve the provision of preventive care.
- Community-based education and outreach efforts could activate patients to demand improved quality across many dimensions and to identify their own care requirements.

“There are many laudable community coalitions and initiatives throughout the country,” the authors state in the Health Affairs report. “But, few have meaningful baseline or post-intervention data on the processes and outcomes of health care to be able to answer whether or not their initiatives improve quality of care.”

More information on the CQI study, the new analysis, and the methods used to evaluate care

SOURCES

- **Eve Kerr**, MD, MPH, and **Elizabeth McGlynn**, PhD, RAND Health, 1700 Main St., P.O. Box 2138, Santa Monica, CA 90407-2138.

delivery are available on the RAND Corp. web site at www.rand.org/

Collaborating on the study were Steven M. Asch, MD, MPH, (RAND, Veterans Affairs Greater Los Angeles Health Care System, University of California Los Angeles); John Adams, PhD, (RAND); and Joan Keesey, BA, (RAND).

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1. Kerr E, McGlynn E, Adams J, et al. Profiling the quality of care in twelve communities: Results from the CQI study. *Health Affairs* 2004; 23:247-256. ■

AMA and consumer group debate tort reform efforts

Public Citizen cites RAND study

Although the researchers themselves focused on deficiencies in the delivery of health care, officials with the nonprofit consumer protection group, Public Citizen, claim the new analysis of health care quality conducted by the RAND Corp. demonstrates that the malpractice insurance crisis is not as great as tort reform advocates claim.

“The medical lobby has a lot of gall asking for favors from Congress,” Public Citizen president **Joan Claybrook** charged in a statement preceding the U.S. House of Representatives vote to pass the tort reform bill, the Health Act of 2004 on May 12. “It should look in the mirror and address the health care quality issues identified in the RAND report rather than asking for handouts.”

The RAND study gave its highest rating for health care quality to Seattle. The city is located in one of the 19 states the American Medical Association (AMA) cites as being in a crisis condition due to rising malpractice lawsuit judgments that have

been responsible for increases in insurance rates, Claybrook noted.

Overall, the RAND study found the quality of health care was higher in cities in six AMA “crisis” states than in two of the states the AMA says are doing “OK” — California and Indiana. The RAND researchers singled out Orange County, CA, and Indianapolis as delivering the lowest-quality cardiac care.

The RAND report studied patients’ medical records in 12 metropolitan areas, compared their care to recognized standards and quality indicators, and found that overall, patients receive only about 55% of the care recommended for their conditions.

But there were local variations and, in most categories, the best care was delivered in cities where the AMA claims a malpractice crisis exists, Claybrook pointed out.

Preventable medical errors kill up to 100,000 people in the United States each year and injure hundreds of thousands more, she said. And research shows that most malpractice payments are made by just a small number of doctors.

An analysis of data from the National Practitioners’ Data Bank shows that just 5.4% of doctors, all of whom have made two or more malpractice payouts, have been responsible for 52.6% of payouts since September 1990. Just 2% of doctors, all of whom have made three or more malpractice payments, have been responsible for 31.1% of all payouts since September 1990.

Damage caps do nothing to lower malpractice insurance rates, and insurers say they would likely not lower malpractice premiums if damages were capped, she says.

The increase in malpractice rates is due to financial hardships faced by insurers during the recent economic downturn, Claybrook adds.

“A better solution, then, is for state medical boards to be more diligent in disciplining doctors who commit malpractice.”

AMA says argument flawed, crisis is real

Evidence that some crisis states are able to continue to provide their citizens with a comparably adequate level of care does not indicate that health quality in these states is not being affected by rising malpractice judgments, AMA tort reform advocates argue.

The association’s crisis designation is given to states that can directly demonstrate drastic changes in availability of quality health care in communities linked specifically to rising

malpractice insurance premiums.

A February 2003 poll conducted by AMA found that 45% of hospitals reported that the professional liability crisis had resulted in the loss of physicians and/or reduced coverage in emergency departments.

According to information posted on AMA’s web site regarding its tort reform effort, previous substantial increases in premiums for professional liability insurance were caused by a number of different factors.

