DEVELOPMENT OF AN EARLY IDENTIFICATION AND RESPONSE MODEL OF MALPRACTICE PREVENTION

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I

INTRODUCTION

The dramatic rise in the incidence of malpractice claims over the past thirty years has revealed several problems with the U.S. system of medical dispute resolution. First, the sudden and unexpected increase in claims has created an insurance crisis wherein various medical specialists have had difficulty obtaining affordable insurance coverage.[1] One such crisis occurred in Florida in the mid-1980's, when an inability of many physicians to procure medical malpractice coverage caused some to limit or curtail their practice. This resulted in access problems for the public. This phenomenon has disproportionately befallen physicians practicing obstetric medicine.[2] Second, besides contributing to periodic crises of access, the current medical dispute resolution system is often responsible for long delays in resolving claims and in compensating victims.[3]

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1. *See* Frank A. Sloan & Randall R. Bovbjerg, *Medical Malpractice: Crises, Response, and Effects*, HEALTH INS. ASS'N AM. RES. BULL. (Health Ins. Ass'n Am., Wash., D.C.), May 1989. Although currently in the middle of a relatively soft insurance market (slow growth of claims and payments with readily available coverage), it is likely that claims and payments will increase dramatically over the next decade. The current focus on slowing the growth of health spending is likely to anger American health care consumers who experience adverse events and wonder whether their outcomes are related to restrictions on referrals, reduced lengths of stay, or to a physician's incentive to save money. *See, e.g.*, Gerald. B. Hickson, *Pediatric Practice and Liability Risk in a Managed Care Environment*, 26 PEDIATRIC ANNALS 179 (1997); *see also* Marcel Frenkel, *Capitation, Disease Management, and Physician Liability*, 23 J. HEALTH CARE FIN. 87 (1997).

2. In 1989, the Institute of Medicine reported that sizable numbers of physicians in every state had eliminated obstetrics from their practice because of liability concerns. *See, e.g.*, INST. OF MED., *The Effects of Medical Liability on Availability of Obstetrical Providers*, *in* MEDICAL PROFESSIONAL LIABILITY AND THE DELIVERY OF OBSTETRICAL CARE 35 (1989).

3. *See, e.g.*, U.S. GEN. ACCOUNTING OFFICE, MEDICAL MALPRACTICE: CHARACTERISTICS OF

Third, compensation is sometimes inequitable, encouraging frivolous suits and making the system expensive to operate. Finally, while there is no evidence that the system reduces bad care, it clearly contributes to increased cost by encouraging unjustified defensive medicine.[4]

A number of strategies have been proposed to reduce the incidence of malpractice claims by making it harder for individuals to file suit. Recommended solutions have included reducing the statute of limitations, promoting the use of arbitration, and setting caps on awards and settlements, especially for pain and suffering.[5] Unfortunately, these strategies tend to make it more difficult for everyone to sue. Justice demands that patients and their families be able to seek full compensation when patients have been injured by negligent medical care and these proposed remedies could have the effect of chilling necessary and beneficent litigation. However, those injured by negligence represent a small minority of the patients and families who actually file suit.[6] Thus, the challenge is to identify what can be done to reduce the number of unfounded claims while simultaneously permitting legitimate claims to proceed.

What is needed are strategies and policies that reduce the likelihood that individuals will pursue invalid claims. To this end, it may be possible to decrease unwarranted litigation through an analysis of the origins of such lawsuits. Numerous studies have highlighted the significance of poor patient-physician rapport in promoting decisions to file suit.[7] Other studies have demonstrated that the incidence of claims is not random. Instead, some physicians attract a disproportionate share of malpractice claims.[8] If such findings are valid, it might be possible to develop a method to identify physicians at risk for attracting suits, and intervene with them in a timely fashion to reduce sources

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CLAIMS CLOSED IN 1984 (1987).

4. *See, e.g.*, Richard A. Reynolds et al., *The Cost of Medical Professional Liability*, 257 JAMA 2776 (1987); A. Dale Tussing & Martha A. Wojtowycz, *Malpractice, Defensive Medicine, and Obstetric Behavior*, 35 MED. CARE 172 (1997). It is difficult to estimate the cost of defensive medicine. Physicians say that fear of being sued influences their care. However, that may be more socially acceptable than admitting that they have ordered an extra test or procedure because they cannot stand even slight degrees of uncertainty in diagnosis or treatment. Such motivations would exist even if physicians enjoyed absolute immunity from civil liability.

5. *See, e.g.*, Eleanor D. Kinney, *Malpractice Reform in the 1990's: Past Disappointments, Future Success?*, 20 J. HEALTH POL., POL'Y & L. 99 (1995); Jeffrey Horwitz & Troyen A. Brennan, *No-Fault Compensation for Medical Injury: A Case Study*, 14 HEALTH AFF. 164 (1995).

6. *See, e.g.*, CALIFORNIA MED. ASS'N & CAL. HOSP. ASS'N, REPORT OF THE MEDICAL INSURANCE FEASIBILITY STUDY (1977); Troyen A. Brennan et al., *Incidence of Adverse Events and Negligence in Hospitalized Patients*, 324 NEW ENG. J. MED. 370 (1991).

7. *See, e.g.*, Gerald B. Hickson et al., *Factors that Prompted Families to File Medical Malpractice Claims Following Perinatal Injuries*, 267 JAMA 1359 (1992) [hereinafter Hickson et al., *Factors*]; Gerald B. Hickson et al., *Obstetricians Prior Malpractice Experience and Patients' Satisfaction with Care*, 272 JAMA 1583 (1994) [hereinafter Hickson et al., *Obstetricians*]; Wendy Levinson & Debra L. Roter, *Physicians' Psychosocial Beliefs Correlate with Their Patient Communication Skills*, 10 J. GEN. INTERNAL MED. 375 (1995).

8. *See, e.g.*, Randall R. Bovbjerg & Kenneth P. Petronis, *The Relationship Between Physicians' Malpractice Claims History and Later Claims: Does the Past Predict the Future?*, 272 JAMA 1421 (1994); Frank A. Sloan et al., *Medical Malpractice Experience of Physicians: Predictable or Haphazard?*, 262 JAMA 3291 (1989).

of patient dissatisfaction that lead to malpractice claims.

The purpose of this article is to describe the development of an early identification and response model of malpractice prevention that is designed to achieve these objectives. The article begins with a rationale for the project. Then it describes the development of a patient complaint analysis system ("PCAS")—a mechanism for identifying physicians who have complaint patterns associated with higher than average risk of malpractice claims—and the results of its use in a large physician multispecialty group. The article then uses PCAS data to support a peer interview approach to changing physician behavior. Finally, it discusses issues associated with attempting to foster changes in physician behavior.

II

BACKGROUND

Justification for an early identification and response model of malpractice prevention follows from what is known about the incidence of malpractice claims, the reasons why people file suits, and the reasons that certain physicians attract a disproportionate share of malpractice claims. Two studies conducted almost a decade apart both suggest that approximately one percent of hospitalized patients suffer injuries due to medical negligence.[9] Both studies also suggest that the overwhelming majority of individuals who are injured through medical malfeasance choose not to sue. In fact, the studies suggest that only two to four percent of patients injured through negligence file claims. At the same time, five to six times as many patients who suffered injuries that are not legally compensable also file malpractice claims.[10] These studies raise important questions: Why do the vast majority of patients injured through medical negligence choose not to file suit, why do so many patients without valid claims file suit?

