By Barry P. Chaiken, *MD, MPH, FHIMSS*

Malpractice Reform Only with Incentives

Viewpoint: Over past issues, this column has introduced readers to the value of clinical information technology tools in the enhancement of patient safety and quality healthcare. While policy makers search for solutions to tort reform, clinical IT can play an important role in any new program. In this column, I link tort reform to pay-for-performance programs that are dependent on data from clinical IT systems. Let me know what you think.

The current medical malpractice environment does little if anything to encourage quality care and enhance safety, and tort reform, as espoused by government leaders, insurance company executives, and some physicians, only adjusts award payments while doing little to change the inherent misguided incentives in the system. Only through real reform of the system, meaning the deployment of incentives that encourage high-quality, safe care, will the crisis of medical malpractice truly be addressed.

The recent announcement by the Centers for Medicare and Medicaid Services (CMS) to begin a pilot program for physician-level pay-for-performance offers healthcare a great opportunity to prevent malpractice cases rather than just compensate victims.

Malpractice Costs Outpace Inflation

Since 1975, medical malpractice costs have outpaced inflation by an average of 11.8%, reaching $27 billion, or nearly $91 per person annually. Reports around the country document how some physicians are closing or limiting their practices due to the rapidly escalating cost of malpractice insurance.

Each time a malpractice crisis arises, much discussion centers on either tort reform that limits awards or tightening of rules by medical licensing boards. Rarely are improvement of care and the prevention of errors and poor outcomes considered part of a proposed solution.

The large majority of serious medical malpractice is performed by a very small number of physicians. Medical licensing boards try their best to weed out these bad practitioners, but historically they have not been very successful. The process of revoking the license of a practitioner is difficult, time-consuming, and expensive.

The malpractice system does little to prevent medical malpractice or generate better quality healthcare. If anything, the system forces good physicians to practice less well as medical-legal incentives encourage them to order tests and do procedures that are sometimes of questionable value. This unnecessary care provides "documentation" if outcomes do not meet expectations. This "defensive" medicine only wastes resources, puts patients at risk, and increases healthcare costs.

Current pay-for-performance programs provide financial incentives to physicians to deliver a certain level of quality care as measured by explicit criteria such as immunization rates among pneumonia patients or use of specific heart medications for patients who suffered a recent heart attack. Although these programs are rolling out in several parts of the U.S., each program uses different performance parameters creating problems for physicians who want to satisfy the "best practice" performance criteria.

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Collecting performance data is becoming an expensive administrative problem for physicians enrolled in several insurance company programs. The CMS initiative, if successful, can help standardize these pay-for-performance programs around some common performance measures. In turn, these measures can be used to facilitate true malpractice reform.

Link Reform to Key Measures

Any tort reform legislation should be linked to a core set of performance measures. Physicians who meet these core measures would receive some degree of protection from excessive malpractice awards through reform legislation targeted at them. Noncomplying physicians would receive no relief.

Although the performance measures will cover only a few diseases,

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they do provide an incentive for the physician to follow evidence-based care. As these incentives influence the care received by all patients, benefits accrue to everyone, not just the litigant in a malpractice case. In addition, if the incentives also reduce the practice of "defensive medicine," we can also expect a decrease in healthcare costs.

By linking malpractice tort reform to a pay-for-performance model, we can improve care for the general population while also continuing to compensate patients who may be injured. Finally we can get the medical malpractice system to proactively prevent injury and improve the health of many, rather than solely reward the injured few.

Barry Chaiken (bchaiken@docsnetwork.com) has more than 18 years of experience in medical research, epidemiology, clinical information technology, risk management, and patient safety. As founder of his own company, he has worked on quality improvement studies and clinical investigations for the National Institutes of Health, the Framingham Heart Study, and Boston University Medical School. Chaiken is board-certified in general preventive medicine and public health and is a Fellow of HIMSS. He is the chief medical officer of ABQAURP and serves on the PSQH Editorial Advisory Board.

2005 CONFERENCE CALENDAR

APRIL 15–19
Creating the Blueprint of the Future
38th AONE Annual Meeting and Exposition
Hyatt Regency Chicago
www.aone.org/aone/edandcareer/conf05/welcome.html

MAY 4–7
Let's Get On with It: Round 2
7th Annual NPSF Patient Safety Congress
World Center Marriott Resort
Orlando, Florida
www.npsf.org/congress/

MAY 16–18
World Conference on Quality and Improvement
American Society for Quality
Washington State Convention and Trade Center
Seattle, Washington
http://wcqi.asq.org/index.html

JUNE 6–7
HIMSS Summit: Achieving National Healthcare Transformation
EHR and the IT Strategic Framework
The New York Marriott Marquis
New York, New York
www.himss.org/ASP/summerConfHome.asp

JUNE 8–10
Redesigning Hospital Care
Institute of Healthcare Improvement
San Diego, California
www.ihi.org/IHI/Programs/ConferencesAndTraining

JUNE 11–15
The Time Is Right
American Society of Health-System Pharmacists Summer Meeting
Boston Convention & Exhibition Center
Boston, Massachusetts
www.ashp.org/meetings/summer/

AUGUST 21–24
The Quality Colloquium
Harvard University
Cambridge, Massachusetts
www.QualityColloquium.com

AUGUST 2 – SEPTEMBER 22
Short Course on Human Factors Engineering and Patient Safety
Systems Engineering Initiative for Patient Safety (SEIPS)
University of Wisconsin-Madison
Madison, Wisconsin
www.fpm.wisc.edu/seips/courses/coursehome.html

SEPTEMBER 22–24
28th Annual Quality Health Care and Patient Safety Conference
ABQAURP
Westin O'Hare
Chicago, Illinois
www.abqaurp.org/live-seminars.asp