



MEDICAL ETHICS IN UTAH

DECEMBER 2003



Published by the Division of Medical Ethics of the Departments of Internal Medicine at LDS Hospital and The University of Utah School of Medicine

Activities and Programs

- Monday, December 1** The Student Literature and Medicine Discussion Group will be held at 12:00 p.m. in Classroom B, UUMC. Jay Jacobson will facilitate this discussion.
- Thursday, December 4** The VAMC Ethics Committee will meet at 8:00 a.m. in the Radiology Conference Room.
- Friday, December 5** The LDS Hospital Bioethics Committee will meet at 7:30 a.m. in the Pugh Board Room.
The Division of Medical Ethics Housestaff Conference will meet at 12:30 p.m. in the VAMC, Tsagaris Conference Room. The topic is "Telling the Truth When the News is Bad." The facilitators will be Leslie Francis, Ph.D., J.D., and Finn Bo Peterson, M.D. This event is approved for 1 CME credit hour through the University of Utah.
- Wednesday, December 10** The Evening Ethics Discussion Group will meet at 7:30 p.m. at the home of Dr. James McGreevy. The subject for our discussion is the first chapter of *Complications: A Surgeon's Notes on an Imperfect Science* by Atul Gawande. Call the Division of Medical Ethics at 408-1135 for more information. This event is approved for 1.5 CME credit hours through the University of Utah.
- Thursday, December 11** The UUMC/LDSH Literature and Medicine Discussion Group will meet at 6:30 p.m. in the UUMC Administration Large Conference Room. Gene Fitzgerald will lead a discussion of *Pushkin's Children* by Tatyana Tolstaya, translated by Jamey Fitzgerald. A light dinner will be served. For more information, call Sherri Matthews in Neil Kochenour's office at 581-2482. This event is approved for 1.5 CME credit hours through the University of Utah.
- Friday, December 12** The Division of Medical Ethics Housestaff Conference will meet at 12:30 p.m. at LDSH, Classrooms D/E/F. The topic is "Telling the Truth When the News is Bad." The facilitators will be Jeff Botkin, M.D., M.P.H., and John Thomson, M.D. This event is approved for 1 CME credit hour through the University of Utah.
- Thursday, December 18** The University of Utah Hospital and Clinics Ethics Committee meets at 12:00 noon in Room 4A444.
- Wednesday, December 24** The PCMC Ethics Committee will meet at 3:30 p.m. in the Board Room.

Upcoming Events

Evening Ethics Discussion Group – Wednesday, December 10, 2003

Atul Gawande is a physician/writer who has received considerable positive attention for his essays in *The New Yorker* and his recent book, *Complications: A Surgeon's Note on an Imperfect Science*. This book was the basis of a provocative discussion at our Physician's Literature and Medicine Group this past August. The first chapter, which serves as the topic for this month's Evening Ethics Discussion Group, describes the experience of a trainee "learning and doing" (but not necessarily in that order) medical procedures that pose significant risk to patients. Among several ethical issues raised in this chapter is a process of learning skills that are essential for subsequent patient care but that potentially or actually put present patients at risk. This raises the question of whether the process of informed consent should include information about the skill and experience of the individual performing the procedure. You may recall that we have discussed informed consent for procedures done on the newly or nearly dead. This discussion will focus on the much more prevalent practice of learning and practicing procedures on patients who are awake and competent, who are fully capable of understanding the risks and benefits of having the procedure done by a trainee, and who can themselves grant or refuse permission.

If you are interested in purchasing a copy of this book, King's English Bookstore has copies in stock (at 1511 South 1500 East, 484-9011). Please contact the Division of Medical Ethics, 408-1135, for more information.

Literature and Medicine Discussion Group – Thursday, December 11, 2003

Gene Fitzgerald, the facilitator for this session, writes:

Pushkin's Children is a series of essays by the 20th Century author Tatyana Tolstaya. The work consists of observations on Russia compiled by Tolstaya since the fall of the Soviet Union in 1991. Most of the essays are masked as reviews and were published in the *New York Review of Books*. The work is made up of her impressions, thoughts, and worries about what the new Russia is, who is Vladimir Putin, coupled with an assessment of the leaders now gone (Gorbachev and Yeltsin in particular). It is an insider's view of the contemporary Russia and presents the western reader with new and intriguing views of the country which is an "enigma wrapped in a riddle."