Answers are provided by studies involving interviews with injured patients. Marlynn May and Daniel Stengel compared the characteristics and complaints of patients with adverse outcomes. Those who had filed suit were compared to patients who believed their outcomes were a result of unsatisfactory medical care but who had chosen not to file suit.[11] May and Stengel found that indi-

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9. *See* CALIFORNIA MED. ASS'N & CAL. HOSP. ASS'N, *supra* note 6; *see also* Brennan et al., *supra* note 6. A more recent study by Andrews and colleagues suggests that the percentage of hospitalized patients who suffer iatrogenic injury on surgical wards may be substantially higher. Previous studies were based on chart reviews. *See* Lori B. Andrews et al., *An Alternative Strategy for Studying Adverse Events in Medical Care*, 349 LANCET 309 (1997). Andrews and colleagues used teams of ethnographers who actually spent time in the hospital. If their conclusions are correct, the proportion of injured patients who subsequently file suit is actually much smaller than previously thought, and the proportion of suits thought to be without merit may, in fact, also be smaller.

10. *See, e.g.*, Brennan et al., *supra* note 6.

11. *See, e.g.*, Marlynn L. May & Daniel. B. Stengel, *Who Sues Their Doctors? How Patients Handle Medical Grievances*, 24 L. & SOC'Y REV. 105 (1990). May and Stengel found that the seriousness of injury was positively correlated with consulting a lawyer and filing suit, and that families who filed claims were more likely to confront their treating physicians directly. *See id.*

viduals were more likely to sue if they believed that their doctors failed to show concern for them as individuals. In a separate study, Charles Vincent and others found that decisions to take legal action were predicted both by the nature of the injury and by what patients perceived to be insensitive handling and poor communication after the original incident.[12]

Additional insight is provided by interviews with closed claimants. In one study, researchers interviewed 127 Florida families who had filed suit alleging medical malfeasance in the perinatal period.[13] All of the cases involved infants who had experienced permanent neurodevelopmental injuries and/or death. As a part of the interview, families were asked, "What prompted you to file a malpractice claim?" More than three-fourths of the respondents cited reasons other than the need for money.[14] One-third indicated they had been advised or influenced to sue by someone outside the immediate family.[15] Most often these influential individuals were members of the medical profession. One-fifth of the respondents stated that they filed suit after deciding that forcing their physician onto the witness stand would be the only way they could ever find out what really happened.[16] The respondents also identified a number of communication difficulties with their physicians predating the adverse event in question. One-fifth of the respondents stated that they filed suit when they suspected that their physician was engaged in a cover-up concerning their child's medical care.[17] A common response was "He would never tell us anything. I decided he must be hiding something." One-fifth of the respondents said they filed suit "so that he won't ever do this to anyone else."[18] Results of this study suggest that persons who file suit are often as concerned about relationship issues with their physicians as with the need for money.

Other studies supporting the development of an early identification and response model of malpractice prevention are those that evaluate the claims histories of physicians. In evaluating the claims experiences of Florida physicians, Frank Sloan and colleagues established that being sued for malpractice is not a random phenomenon.[19] According to their study, some physicians appear to attract a disproportionate share of malpractice claims. They reported that within each specialty, three to eight percent of physicians were responsible for 75 to 85 percent of all payments for awards and settlements. Moreover, an individual physician's risk of being sued appears quite stable. Randall Bovbjerg

12. *See, e.g.*, Charles Vincent et al., *Why Do People Sue Doctors? A Study of Patients and Relatives Taking Legal Action*, 343 LANCET 1609 (1994). The study involved 227 British patients and families who were actively engaged in suing their treating physicians at the time of the interviews.

13. *See* Hickson et al., *Factors*, *supra* note 7, at 1360. This study was made possible when Florida enacted tort reform requiring centralized reporting of all claims filed in the state. Up until that time, it was difficult to conduct interviews with large numbers of claimants.

14. *See id.* at 1361

15. *See id.*

16. *See id.*

17. *See id.*

18. *See id.*

19. *See* Sloan et al., *supra* note 8.

and Kenneth Petronis examined the claims experience of Florida physicians during a baseline and subsequent period.[20] Their study suggests that the past does predict the future. The studies of Sloan and Bovbjerg raise a number of important questions: Why do certain physicians attract so many claims, and do high suit physicians treat litigation prone populations? No evidence supports this popular idea. Do they treat more complex patients? While practitioners of some specialties certainly perform larger numbers of complicated cases, a disproportionate share of suits are still filed against a small proportion of physicians within those populations. Perhaps the questions should focus not on patients but on physicians and their behavior. Do physicians demonstrating a high incidence of malpractice claims lack technical competence? Or do they, for whatever reason, merely have some difficulty connecting with their patients?

To examine these questions, researchers began by identifying the malpractice claims experience of Florida obstetricians and then sorting the obstetricians into high, low, or no malpractice risk groups.[21] A sampling of deliveries (*n=1536*) attended by these obstetricians was obtained from Florida Vital Statistics. None of the families identified for the study had ever filed a malpractice claim. These families were contacted and asked to participate in a one-hour interview. As a part of the interview, women were asked their perceptions of the care they received during and after their pregnancy. A consistent pattern emerged when researchers compared women's perceptions of the care they received to the malpractice risk experiences of their obstetricians. Women who were under the care of physicians having the highest number of malpractice claims were significantly more likely to complain that they felt rushed, uninformed about certain tests, and basically ignored. In response to the open-ended question "what part of your care were you least satisfied with?," women seeing high malpractice risk physicians offered twice as many complaints as those whose care was provided by a "no claims" physician. Problems with physician-patient communication were the most commonly cited complaints.

As part of the study, families allowed researchers to obtain medical records for the mother-infant pairs. Stephen Entman and colleagues reviewed these records with no knowledge of the treating physician's malpractice risk group.[22]

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20. *See* Bovbjerg & Petronis, *supra* note 8. The authors found that having only a single unpaid claim during the baseline period doubled the odds of a claim during the follow up period.

21. *See* Stephen Entman et al., *The Relationship Between Malpractice Claims History and Subsequent Obstetric Care*, 272 JAMA 1588 (1994). High malpractice risk physicians experienced at least 0.57 suits per year. These physicians were further subdivided into two groups based upon the size of payments and awards made on their behalf. Patients whose doctors had high numbers of suits but less than average payments said their physicians were not concerned about them as individuals. *See also* Hickson et al., *Factors*, *supra* note 7.

22. *See* Entman et al., *supra* note 21, at 1590. There are several limitations of this study. First, the study was confined to chart reviews. Documentation does not always reflect exactly what has occurred. Charting should occur contemporaneously with events, and problems may not be recognized until after the fact. Second, although Entman and colleagues reviewed 446 charts, many charts involved reviews of infants with normal outcomes (328). Consequently, it may be that differences exist in the technical competence of high- versus no-malpractice risk obstetricians that could not be detected based upon the limitations of the study. However, if differences do exist, they are not of the same

Objective and subjective assessments of the technical quality of care delivered revealed no differences among the obstetricians assigned to the various malpractice risk groups. Specifically, high, middle, and no malpractice risk physicians could not be distinguished on the quality of their documentation, use of ancillary tests, medical episodes with marginal or inadequate care, or by subjective judgment of the physician reviewers.