Why professional liability insurance increased

The article on AMA’s web site explains that, in the early 1970s, a number of insurers left the professional liability market due to soaring malpractice costs and inadequate rates. The exodus created a crisis of insurance availability. This was remedied by a variety of initiatives over the next 15 years. These initiatives included tort reform at the state level, increased diagnostic testing, improved peer review, and increased communication between physicians and patients. Aggressive campaigns to reform state laws governing medical liability lawsuits also began in the 1970s and were successful in a number of states including California, Louisiana, Indiana, and New Mexico. For the full article, please see the AMA web site at www.ama-assn.org/

These efforts appear to have had a positive impact, AMA maintains: the number of claims stabilized. Also the severity of verdicts, in the form of the dollar amount, has continued to increase nationwide, except for the states that enacted effective reforms.

Now rapidly increasing jury awards appear to be the factor largely responsible for increases in costs to insurers and the resulting rise in premiums.

According to data AMA obtained from the firm, Jury Verdict Research, the median medical liability award in medical liability cases jumped 110% from 1994 to 2002, topping \$1 million. The average award reached \$3.9 million in 2001.

Research into the financial health of the largest malpractice insurers also does not support claims by Public Citizen and others that the premium increases have been enacted to offset financial losses due to poor investments or market downturns, AMA continues.

Figures reported by the accounting firm A.M. Best, representing 76% of the industry, show that 80% of investments by Physician Insurers Association of America (PIAA) companies

SOURCES

- **Joan Claybrook**, Public Citizen, 215 Pennsylvania Ave., S.E., Washington, DC. 20003.
- **American Medical Association**, 515 N. State St., Chicago, IL 60610.

between 1995 and 2001 were in high-grade bonds, with the remainder divided among stocks, mortgages, real estate, and working cash. Increased losses on claims are the primary contributor to higher medical liability premium rates, according to the A.M. Best analysis.

Insurers are not charging and profiting from excessively high premium rates, AMA states.

Insurers not gouging to recover loss

According to the PIAA, physician-owned and/or operated insurance companies insure 60% of all physicians in private practice. Further, none of the insurance companies studied by a recent Government Accounting Office report experienced a net loss on investments.

Annual statement data summarized in Best's *Aggregates & Averages, Property-Casualty, 2003* edition, showed that the investment yields of medical liability insurers have been stable and positive since 1998. Those returns have ranged from 4.5%-5.4%, and include income from interest, dividends, and real estate income. Medical liability insurers have approximately 80% of their investments in the bond market. Therefore, their total returns on invested assets are strongly influenced by bond market performance, and less so by stock market performance. Best's *Aggregates and Averages* indicate that insurers' total returns on invested assets has fallen by only 5.1 percentage points over that period.

The AMA insists that federal liability reform legislation is needed to prevent more physicians from leaving medical practice and preserve citizens' access to health care.

"The Health Act gives the patients of America the common-sense medical liability reforms they seek," AMA president **Donald J. Palmisano, MD, JD**, said in a statement following the bill's passage in the House. "Patients are losing access to critically important medical services because of skyrocketing liability premiums. They are demanding action. Now we urge the Senate to hear the voice of the people and pass reforms to help increase access to medical care." ■

Report on ART approved by pro-choice advocates

Groups laud focus on protection for women, children

The recent report on assisted reproductive technology (ART) by the President's Council on Bioethics has been drawing a favorable reception from groups advocating women's health and reproductive choice.

The nonprofit advocacy organizations, Our Bodies, Ourselves and the Center for Genetics and Society released a joint statement on April 1 regarding the initial release of the report "Reproduction and Responsibility: the Regulation of New Biotechnologies."

The recommendations proposed by the council would offer needed regulations of risky new technologies, without infringing on reproductive freedom, the statement indicates. The groups say they consider the report a positive step forward for the following reasons:

1. It recommends putting women and children at the center of concern of policies regarding the assisted reproduction industry. Focusing on the well-being of children, as well as on the services provided to adults who are infertile, will make a critical difference in distinguishing practices that are reasonable and ethical from those that are not.
2. It underscores the need for better research to define the risks of these new technologies. Without such data, women — the ones who most often undergo the risks involved — cannot make informed decisions. These risks have far too often been glossed over, even though many studies have called for more in-depth investigations.
3. It documents why we need public oversight of assisted reproduction, a field that is much less regulated and privatized than other areas of medical practice. Although most *in vitro* fertilization (IVF) practitioners are responsible and trustworthy, the voluntary standards set by trade associations such as the American Society for Reproductive Medicine have been inadequate.
4. It contains language that effectively prohibits human reproductive cloning — a goal shared by the vast majority of Americans, as well as by many other countries that have already implemented prohibitions on human reproductive cloning.