MEDICAL ETHICS IN UTAH

Upcoming Cowan Memorial Lectures - Thursday, January 15, 2004

The Max and Sara Cowan Memorial Lectures in Humanistic Medicine for 2004 will be held on Thursday, January 15, 2004. We are privileged to have Carl Elliott, M.D., Ph.D., Director of Graduate Studies at the University of Minnesota Medical School Center for Bioethics, where he is an Associate Professor in the Department of Pediatrics, as our 2004 Cowan Lecturer. Dr. Elliott is also an Associate Professor in the Department of Philosophy at the University of Minnesota. He currently holds an appointment as Visiting Associate Professor at the Institute for Advanced Study in the School of Social Science at Princeton University. He will speak at Grand Rounds in UUMC Classroom A at 7:45 a.m. that day, and will present a public lecture at 4:00 p.m. at the Skaggs Pharmacy Auditorium.

Dr. Elliott has written extensively on the ethics of enhancement technologies, the philosophy of psychiatry, the work of Ludwig Wittgenstein and the work of Walker Percy. He is the author of such well-respected books as *A Philosophical Disease: Bioethics, Culture, and Identity* and *Better Than Well: American Medicine Meets the American Dream*, which was published this year. Dr. Elliott also edited *Slow Cures and Bad Philosophers: Essays on Wittgenstein, Medicine and Bioethics* and *The Last Physician: Walker Percy and the Moral Life of Medicine*.

MEDICAL ARBITRATION AGREEMENTS

Medical arbitration agreements have been in the Utah news lately and seemed a topic worth looking into. While this is not a complete analysis of the issue, I hope it puts the issue before our readers, clears up some confusion, and where confusion remains, offers questions and sources for further analysis.

BACKGROUND

The process of arbitration has always been available as a legal remedy. Many in the legal profession see it as a particularly valuable tool. Arbitrators tend to be more knowledgeable than juries about the issues before them. Arbitration is usually less time consuming, less expensive, and less emotionally or personally charged than litigation.

The 2003 Utah legislative session brought clarification about the responsibilities of physicians and their staff when asking patients to sign arbitration agreements. Language was also added giving the patient 30 days after signing the agreement to rescind their signature. The Utah Medical Association has been educating their members about the agreements, and urging them to consider asking patients to sign arbitration agreements. The UMA stresses that the decision is a highly individual one for each physician and offers the following as some of the reasons to support arbitration:

1. As a way to bring the malpractice crisis under control;
2. To give each physician the ability to retain his or her freedom in deciding whom to take on as a patient and to make arbitration part of that decision;
3. To create an atmosphere that will continue to encourage bright young medical students to stop avoiding certain specialties because of their potential high-cost malpractice exposure; and
4. To gain some assurance of fairness that claims brought against physicians will be based on the merits and not on emotions.

DISCUSSION

Ability to pursue redress

Arbitration maintains an individual's legal rights to pursue an action against a doctor. It does change the forum in which that action would be undertaken from a litigation

system with judge and jury, to an arbitration panel of three people. In theory, both sides are giving up the same thing. The right being waived is one to go to trial. But since a doctor would never take a patient to court when an injury or adverse event occurs to that patient, the real effect may be that the patient is the only one giving up the right to litigation.

Expense

Arbitration panels have three individuals on them. Each side may choose an arbitrator and they jointly select one from a list of individuals approved as arbitrators by the state or federal courts of Utah (any attorney with 10 years experience may apply to be on this list.) The patient and physician share the fees and expenses of the neutral arbitrator, and each pays the fees and expenses of their chosen arbitrator. This is in addition to any attorney's fees incurred, which, for the patient, can still be negotiated as a contingency fee. If attorney fees have traditionally been paid for by contingency (for the patient) and an insurance company (for the doctor), neither individual involved in arbitration would find a savings or additional expense here. However, the arbitrators' fees and expenses might represent new costs in this process.