Do high malpractice risk physicians differ from their low risk colleagues primarily by an inability to establish and maintain rapport? Wendy Levinson and her colleagues audio-taped a series of medical encounters between patients and physicians.[23] The encounters were analyzed by coders blind to the malpractice experiences of the physicians. When compared with physicians who had been sued previously, primary care physicians with no malpractice claims tended to use more statements of facilitation and orientation about the flow of the visit. In the affect domain, no-claims physicians used more humor in encounters than high risk physicians did. The authors speculated that these techniques made patients feel as though they were valued as individuals by their physicians. Physicians in the high malpractice risk group appear less able to make their patients feel valued.

Results of numerous studies thus indicate that high malpractice risk relates in large measure to both problems of establishing and maintaining rapport and communicating effectively during critical moments. If this is true, the questions that arise are: Is it possible to identify physicians at high risk for attracting malpractice suits from something other than claims data? If so, can changes in interpersonal skills be promoted in order to reduce malpractice risk?

Many hospitals and large medical groups operate offices of patient affairs (sometimes called ombudsmen or patient advocates) to receive complaints and to respond to patient/family needs. Some facilities centralize such reporting and record complaints verbatim so that they may be forwarded to appropriate personnel. In these systems, patient complaints are typically considered one at a time. Many are forwarded directly to the physician(s) involved. In other systems, complaints are directed to a physician chief of staff, who then forwards the complaint to the involved party or parties. Our first hypothesis is that by analyzing complaints voluntarily offered by dissatisfied patients, one can identify a relatively small number of physicians who attract a large number of patient complaints. We also hypothesize that the allegations about these high complaint physicians will be consistent with the complaint profiles of physicians at high risk for malpractice claims, that is, failures of interpersonal aspects of care.

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magnitude as the differences documented in physicians' abilities to establish and maintain rapport with their patients.

23. *See, e.g.*, Wendy Levinson et al., *The Relationship with Malpractice Claims Among Primary Care Physicians and Surgeons*, 277 JAMA 553 (1997). Although Levinson identified differences between claims and no-claims primary care physicians, her study failed to identify differences between claims and no-claims surgeons.

III
METHODS

A. Subjects

Subjects for this study were members of a 717-member multispecialty physician group, all of whom were insured by the same malpractice carrier that also covered the clinics and hospital in which the physicians worked. The group included primary and specialty physicians who are faculty of a medical school located in a metropolitan area with a population of approximately 1.4 million persons.

Approval for the study was obtained from the institution's Committee for the Protection of Human Subjects. The study was agreed upon by representatives of the medical group's executive leadership, medical school department chairs, hospital administration, office of risk management, insurance trust committee, and quality assurance department.

B. Procedures

1. *Data source.* The institution in which this study was conducted maintains an Office of Patient Affairs ("OPA") whose mission is to help patients with any aspect of their experience with the medical center. In addition to recording compliments and assisting patients with a variety of hospitality services, the OPA functions as an advocate for patients who have complaints or concerns about medical services. Since mid-1990, the OPA has maintained a computerized database file in which every patient complaint is logged along with the name of the person or persons alleged to have caused the problem (if known), what steps were taken to investigate and resolve the problem, and the outcome (if known). The OPA routinely forwards patient complaints and comments to the parties allegedly responsible and, if the complaint involves an allegation that someone was harmed, forwards them to the Office of Risk Management for review and action. OPA complaint files from July 1990 through December 1995 constituted the raw data for this study.

2. *Patient Complaint Analysis System.* OPA patient complaint data were scored according to a Patient Complaint Analysis System ("PCAS"), which characterizes the nature of the dissatisfaction with medical care and identifies the alleged offender(s). The PCAS allows judges to choose among 35 operationally defined complaint categories drawn from patient satisfaction studies.[24] Consistent with previous research, each complaint is assigned to one

24. *See, e.g.*, Linda A. Anderson & Marc A. Zimmerman, *Patient and Physician Perceptions of Their Relationship and Patient Satisfaction*, 20 PATIENT EDUC. & COUNSELING 27 (1993); Judith A. Hall & Michael C. Dornan, *Meta-Analysis of Satisfaction with Medical Care: Description of Research Domain and Analysis of Overall Satisfaction Levels*, 27 SOC. SCI. & MED. 637 (1988); Judith A. Hall & Michael C. Dornan, *What Patients Like about Their Medical Care and How Often They Are Asked: A Meta-Analysis of the Satisfaction Literature*, 27 SOC. SCI. & MED. 935 (1988); Barbara M. Korsch et al.,

of thirty-five specific categories subsumed under six general types, including physician communication, humaneness, care and treatment, access and availability, environment, or billing problems. (See Tables 1 & 2) Inter-rater reliabilities in initial norming studies ranged from 0.78 to 0.93, reflecting good agreement among judges responsible for assigning complaints to categories.

Three judges used the PCAS Coding Manual to code all patient complaints contained in 8,329 OPA complaint reports compiled during the target time period (for example, "the doctor was rude," "the doctor didn't give me enough information about how to take care of myself," etc.). Raters also identified the person allegedly responsible for each complaint. Codes were entered on hard copy to provide flexibility in doing reliability studies. Pre-study reliabilities for the three judges ranged from 0.68 to 0.97 and averaged 0.87, reflecting adequate agreement among raters for most complaints. A second reliability check conducted during the coding yielded inter-rater reliabilities of 0.77 to 0.99 and averaged 0.88. Test-retest reliabilities on a sample of 30 patient complaints judged a month apart averaged 0.90, reflecting good consistency within individual raters over time. Inter-rater and test-retest reliabilities of identification of the alleged offender were consistently high, 0.96 to 0.99. Because of the sensitive nature of the study, two raters reviewed every complaint and its coding. Differences were resolved by consensus among the two raters or by using the third judge as a tie-breaker.

The next step was to create a complaint-based computerized database containing the individual coded complaints. The database also contained variables that identified the report, the person alleged to have given each offense, and the responsible doctor or supervisor (attending physician or unit director). The database contained 13,673 complaint events, 2,248 of which identified an attending physician as the alleged offender.

Gaps in Doctor-Patient Communication: Doctor-Patient Interaction and Patient Satisfaction, 42 PEDIATRICS 855 (1968); Debra L. Roter et al., *Patient-Physician Communication: A Descriptive Summary of the Literature*, 12 PATIENT EDUC. & COUNSELING 99 (1988); John E. Ware, Jr. & Ron D. Hays, *Methods for Measuring Patient Satisfaction with Specific Medical Encounters*, 26 MED. CARE 393 (1988); John E. Ware et al., *Dimensions of Patient Attitudes Regarding Doctors and Medical Care Services*, 13 MED. CARE 669 (1975); Michael J. Weaver et al., *A Questionnaire for Patients' Evaluations of Their Physicians' Humanistic Behavior*, 8 J. GEN. INTERNAL MED. 135 (1993); Matthew H. Wolf et al., *The Medical Interview Satisfaction Scale: Development of a Scale to Measure Patient Perceptions of Physician Behavior*, 1 J. BEHAV. MED. 391 (1978). Multiple studies have sought to define the various domains of patient satisfaction. Although there is consistency about these domains across the various studies, the real challenge is how satisfaction is assessed in any given patient. Most satisfaction instruments that have emerged from this research utilize closed-ended questions in which individuals are asked the extent to which they agree or disagree with a given statement. The problem with such a methodology is that, in general, it does not allow patients to indicate those issues that are of greatest concern and may not capture real complaints at all if the patients do not understand the statement or if the evaluator has not anticipated the particular source of dissatisfaction. *See, e.g.*, Stephen Bruster et al., *National Survey of Hospital Patients*, 309 BRIT. MED. J. 1542 (1994). It is our strong belief that the most effective methods of assessing satisfaction utilize open-ended responses with subsequent analysis.