5. It recommends that the selling of human embryos be prohibited and that certain restrictions on the patenting of human embryos be made more explicit via legislation. This would allow an important public discussion about the commercial control of reproduction and health care.

The report also proves that people with very different personal beliefs regarding abortion, embryonic stem cell research and the use of ART can find common ground, they add.

"The core recommendations of this report are consistent with the values of pro-choice progressives and social justice advocates; indeed, they promote and affirm those values," the statement concludes. "The report demonstrates that when the stakes are high enough, individuals with philosophical, political, and religious disagreements can find ways to move forward together."

Broad focus allows cohesive examination

A key strength of the council's effort is that they considered all facets of assisted reproductive technology from established techniques like in IVF to the still-experimental issue of therapeutic and reproductive embryonic cloning, as well as the use of prenatal genetic screening, among other things, says **Adrienne Asch**, the Henry R. Luce Professor in Biology, Ethics, and the Politics of Human Reproduction at Wellesley (MA) College.

The breadth of the report allows the debate to focus on articulating key basic societal values about reproduction that need to be clarified, she says.

"I think this report tries to get at underlying values and social questions and policy questions that go across all of these technologies, and I think that is a real advance," she notes. "I think that one of the reasons every time a new [genetic] advance happens, everyone gets all crazy is because they haven't tried to figure out what makes all of these things have anything in common."

We, as a society, must begin a discussion about

SOURCES

- **Adrienne Asch**, Wellesley College, 106 Central St., Wellesley, MA 02481.
- **Marcy Darnovsky**, Center for Genetics and Society, 436 14th St., Suite 1302, Oakland, CA 94612.

the values we want to honor with the use of ART, and the dangers we want to guard against, Asch says.

"We have to decide whether we want technologies to do certain things or we don't," she explains. "But each of these technologies needs to be thought out in light of the questions about values that it gives rise to. I think, if we could get our values and commitments straight, we could evaluate cloning or stem cell research or genetic screening in light of the way they affect the sort of overarching values that we hold."

Effective flexible policy needed

A comprehensive approach to reproductive and genetic technologies is a way to ensure policy that is both effective and flexible, adds **Marcy Darnovsky**, president of the Center for Genetics and Society.

"A good example is Canada's recently enacted Assisted Human Reproduction Act, which establishes principles for regulating these technologies. [The Canadians set] up a new federal agency to license and oversee all private and public clinics and laboratories using human gametes and embryos," she states. "Canada now joins the United Kingdom, Germany, and Australia as countries that have adopted comprehensive, responsible policies addressing human genetic and reproductive technologies. These policies embody differing social and political values but agree on core principles."

The report and other information from the President's Council on Bioethics is available on-line at www.bioethics.gov/ ■

COMING IN FUTURE MONTHS

■ New England donor kidney allocation policy

■ AMA proposal to require registration of clinical trials, publication of negative research results

■ Hospital policies on nonbeneficial care

■ Incapacitated patients without surrogate decision makers

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To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this activity, you must complete the evaluation form provided at the end of each semester and return it in the reply envelope provided to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you. ■

CME Questions

- Which of the following is NOT a core principle of mediation?
 - Confidentiality
 - Party autonomy
 - Full disclosure of information
 - Informed consent
- According to our article, what percentage of health care workers reported experiencing workplace intimidation that affected their behavior with regard to medication administration in the past 12 months?
 - 40%
 - 50%
 - 39%
 - None of the above
- The RAND Health study evaluated the quality of care in how many communities nationwide?
 - 10
 - 6
 - 12
 - 25
- Which nonprofit organization recently published a joint statement in support of the recommendations made in the President's Council on Bioethics report "Reproduction and Responsibility?"
 - NOW
 - Our Bodies, Ourselves
 - Feminist Majority
 - None of the above

Answers: 1-C; 2-A; 3-C; 4-B.

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