Access to Remedy

There is some anticipation that an arbitration option might actually increase the number of actions filed for malpractice. The process might appear more user-friendly because of its compressed time span and therefore reduction in procedural costs. Trial lawyers who faced extended preparation costs over a longer litigation period, might now be more willing to take cases in which the damages are smaller (cases that appear strong on their merits but small on damages), because the smaller contingency fee will now cover the smaller legal expenses to take a case to arbitration. If this turned out to be the case, arbitration could allow more people to seek and receive remedies.

Access to Care

If a patient does not want to sign an arbitration agreement, the physician is encouraged to explore the reasons and try to reassure the patient of the fairness and advantages of the arbitration process. If a patient absolutely refuses to sign the physician is free to decline to begin or continue their relationship. It is important that the patient not feel abandoned by the physician in this process, and physicians are encouraged to continue care for 30 days while helping the patient find other care.

MEDICAL ETHICS IN UTAH

The possibility exists that this might not work as well in practice as in theory. One can easily think of examples where geographic isolation (especially regarding specialty care), or insurance carrier limitations on which providers a patient can see – or worse, the two in combination – could leave a patient who chooses not to sign an arbitration agreement without other options for care. There is no obligation on physicians to use arbitration agreements with their patients, and the UMA encourages physicians to give individual consideration to each case. However, a patient with no other reasonable options for care, may not be entering such an agreement as freely as we might like.

Mechanics

The Utah legislation does have a six-year time limit on it, after which the UMA and other supporters will need to document whether or not arbitration has had an effect on damages awarded and the cost of malpractice premiums. Perhaps a measure of physician, patient, and insurer satisfaction with the use of arbitration agreements should also be a part of this assessment. Arbitration does not change the statute of limitations relevant to injury. There is some question, however, whether the same process which stops the clock on statute of limitations while litigation is being pursued, also would stop the clock during arbitration. This may be something that needs another look.

Tort Reform

Arbitration is one remedy proposed for the rapidly increasing cost of malpractice premiums. It is noticeably hidden, if not altogether absent, from the AMA website on medical liability reform. The AMA is heavily focused on tort reform. If tort reform – especially caps on pain and suffering awards – is the big hope for bringing some of this under control, states which have caps should be in better shape as far as malpractice insurance costs are concerned. Conversely, states identified as being in crisis should be those without caps. As with most pieces of this question, it doesn't seem to be as clear cut as that.

The AMA has identified 19 states as being in a malpractice insurance crisis. Indicators of crisis include awards that are extremely high; doctors retiring early, moving out of state, or not choosing the higher risk specialties because of the high cost of insurance; insurance companies going out of business or no longer offering policies to doctors in these states. Of these 19, Missouri (\$547,000 cap adopted in 1988) and West Virginia (\$1,000,000 cap adopted in 1986) have had caps on these damages for a number of years. It might be pointed out that a cap of \$1,000,000 is hardly any cap at all, but we'll see another state later with the same dollar amount cap, which is identified by the AMA as being in good shape.

The AMA has identified 25 additional states as showing problem signs. Of these, 11 have caps on pain and suffering damages (\$ amount/year adopted): Alaska (\$500,000/1997); Hawaii (\$375,000/1976); Idaho (\$682,000/1990); Kansas (\$250,000/ 1994); Maryland (\$805,000/1986); Massachusetts (\$500,000/1997); Michigan (\$624,000/1993); Montana (\$250,000/1997); North Dakota (\$500,000/1996); Utah (\$250,000/1996); Virginia (\$1,000,000/1992.)

And finally, the AMA has identified six states as being in good shape. All six of these have caps on pain and

suffering awards that range from \$250,000 (California and Colorado), \$350,000 (Wisconsin), \$500,000 (Louisiana), \$600,000 (New Mexico), to \$1,000,000 (Indiana). [The identification of states by malpractice crisis levels is from the AMA's website. The identification of state cap dollar amounts and year adopted is from the Weiss Ratings website.]