C. Results

The major question was whether patient complaints were equally distributed across all physicians. Figure 1 illustrates that 90% of the members of the physician group were named in fewer than ten patient complaints during the study period, and no complaints were recorded for 40% of the members of the group. The 641 physicians with few or no complaints were arbitrarily defined as "low-complaint physicians." The remaining 76 physicians (just over 10% of the population) were defined as "high-complaint physicians."

FIGURE 1
CUMULATIVE FREQUENCY DISTRIBUTION OF COMPLAINTS FOR 717 PROVIDERS

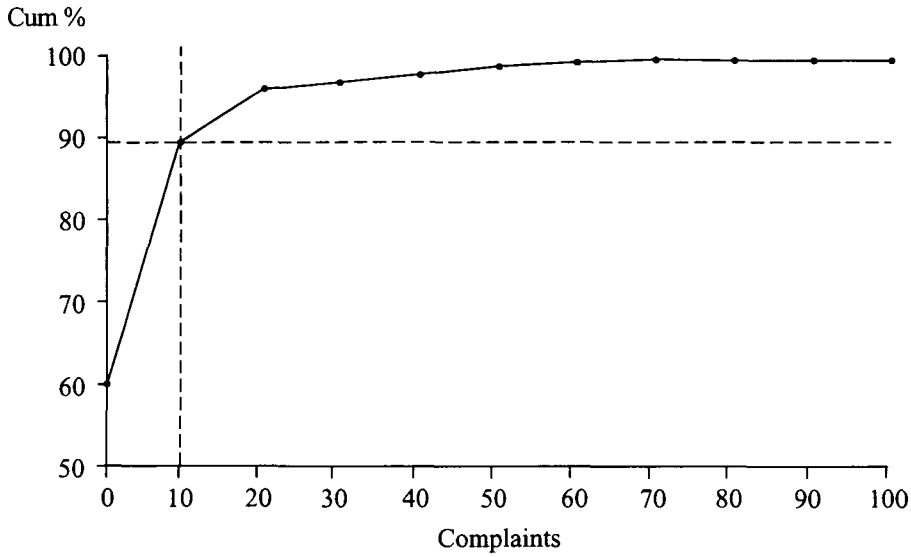

Table 1 contains the raw numbers of complaints (by general class and specific type) made by patients or family members who identified physicians by name. Complaints are presented separately for low-complaint and high-complaint physicians. Table 2 presents the proportions of complaints for both groups of physicians within each code. The data show that the High-Complaint physicians, 10% of the group, disproportionately accounted for two-thirds of patient complaints overall and for approximately two thirds of *each type* of patient complaint.

TABLE 1
RAW NUMBERS OF COMPLAINTS

Code Class	Code	MD Group < 10 Complaints n=641 MDs	MD Group >=10 Complaints n=76 MDs	ALL n=717 MDs
Communication		**125**	**278**	**403**
	Poor Communication	40	107	147
	Paper/Chart Problem	26	44	70
	Did Not Listen	19	35	54
	Poor MD-MD Communication	16	32	48
	MD "Jousting"	7	22	29
	Lied To, Misled	2	11	13
	Who's In Charge	6	6	12
	MD Uniformed	3	8	11
	Confidence Breach	4	5	9
	Made Me Worry	1	6	7
	Communication Too Personal	1	1	2
	Lewd Behavior	·	1	1
Care & Treatment		**240**	**434**	**674**
	Treatment Problem	81	161	242
	Diagnosis Problem	67	103	170
	Adverse Outcome	29	69	98
	Incompetent	39	42	81
	Discharge Problem	18	37	55
	Medication Problem	6	22	28
Humaneness		**64**	**95**	**159**
	MD Rude	35	60	95
	MD Discriminated	19	25	44
	MD Yelled At Patient	3	4	7
	Patient Felt Coerced	2	3	5
	MD Blamed Patient	3	2	5
	Rough Handling	1	1	2
	MD Assaulted Patient	1	·	1
Access		**59**	**153**	**212**
	Made Me Wait	30	80	110
	Refused Access	13	32	45
	Calls Not Returned	5	19	24
	Continuity Of Care	5	11	16
	Was Rushed	6	11	17
Environment		**5**	**7**	**12**
	Unsafe Environment	5	4	9
	Meal Problems	·	2	2
	Parking Problems	·	1	1

		MD Group		
		< 10 Complaints	>=10 Complaints	ALL
Code Class	Code	n=641 MDs	n=76 MDs	n=717 MDs
Billing/Payment		**281**	**507**	**788**
	$ Adjustment Requested	149	280	429
	$ Adjustment Granted	132	227	359
ALL		774	1474	2248

TABLE 2
PROPORTIONS OF COMPLAINTS WITHIN EACH CODE

		MD GROUP	
		< 10 COMPLAINTS	>=10 COMPLAINTS
CODE CLASS	CODE	n=641 MDs	n=76 MDs
Communication		**31%**	**69%**
	Poor Communication	27%	73%
	Paper/Chart Problem	37%	63%
	Did Not Listen	35%	65%
	Poor MD-MD Communication	33%	67%
	MD "Jousting"	24%	76%
	Lied To, Misled	15%	85%
	Who's In Charge	50%	50%
	MD Uniformed	27%	73%
	Confidence Breach	44%	56%
	Made Me Worry	14%	86%
	Communication Too Personal	50%	50%
	Lewd Behavior	·	100%
Care & Treatment		**36%**	**64%**
	Treatment Problem	33%	67%
	Diagnosis Problem	39%	61%
	Adverse Outcome	30%	70%
	Incompetent	48%	52%
	Discharge Problem	33%	67%
	Medication Problem	21%	79%
Humaneness		**40%**	**60%**
	MD Rude	37%	63%
	MD Discriminated	43%	57%
	MD Yelled At Patient	43%	57%
	Patient Felt Coerced	40%	60%
	MD Blamed Patient	60%	40%
	Rough Handling	50%	50%
	MD Assaulted Patient	100%	·

CODE CLASS	CODE	MD GROUP < 10 COMPLAINTS n=641 MDs	MD GROUP >=10 COMPLAINTS n=76 MDs
Access		**28%**	**72%**
	Made Me Wait	27%	73%
	Refused Access	29%	71%
	Calls Not Returned	21%	79%
	Continuity Of Care	31%	69%
	Was Rushed	35%	65%
Environment		**42%**	**58%**
	Unsafe Environment	56%	44%
	Meal Problems	·	100%
	Parking Problems	·	100%
Billing/Payment		**36%**	**64%**
	$ Adjustment Requested	35%	65%
	$ Adjustment Granted	37%	63%
ALL		34.0%	66.0%

What were patients' most common complaints? Table 3 depicts the overall proportions of each type of complaint. Complaints about bills led the list, followed by care and treatment issues. Concerns about communication, humaneness, and access issues followed. Complaints about environmental concerns rarely mentioned physicians by name.

Among patients' complaints about their bills were the following: they had been charged excessively for the services provided; they never saw a physician whose name appeared on the bill; they were billed for a treatment that had caused harm; they were charged for someone else's care; or they were cared for by "lower level" health care providers but were billed for an attending physician's time.

TABLE 3
OVERALL PROPORTIONS OF EACH TYPE OF COMPLAINT

		MD Group		
		< 10 Complaints	>=10 Complaints	ALL
Code Class	Code	n=641 MDs	n=76 MDs	n=717 MDs
Communication		**6.0%**	**12.0%**	**18.0%**
	Poor Communication	2.0%	5.0%	7.0%
	Paper/Chart Problem	1.0%	2.0%	3.0%
	Did Not Listen	0.8%	2.0%	2.0%
	Poor MD-MD Communication	0.7%	1.0%	2.0%
	MD "Jousting"	0.3%	1.0%	1.0%
	Lied To, Misled	0.1%	0.5%	0.6%
	Who's In Charge	0.3%	0.3%	0.5%
	MD Uniformed	0.1%	0.4%	0.5%
	Confidence Breach	0.2%	0.2%	0.4%
	Made Me Worry	0.0%	0.3%	0.3%
	Communication Too Personal	0.0%	0.0%	0.1%
	Lewd Behavior	·	0.0%	0.0%
Care & Treatment		**11%**	**19.0%**	**30.0%**
	Treatment Problem	4.0%	7.0%	11.0%
	Diagnosis Problem	3.0%	5.0%	8.0%
	Adverse Outcome	1.0%	3.0%	4.0%
	Incompetent	2.0%	2.0%	4.0%
	Discharge Problem	1.0%	2.0%	2.0%
	Medication Problem	0.3%	1.0%	1.0%
Humaneness		**3.0%**	**4.0%**	**7.0%**
	MD Rude	2.0%	3.0%	4.0%
	MD Discriminated	1.0%	1.0%	2.0%
	MD Yelled At Patient	0.1%	0.2%	0.3%
	Patient Felt Coerced	0.1%	0.1%	0.2%
	MD Blamed Patient	0.1%	0.1%	0.2%
	Rough Handling	0.0%	0.0%	0.1%
	MD Assaulted Patient	0.0%	·	0.0%
Access		**3.0%**	**7.0%**	**9.0%**
	Made Me Wait	1.0%	4.0%	5.0%
	Refused Access	0.6%	1.0%	2.0%
	Calls Not Returned	0.2%	0.8%	1.0%
	Continuity Of Care	0.2%	0.5%	1.0%
	Was Rushed	0.3%	0.5%	0.8%
Environment		**0.0%**	**0.0%**	**1.0%**
	Unsafe Environment	0.2%	0.2%	0.4%
	Meal Problems	·	0.1%	0.1%
	Parking Problems	·	0.0%	0.0%

Code Class	Code	MD Group < 10 Complaints n=641 MDs	MD Group >=10 Complaints n=76 MDs	ALL n=717 MDs
Billing/Payment		**13.0%**	**23.0%**	**35.0%**
	$ Adjustment Requested	7.0%	12.0%	19.0%
	$ Adjustment Granted	6.0%	10.0%	16.0%
ALL		34.0%	66.0%	100%

Examples of patient complaints about care and treatment include the following:

> (1) Treatment problem: The patient complained that the doctor put her on a new medication and did not monitor her for two months.
>
> (2) Medication problem: A father states that his 18 month-old son was given ten times the amount of a drug than was intended.
>
> (3) Adverse or poor outcome: "My wife went back to Dr. L who told her that her pain was scar tissue. He removed the scar tissue and now she says the pain is worse."

Patients' complaints about communication issues are similar to the following:

> (1) The Doctor seemed uninformed about the case: "The doctor my daughter saw didn't know her medical history and didn't appear to have read any of the chart." "The staff asked [my father] to sign papers that he already signed and would have repeated CT scans if dad had not reminded them that he brought copies from the other hospital."
>
> (2) Poor Communication: "She was...concerned that D's surgeons did not talk with the family after surgery was completed." "Several EEG's and a CAT scan were done and we couldn't get information about the results from Neurology."
>
> (3) Lied to, misled: "Mrs. D says that Dr. H told them that the thumb could not be saved because it was too jagged. She wonders if it was not saved because of the five-hour delay before they began surgery."

(4) Did not listen: "Mom says she has been trying for months to convince Dr. A that her child has a problem with his knee, but Dr. A just says it's fine."

(5) Made me worry: "Mrs. U says that the residents 'scared me to death' by telling her that the suture lines on her baby were multiple fractures."

(6) Doctor jousting: "Dr. J told me, 'It will probably take a week to get your blood work back. This place is very inefficient. You can't imagine how inefficient this place is.'" "She says her son's doctors told her he had gotten the initial infection in the OR and that it was probably from one of the team members who did not wash their hands well after having a BM."

Patients are hurt and angered when their care lacks essential humaneness, as in the following examples:

(1) Doctor was rude: "I felt as if I were being reprimanded by questioning the delay (in instituting my daughter's treatment).... Dr. X seemed unconcerned and arrogant."

(2) Doctor angry, yelled at patient: "Mrs. B states that Dr. G was screaming at her husband at one point." "Dr. V never raised his voice but spit out his words like bullets. It was obvious that he was angry."

Access issues resulting in patient complaints were like the following:

(1) Made me wait, Doctor was not available: "Dr. C did not visit mother until the day she was discharged." "The patient's father says his daughter got extremely sick, so he was given an appointment at noon. He says he waited five hours before they saw a physician."

(2) Was rushed: "After complaining about lack of thoroughness in the exam, the mom said Dr. K's exam was hasty and did not last more than five minutes."

(3) Calls not returned: "She said that she...left numerous messages and rarely received a return call during her lengthy illness."

(4) Refused access: "Mr. I says that now he can't get an appointment in the clinic because he's missed several appointments." "Attempts

> were made for her to see another MD who refused to see her since she is Dr. G's patient."

While complaints about the medical environment rarely mentioned physicians by name, patients often perceive that the environment may adversely affect their physicians' abilities to care for them. For example:

> (1) Unsafe, inefficient environment: "The patient complained that the ED was filthy and disorganized." "Mr. K was admitted for a CT scan, but was unable to have the testing done because the CT scanner was down."
>
> (2) Meal problems: "Mrs. W states that despite being a diabetic who needs to eat on time, her meal tray was not delivered until 9 p.m. the day she was admitted."
>
> (3) Parking problem: "Mr. Q states that by the time he found a parking place and walked all the way back to the clinic, his wife had already been seen, and none of his questions had been addressed."