There seems to be confusion about the effects of caps on malpractice damages awards and therefore on the cost of premiums to physicians. If tort reform in the guise of damage caps is the clear solution that so many seem to think, then why are some of the states identified as in crisis states with caps already in place? And why do 11 of the 25 states identified as showing signs of impending trouble already have caps in place? The answer seems to be that tort reform simply isn't the exclusive answer to this problem. Some of the other reasons given significant study and press are discussed below.

Insurance Investments

A number of observers believe the cycle of insurance company investments, and their subsequent hard and soft markets, correlate better with the patterns of changes in malpractice premium rates than do jury awards – either numbers of awards or dollars. The GAO report purports that while there are numerous reasons for increases in malpractice premium rates, they rank the losses on claims as the primary reason. Others disagree. As we saw above, there isn't a consistent correlation between caps on damages and the designation of crisis status by the AMA, to warrant focus only on the tort reform. If issues with insurance company investments are a contributing factor, perhaps they should be addressed simultaneously with tort reform.

Insurance Market Practices

There is significant variation in the cost of premiums, within the same specialty but in different regions of the country. According to the GAO report, premium rates for the same coverage in the same specialty can vary by a factor of as much as 17 among states. The report points out that "the largest writer of medical malpractice insurance in Florida increased premium rates for general surgeons in Dade county by approximately 75 percent from 1999 to 2002, while the largest insurer in Minnesota increased premium rates for the same specialty by about 2 percent over the same period." Is it relevant that neither of these states has caps on pain and suffering awards? Some may read this as justification of the need for tort reform and stop there. It might be that with an issue this complex, within a health care system as varied, layered and complex as we have in the United States, the solution also needs to have layers and complexity.

Changes in the Insurance Market

Many insurers have changed from 'occurrence-based' policies to 'claims-based' policies, which, while it increases predictability of losses for a given year, changes the dollar amount of premiums paid. Physicians have been forming their own nonprofit insurance companies. Hospitals and physician groups have increasingly turned to self-insurance. Various laws passed in all states to reduce malpractice premium rates make it harder to predict how future insurance markets will behave. Any or all of these changes to the insurance market could be having effects on the way malpractice insurance responds to changing economic pressures.

MEDICAL ETHICS IN UTAH

Health Care Costs Increasing

Since health care costs currently are increasing at rates in the double digits, those increased costs are reflected in malpractice awards – the economic portion. The GAO report also points out that data which would allow us to distinguish economic from non-economic awards, or settlement versus verdict awards are not available. How can we be sure that it is tort reform, and tort reform only, that is going to bring this behemoth to its knees?

Professional Standards

There are some who point out that if physicians themselves were more willing to impose strong and consistent sanctions on what might be called ‘repeat offender’ physicians, malpractice costs could go down and trust in the profession overall would certainly improve.

Adverse Events vs. Errors

The 1999 IOM report has brought a lot of attention and awareness to the incidence of errors in medicine. One of the hoped for results of the research leading up to the IOM report was a changed atmosphere that encouraged the acknowledgement and reporting of errors, intending to make it easier to find solutions. There does seem to be a tendency for consumer groups to play the emotional card a bit strongly here, which might be counterproductive. As long as this is the case, health care providers have even less incentive to come forward to try to help the entire system, or other individuals within it, change behaviors that might reduce the errors. A malpractice insurer in Colorado is looking at handling medical errors somewhat differently. When a patient suffers from an error, the insurer works with the patient to cover costs for additional medical care and lost wages. The firm reports this is reducing claims filed against doctors.

CONCLUSION

Utah has had caps on noneconomic damages in place since 1996, and yet we have this recent effort to encourage physicians to use arbitration agreements with their patients. This additional effort might support the notion that tort reform by itself isn’t going to get us where we need to be.