IV

DISCUSSION

Systematic analysis of patient and family complaints recorded in an office of patient affairs revealed that a small percentage of physicians in a large multispecialty group attracted a disproportionate share of complaints. "High-Complaint" physicians (10% of the group) accounted for approximately two-thirds of the complaints concerning the quality of physician communication, care and treatment, humaneness, access to care, the environment, and billing. This finding is consistent with the results from a previous study, in which a small number of high-malpractice physicians accounted for disproportionate numbers of patient complaints.[25] The types of complaints about physicians in this current study were also similar to those recorded for obstetricians in the Florida study mentioned above.[26]

Why do certain physicians attract larger numbers of patient complaints? The answer may be similar to why a relatively small group of physicians attract so many malpractice suits. It may be that both high-complaint and high-malpractice risk physicians simply have difficulty establishing and maintaining rapport with their patients. Reasons for this difficulty are clearly multifactorial and relate to the physician's beliefs and attitude, family of origin influences, gender, and sociocultural influences.[27] Furthermore, some physicians who func-

25. *See* Hickson et al., *Obstetricians, supra* note 7.
26. *See id.*
27. *See, e.g.*, Glynis Bean & Louise H. Kidder, *Helping and Achieving. Compatible or Competing*

tion adequately in routine settings may be challenged to maintain relationships in certain clinical situations, including dealing with difficult and dying patients, and when mistakes have been made.[28] Yet from a risk management perspective, these are the very situations when rapport must be optimal.

Are there other reasons that certain physicians attract more complaints? One possibility is that they care for large numbers of patients or deliver large dollar volumes of service. Examination of patient encounters and relative value units ("RBRVs")[29] of service delivered by high and low-complaint physicians in the current study revealed a modest positive correlation ($r=.34$, $p<.05$). However, only twelve percent of the variation in complaints was explained by RBRVs ($r^2=.12$). In other words, the quantity of patient care delivered by a physician plays only a minor role in his being named in greater numbers of complaints.

Another possibility is that differences in patient complaints occurred based upon the type of medicine practiced (that is, surgery vs. nonsurgery). Wendy Levinson and Debra Roter have documented differences between surgeons and nonsurgeons with respect to their communications skills.[30] We, however, could identify no significant correlation between physician complaint numbers and the specialty practiced. Similarly, no differences were identified based upon physician gender or length of practice. This is not to say that differences do not

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Goals for Men and Women in Medical School?, 16 SOC. SCI. & MED. 1377 (1982); David Field & Angela Lennox, *Gender in Medicine: The Views of First and Fifth Year Medical Students*, 30 MED. EDUC. 246 (1996); Daniel H. Funkenstein, *The Learning and Personal Development of Medical Students and the Recent Changes in Universities and Medical Schools*, 43 J. MED. EDUC. 883 (1968); A. A. Marshall & Robert C. Smith, *Physicians' Emotional Reactions to Patients: Recognizing and Managing Countertransference*, 90 AM. J. GASTROENTEROLOGY 4 (1995); Laeth S. Nasir, *Evidence of Discrimination Against International Medical Graduates Applying to Family Practice Residency Programs*, 26 FAM. MED. 625 (1994); Dennis H. Novack et al., *Calibrating the Physician*, 278 JAMA 502 (1997).

28. *See generally*, C. BOSK, FORGIVE AND REMEMBER: MANAGING MEDICAL FAILURE (1979); James E. Groves, *Taking Care of the Hateful Patient*, 298 NEW ENG. J. MED. 883 (1978); David Hilfiker, *Facing our Mistakes*, 310 NEW ENG. J. MED. 118 (1984); Dennis H. Novack, *Active Management of Problem Patients*, 50 BRIT. J. HOSP. MED. 573 (1993); Dennis H. Novack, *A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients: The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT)*, 274 JAMA 1591 (1995); Dennis H. Novack, *Adrienne*, 119 ANNALS INTERNAL MED. 424 (1993). In situations involving adverse patient outcomes, physicians may be perceived to withdraw from the patient and family. Sometimes families assume that the withdrawal occurs because care has not been exemplary or that there is something to hide. This may be particularly problematic for primary care physicians whose patients were admitted to intensive care units and must turn care over to someone else. In such circumstances, the primary physician may feel like a fifth wheel. Families may not see their former doctor and may, subsequently, misunderstand statements made by unit staff and come to believe that poor care was delivered prior to admission. In these circumstances, families may be prompted to file suit.

29. *See generally* William C. Hsiao et al., *Results, Potential Effects, and Implementation Issues of the Resource-Based Relative Value Scale*, 260 JAMA 2429 (1988). Hsiao and his colleagues developed the resource-based relative value scale based on the resource input costs of services and procedures delivered by physicians in eighteen major specialty areas. The resource cost of a physician's service consists of (1) the time consumed in providing a service or procedure; (2) the intensity of the work, defined to include the mental effort, judgment, technical skill, and stress involved; (3) the amortized cost of physician training; and (4) the overhead cost of practice.

30. *See* Levinson & Roter, *supra* note 7.

exist. After all, only 717 physicians were studied, and, perhaps, examination of a larger physician population would identify factors that contribute to differences in complaint generation. In the meantime, ten percent of the physicians studied stand out in terms of attracting patient complaints. Our hypothesis is that they will also stand out in terms of their malpractice risk. This hypothesis is being addressed in a subsequent study.

Two tools created as part of our work deserve mention. The first is the development of the PCAS, which was designed to systematically analyze patient/family complaint narratives. Unlike traditional patient satisfaction questionnaires with closed-ended responses that principally serve institutional marketing purposes, the PCAS captures potential problems in patients' and families' own words, and allows identification of alleged offenders and/or services, and allows aggregation of complaints over time. Our evaluation of the PCAS also indicated that research assistants with limited or no medical background exhibited acceptable inter-rater and test-retest reliability in coding complaints.

The second tool that deserves mention is based on the aggregated complaint data. Specifically, the distribution of complaints alleged against each physician forms the basis for a "report card" that can be presented to high-complaint physicians. The report card is composed of a graph that depicts an index of complaints received per unit of time (x-axis) and the number of physician group members with that complaint value (y-axis). The individual's complaint score is highlighted so that the physician can see how he or she compares with peers. Representative quotes from patient complaints and a listing of the most common types of complaints alleged against the physician complete the report card. These report cards are being used in an intervention study where respected peers share the data on the report card with high-complaint physicians and seek to learn the nature of the problems, if any, that underlie the complaints. The study hypothesis is that such an intervention will influence positive behavioral changes in some physicians. Pilot testing suggests that half of those who receive the intervention will demonstrate change.

Improving physician practice behavior has been the subject of increasing interest over the past two decades, as society attempts to cope with the ever increasing cost of medical care. Review of the medical literature concerning how to promote change suggests at least six methods: education, feedback, participation by physicians in efforts to bring about change, administrative rules and regulations, financial incentives, and penalties.[31] The first line of intervention in our current project involves the first three methods: education, feedback, and physician participation. Specifically, our hypothesis is that "report cards" that graphically compare the complaint experience of one doctor with his or her peers will serve as an effective educational and feedback tool via their presentation and discussion by respected and respectful colleagues. Should changes

31. *See, e.g.*, Peter J. Greco & John M. Eisenberg, *Changing Physicians' Practices*, 329 NEW ENG. J. MED. 1271 (1993) (summarizing research on changing physician behavior).

not occur, the second line of intervention will include elements drawn from the latter three strategies: administrative rules, financial incentives, and penalties.

Education and feedback provide physicians with information about how their practice compares with others or with some accepted practice guideline. Feedback has been effective in reducing hospital lengths of stay, the number or types of medications prescribed, outpatient tests ordered, and increasing compliance with health promotion guidelines.[32] Other studies, however, have shown that feedback has little effect.[33] Review of the feedback literature suggests that there is at least one prerequisite before physicians will alter practice behavior: They must recognize the need for change. If a meaningful relationship between patient complaints and malpractice-related risk management activity can be established, such an outcome is likely to provide high-complaint physicians (and their administrators and insurers) with clear and convincing evidence of the need for change.

The research on physician behavior change suggests that "report cards" should be shared in a sensitive and supportive way by a respected colleague. Such a method of providing feedback is likely to be far more effective than simply mailing the report cards periodically or having them shared by nonphysician personnel from the OPA, the risk management department, the malpractice insurer, or the medical group administration.[34]

Over the past two decades, interest has developed in the use of clinical

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32. *See, e.g.*, Donald M. Berwick & Kathryn L. Coltin, *Feedback Reduces Test Use in a Health Maintenance Organization*, 255 JAMA 1450 (1986); John E. Billi et al., *The Effects of a Low-Cost Intervention Program on Hospital Costs*, 7 J. GEN. INTERNAL MED. 411 (1992); Kurt Kroenke & Ellen M. Pinholt, *Reducing Polypharmacy in the Elderly: A Controlled Trail of Physician Feedback*, 38 J. AMER. GERIATRIC SOC'Y 31 (1990); Linda M. Frazier et al., *Can Physician Education Lower the Cost of Prescription Drugs? A Prospective, Controlled Trial*, 115 ANNALS INTERNAL MED. 116 (1991); Larry M. Manheim et al., *Training House Officers to be Cost Conscious: Effects of an Educational Intervention on Charges and Length of Stay*, 28 MED. CARE 29 (1990); Stephen J. McPhee et al., *Promoting Cancer Screening: A Randomized, Controlled Trial of Three Interventions*, 149 ARCHIVES INTERNAL MED. 1866 (1989). Physicians tend to move toward the norm. Managed care organizations have found that providing physicians with financial report cards effectively reduces excess care perceived to be of limited value. Increasingly, physicians have become accustomed to receiving report cards that compare their patients' medical costs with those of other physicians in the given plan.

33. *See, e.g.*, Charles O. Hershey et al., *The Effect of Computerized Feedback Coupled with a Newsletter upon Outpatient Prescribing Charges: A Randomized Controlled Trial*, 26 MED. CARE 88 (1988); Thomas J. Meyer et al., *Reduction of Polypharmacy by Feedback to Clinicians*, 6 J. GEN. INTERNAL MED. 133 (1991).

34. *See, e.g.*, Wayne A. Ray et al., *Persistence of Improvement in Antibiotic Prescribing in Office Practice*, 253 JAMA 1774 (1985); William Schaffner et al., *Improving Antibiotic Prescribing in Office Practice: A Controlled Trial of Three Educational Methods*, 250 JAMA 1728 (1983). Ray and Schaffner conducted a series of studies designed to reduce inappropriate prescribing of chloramphenicol and tetracycline for young children. Inappropriate prescribing was identified through the use of a Medicaid database that linked child, physician, and filled prescription. Physicians found themselves confronted with data about their own prescribing as well as information about the contraindications for these drugs in young children (aplastic anemia, dental staining). The method by which the information was delivered appeared to be the key. Physicians who received feedback by mail demonstrated no change in prescribing. They probably discarded the information in the circular file. Those who received the information from a colleague, however, demonstrated changes in prescribing that persisted over time. It is hard to imagine how physicians would fail to reconsider their prescribing habits when faced by a respected member of the profession who is armed with data.

practice guidelines or practice standards to reduce needless or wasteful variation in care or to identify and eliminate inappropriate care. Although countless documents have been produced, guidelines in themselves have had only modest effects in promoting changes in practice behavior.[35] However, when guidelines or practice standards are delivered by a respected peer or "opinion leader," there is often a marked effect.[36] In one study, the rate of cesarean sections was dramatically reduced when opinion leaders were recruited, trained, and then returned to their medical communities to educate their colleagues.[37] In another study, Wayne Ray and colleagues, using a process known as "academic detailing," visited practicing physicians and shared information about their inappropriate prescribing.[38] They then observed changes in prescribing that persisted over time. A dramatic effect was not observed when information concerning inappropriate prescribing was simply forwarded via mail or shared by nursing personnel.[39]

The early identification and response model of malpractice prevention follows, in part, on the studies by Ray and colleagues. Specifically, each high-complaint physician will be visited by a respected physician colleague who will be responsible for sharing the "report card," discussing the reasons that might underlie patient complaints, and building in follow-up accountability.

Such an intervention program would not be complete, however, unless it were coupled with targeted programs of continuing medical education and with resources necessary to assess office practice and organization or train those who request assistance with improving their communication skills. The research team anticipates that physicians who recognize that they stand out from the norm may begin to think about ways to improve patients' perceptions of their practices. The fact that a physician recognizes that they stand out may make them more receptive to programs of risk management education, and, therefore, may make those educational programs far more effective, especially when the high-complaint physician recognizes the need for change.

Although our hypothesis is that the early identification and response model will be effective in promoting behavioral changes of many high-complaint physicians, not everyone will respond. Some physicians, for whatever reason, will be unable or unwilling to respond. In such circumstances, what alternatives might medical leadership have in dealing with these high-complaint physicians? One approach would be to do nothing. The leaders could simply be content with the fact that many, if not most, physicians had changed behavior and perhaps, as a result, reduced patient dissatisfaction and lowered the medical

35. *See* Jacqueline Kosecoff et al., *Effects of the National Institutes of Health Consensus Development Program on Physician Practice*, 258 JAMA 2708 (1987).

36. *See* Jonathan Lomas et al., *Do Practice Guidelines Guide Practice? The Effect of a Consensus Statement on the Practice of Physicians*, 321 NEW ENG. J. MED. 1306 (1989).

37. *See* Jonathan Lomas et al., *Opinion Leaders vs. Audit and Feedback to Implement Practice Guidelines: Delivery after Previous Caesarean Section*, 265 JAMA 2202 (1991).

38. *See* Wayne A. Ray et al., *supra* note 34; *see also* William Schaffner et al., *supra* note 34.

39. *See id.*

group's collective malpractice risk.

Another approach might involve intensifying peer pressure. Chiefs of clinical services, departmental chairs, or hospital administrators might be brought into the process. Physicians with high complaint scores could be encouraged to change or face more intensive monitoring. Medical leadership might consider use of financial incentives or disincentives based on physicians' relative performances. Physicians who score well might be rewarded, and/or those who perform poorly might be penalized. Money has long been recognized as a powerful motivator of physician behavior.[40]

Finally, it is conceivable that for those few physicians who are absolutely resistant to change, in spite of peer pressure and/or financial incentives, medical groups might seek to take administrative action, including limiting the practice privileges of high-complaint physicians or dismissing nonresponding physicians from the medical group. When such action is contemplated, the group needs to recognize they face potential legal action and should conduct themselves in ways designed to reduce their risk.