In 1999, 40% of hospitals and physicians surveyed in California didn’t use arbitration agreements because they were unfamiliar with them, another 30% because they thought the agreements set the wrong tone with their patients. Setting the wrong tone might be a real worry if the primary reason for using the agreements is to bring malpractice premiums under control. This is probably seen by many consumers as a direct benefit to physicians, and only indirectly benefiting patients. The polarization of positions on this issue is extreme, and unfortunately, typical of the political arena. One wonders if a better reason for promoting arbitration agreements might be because they can be another tool in the efforts to control health care costs, serving the interests of all parties more efficiently and economically. To this end, the UMA might consider inviting consumer interest organizations to come on board in the promotion of arbitration agreements, broadening its own perspective and perhaps the appeal of this potentially valuable tool.

- Beverly Hawkins, DME Research Associate

REFERENCES

Thanks to those individuals who talked through these issues with me and supplied references.

- America’s Medical Liability Crisis: A National View (map). AMA website: www.ama-assn.org/ama1/pub/upload/mm/-1_liab_19stat.pdf.
- Binding Arbitration Is Not Frequently Used to Resolve Health Care Disputes. Rand Institute for Civil Justice Research Brief. 1999. www.rand.org/publications/RB/RB9030/index.html.
- Confronting the Myths on Medical Liability Reform. AMA website: www.ama-assn.org/ama1/pub/upload/mm/399/mlrmyths.pdf.
- Educating the Public on Arbitration. R. Chet Loftis. UMA Medibyte. October 28, 2003.
- Hype outraces facts in malpractice debate. Peter Eisler. USA Today. March 5, 2003.
- The Impact of Non-Economic Damage Caps on Physician Premiums, Claims Payout Levels, and Availability of Coverage. Weiss Ratings Inc. website: www.weissratings.com/malpractice.asp.
- June 3, 2003.
- Implementing Arbitration. UMA Packet
- Investigative Reports, Independent Researchers Agree: Caps Won’t Solve Medical Malpractice “Crisis”. Public Citizen website: www.publiccitizen.org/congress/civjus/medmal.
- Medical Liability Reform Fast Facts. AMA website: www.ama-assn.org/ama/pub/article/6282-7342.html.
- Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates. United States General Accounting Office (GAO-03-702). June 2003. www.gao.gov (follow this trail: GAO reports; Find GAO Reports; Full Text; enter GAO-03-702 for number; Accessible Text. This will give you the text of the report, but not the figures or tables)
- Medical Malpractice Insurance: Stable Losses/Unstable Rates (national and individual state reports). Americans for Insurance Reform website: www.insurance-reform.org.
- Medical Misdiagnosis in West Virginia: Challenging the Medical Malpractice Claims of the Doctors’ Lobby. January, 2003. Public Citizen website: www.citizen.org/congress/civjus/medmal/articles.cfm?ID=8845.
- Testimony before the Subcommittee on Health of the House Committee on Energy and Commerce: Regarding Medical Malpractice Insurance Rates. Travis Plunkett. July 17, 2002. Consumer Federation of America website: www.consumerfed.org/Med_Mal_House_testimony.pdf.
- To Err Is Human: Building a Safer Health System. Kohn LT et al. Institute of Medicine. 1999.

DIVISION OF MEDICAL ETHICS

LDS Hospital, (801) 408-1135

Web Site: <http://uuhsc.utah.edu/ethics>

Division Members:

Jay A. Jacobson, M.D., Chief
Armand M. Antommara, M.D., Ph.D.
Margaret P. Battin, M.F.A., Ph.D.
Jeffrey R. Botkin, M.D., M.P.H.
Leslie P. Francis, Ph.D., J.D.
Gail A. DeLuca Havens, Ph.D., APRN, BC

Program Associates:

Howard Mann, M.D.
Mark Matheson, D.Phil.
Aden Ross, Ph.D.

Research Staff:

Beverly Hawkins, B.A.
Evelyn Kasworm, B.S.

Administrative Staff:

Kathryn Bartholomew, B.Mus.
Gayle Wyner, M.S.W.