V

MALPRACTICE PREVENTION AND THE HEALTH CARE QUALITY IMPROVEMENT ACT

Hospitals and physician groups can pursue many strategies to change physician behavior. They can require that physicians be monitored, they can restrict privileges, and ultimately, they can deny or revoke physicians' credentials to practice in their facility or group. Physicians subjected to these sanctions often sue, alleging such claims as defamation, interference with contractual relations, intentional infliction of emotional distress, and antitrust violations such as monopolization.[41] Often hospitals and physician groups can prevail on the merits in

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40. *See, e.g.*, Gerald B. Hickson et al., *Physician Reimbursement by Salary or Fee-for-Service: Effect on Physician Practice Behavior in a Randomized Prospective Study*, 80 PEDIATRICS 344 (1987); Alan L. Hillman, *How Do Financial Incentives Affect Physicians' Clinical Decisions and the Financial Performance of Health Maintenance Organizations?*, 321 NEW ENG. J. MED. 86 (1989). Although most people believe that money affects physician behavior, there has been relatively little empirical research on the issue. Hickson and colleagues conducted the only truly randomized study on reimbursement effects on physician practice behavior. In this study, pediatric residents were randomly assigned to receive either a very small ($2.00) fee for each patient they attended or a salary supplement for their clinical activities. Patients who were assigned to fee-for-service physicians experienced 20% more visits during the nine-month study than patients who were attended by salaried physicians. The greatest difference in the number of visits was for general health maintenance. Patients seeing fee-for-service physicians completed 40% more well child visits than patients seeing salaried physicians. Analyses of each visit revealed that patients assigned to fee-for-service physicians were more likely to have well child visits judged to be in excess of American Academy of Pediatrics standards and were significantly less likely to miss indicated visits. Patients seeing salaried physicians received almost no care judged to be excessive. They did, however, miss numerous indicated visits. Perhaps most interesting, after completion of the study, the residents were asked, "How did your method of reimbursement influence your practice behavior?" The response was unanimous. All subjects denied that payment had any influence on what they did. Physicians may often be unaware of environmental factors that influence their decision making.

41. *See generally* Barry. R. Furrow et al., *Quality Assurance and Risk Management*, *in* HEALTH LAW 158-254 (1995); Barry R. Furrow et al., *The Health Care Quality Improvement Act of 1986*, *in*

such suits if they can demonstrate that statements made about a physician were true or that the physician suffered no antitrust injury. Even so, the threat of such litigation can pose a real deterrent to physicians and hospitals that wish to promote physician behavior modifications.

Fortunately, both states[42] and the federal government have passed laws to protect such peer review activities.[43] Among the most important of these is the Health Care Quality Improvement Act ("HCQIA")[44] Under the Act, professional peer review bodies[45] and their members are immune from state and federal liability for any professional review action undertaken:

> (1) in the reasonable belief that the action was in furtherance of quality health care;
>
> (2) after a reasonable effort to obtain the facts of the matter;
>
> (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances; and
>
> (4) in the reasonable belief that the action was warranted by the facts known after such reasonable efforts to obtain facts and after meeting the requirement of paragraph (3).[46]

These review actions include any actions "based on the competence or professional conduct of any individual physician (which conduct affects or could affect adversely the health or welfare of a patient or patients), and which affects (or may affect) adversely the clinical privileges" of the physician.[47] Those who provide information to such bodies are similarly immune from liability unless they conveyed information that they knew to be false.[48]

One question that might arise is whether problems with physicians' communication and other interpersonal skills pose enough of a threat to patients' health and welfare to warrant HCQIA protection. In most reported cases, immunity is applied when physicians are dismissed because their practice patterns

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HEALTH LAW 555-676 (1995) [hereinafter, Furrow et al., *The Health Care Quality Improvement Act]*; Robert S. Adler, *Stalking the Rogue Physician: An Analysis of the Health Care Quality Improvement Act*, 28 AM. BUS. L.J 683, 697-98 (1991).

42. *See* Furrow et al., *The Health Care Quality Improvement Act*, *supra* note 41, at 555-676.

43. Note, *Defending the System: Application of the Intra-enterprise Immunity Doctrine in Physician Peer Review Antitrust Cases*, 75 TEX. L. REV. 409 (1996).

44. 42 U.S.C. §§11101-11152 (1997).

45. This term is defined as a "health care entity and the governing body or any committee of a health care entity which conducts professional review activity, and includes any committee of the medical staff of such an entity when assisting the governing body in a professional review activity." 42 U.S.C. § 11151(11) (1997).

46. 42 U.S.C. § 11112(a) (1997). The conditions that must be met by hospitals for notice and hearing are set forth in § 11112(b). By contrast, physician groups and HMOs are covered only if they have a formal peer review process as defined in 45 CFR § 60.2; 42 U.S.C. § 11151(4)(A)(i),(ii) (1997).

47. 42 U.S.C. § 11151(9) (1997). Note that the statute does explicitly exclude some activities from being considered as evidence of the physician's competence, such as participation in a prepaid health plan or being salaried, but none of these apply to concerns about patients' complaints about their physicians' communication skills and care.

48. 42 U.S.C. § 11111(a)(2) (1997).

pose a risk of physical harm to their patients.[49] However, at least one court has allowed a hospital to obtain immunity from claims by a physician who was fired for abusive and disruptive behavior,[50] and it seems clear that poor physician-patient relationships can adversely affect patients' welfare. Thus, efforts to improve physicians' interactions should be included within the peer review mechanism of the institution or group to minimize the risk of liability.

VI

CONCLUSION

Many physicians view themselves as victimized by the current system of medical dispute resolution in the United States, often pointing to legal decisions they believe are inconsistent with "the facts of the case." These physicians simply do not appreciate the differences between the standards of medical/scientific proof and the standards of legal proof. They feel victimized because courtroom standards of proof seem less rigorous and more variable. Institutions, insurers, and physician groups that make it a policy to share aggregated patient complaint data with their doctors may help avoid litigation based less on breach of duty than breach of etiquette.

The proposed project is significant for several reasons. First, it provides a vehicle for teaching the medical community about the compelling relationship between patients' dissatisfactions with interpersonal aspects of care and their decisions to file suit. Second, the early identification and response model provides medical groups with a tool that may be utilized to identify peers who need targeted intervention. Third, physicians in the new medical market are placing increasing emphasis on customer satisfaction and the need to promote good relationships. Fourth, data from such a model might complement information available from the National Practitioner Data Bank.[51] Although Data Bank information is important, it focuses on a physician's claims experience without capturing the reasons underlying those claims (patient satisfaction being one important component of the care process). Finally, patient complaints are more frequent than lawsuits, allowing, we believe, earlier and potentially more economically efficient interventions. The policy implication is clear: Peer review efforts should include early identification and response systems for reducing patient dissatisfaction in the hopes of reducing malpractice claims.

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49. *See* Bruce P. Ogden, *How to Terminate a Physician's Clinical Privileges Without Paying Him a Million Dollars: The HCQIA's Federal Peer Review and Data Bank Reporting Immunities*, 9 HEALTH LAW. 11 (1997); Kenneth G. Starling, *Antitrust Defenses in Physician Peer Review Cases*, 63 ANTITRUST L.J. 399 (1995).

50. *See, e.g.*, Bryan v. James E. Holmes Reg. Med. Ctr., 33 F.3d 1318 (11th Cir. 1994), *cert. denied*, 115 S.Ct. 1400 (1995).

51. *See, e.g.*, Robert E. Oshel et al., *The National Practitioner Data Bank: The First 4 Years*, 110 PUB. HEALTH REP. 383 (1995).