Chapter 6

Disciplinary Actions, Sanctions, and Malpractice Compensation

CONTENTS

Page

Introduction . . . . . ". ""121
Disciplinary Actions by State Medical Boards 122
Reliability of the Indicator 123
Validity of the Indicator 123
Feasibility of Using the Indicator 126
Sanctions Recommended by Peer Review Organizations and Imposed by HAS. 126
Reliability of the Indicator 127
Validity of the Indicator 130
Feasibility of Using the Indicator 132
Malpractice Compensation 133
Reliability of the Indicator 134
Validity of the Indicator 134
Feasibility of Using the Indicator 137
Conclusions and Policy Implications 138
Disciplinary Actions by State Medical Boards 138
Sanctions Recommended by PROs and Imposed by HHS 139
Malpractice Compensation 140
Combinations of Indicators 141

Figures

Figure *Page*

6-1. Overview of the PRO/HHS Sanction Process for Substantial Violations . 128
6-2. Overview of the pRO/HHS Sanction Process for Gross and Flagrant Violations 128

Tables

Table *Page*

6-1. Physician Disciplinary Actions by Skateboards, 1986 124
6-2. Interjudge Consistency in Complex Human Judgments 135

Chapter 6

Disciplinary Actions, Sanctions, and Malpractice Compensation

INTRODUCTION

Federal and State laws and regulations and private sector medical entities have established many methods to discipline and sanction errant members of the medical profession. This chapter evaluates as possible indicators of the quality of medical care three such activities:

- disciplinary actions taken by State medical boards, [1]
- sanctions recommended by utilization and quality control peer review organizations (PROS) and imposed by the U.S. Department of Health and Human Services (HHS), and
- malpractice compensation, particularly court awards.

Disciplinary actions by State medical boards, PRO/HHS sanctions, and malpractice compensation, either separately or in conjunction with each other and other indicators, may have the potential to identify physicians who do not follow accepted standards of care. Those physicians who are disciplined, sanctioned, or successfully sued for malpractice may actually provide substandard care. On the other hand, not all physicians who provide substandard care are disciplined or successfully sued. Studies of avoidable injuries indicate that the universe of avoidable adverse outcomes may be significantly greater than the number of disciplinary actions, sanctions, and malpractice suits (152,595). These studies suggest a large number of poor-quality physicians are not identified or penalized, thereby pointing to the ineffectiveness of existing systems to identify all those individuals providing poor-quality care.

This chapter uses procedures somewhat different from those described in appendix C to evaluate the reliability and validity of disciplinary actions, sanctions, and malpractice compensation as indicators of the quality of care. There are two reasons for modifying the procedures described in appendix C when considering these three indicators. First, the procedures described in appendix C apply to a systematic synthesis of the literature, and studies that examine the causal relationship between any of the three indicators discussed in this chapter and the quality of care are not available. In the absence of research studies, this chapter uses deductive reasoning from the indirect evidence of descriptive information to provide some insight into the reliability and validity of disciplinary actions, sanctions, and malpractice compensation as indicators of quality.

The second reason for modifying the procedures outlined in appendix C is that the three potential indicators discussed in this chapter are essentially legal processes that rely on judgment and have little or no science base. [2] For purposes of this chapter, the term reliability refers to consistency of the decisions made by a legal body *(e.g.,* disciplinary actions taken by State medical boards). The term validity refers to the scope of the decisions made by a legal body and the capacity of the decisions to actually measure quality. Evidence on reliability and validity is derived from examining the structure of the legal bodies, the grounds for taking actions, the procedures used in taking actions, and the types of actions taken. In the case of disciplinary actions by State medical boards and PRO/HHS sanctions, judicial review of the actions is also examined.

A possible confounding issue in OTA'S analysis is that the reliability and validity of disciplinary actions, PRO/HHS sanctions, and malprac-

[1] In the following discussion, State licensing bodies and State disciplinary bodies will be called State medical boards, although their official titles as well as their organizational loci vary among States.

[2] Reliability and validity, as described in app. C, are concepts used in applied social science and are not traditionally associated with legal systems.

tice compensation as indicators of the quality of medical care depend to a large extent upon peer review.[3] Differences in criteria used by peer physicians, even experts, in making decisions about medical diagnosis and treatment are well documented (71,185). Such differences may have troublesome implications for the reliability and validity of expert peer opinion in disciplinary actions taken by State medical boards, sanctions recommended by PROS and imposed by HHS, and malpractice compensation.

Analyses of the reliability and validity of disciplinary actions, sanctions, and malpractice compensation as indicators of the quality of care are presented below, Also presented are analyses of the feasibility of using each indicator. The final section of this chapter draws conclusions about the current usefulness of the actions, used singly and together, as quality indicators; suggests methods for improving the reliability and validity of the three actions as quality indicators; and discusses current and future means of disseminating information about the three.

[3]State **medical boards use the expert opinion of their physician members to interpret and apply the vague language often found in legislation governing license discipline. Furthermore, "expert" peers testify when physicians are brought up for hearings. The entire sanction process within PROs depends upon peer opinion, from the original identification of a possible violation to succeeding reviews of the violation. Peer review is also an important part of malpractice cases that are heard in court. "Expert" peers testify to the standard of care that can be applied to the case and whether the defendant met the standard.**

DISCIPLINARY ACTIONS BY STATE MEDICAL BOARDS

The legal authority for licensing physicians to practice medicine and for restricting or revoking licenses rests with the States. In most States, the same body that grants licenses to applicants that it has determined are qualified to practice medicine also disciplines physicians who it has decided are unfit to continue practice (32,260). All State medical boards have the authority to revoke or suspend a physician's license. Other disciplinary actions include probation, limitations, fines, reprimands, letters of censure, letters of concern, and collecting costs of proceedings (206). The general grounds for disciplinary actions are unprofessional conduct or professional incompetence **(32).** The medical practice act of each State mandates specific grounds, such as incorrect *drug* prescription and substance abuse, for disciplining physicians.

Medical licensure is intended to grant the privilege of practicing medicine to individuals who are of good moral character and are competent to provide safe care to the public **(70** Corpus Juris Sec. 19), but it does not ensure continuing competence—an important issue in light of changing medical knowledge and techniques. The purpose of disciplinary actions by State medical boards is to "protect the public against unfit practitioners" (7o Corpus Juris Sec. 35). State medical boards, which historically have been very conservative in censuring physicians (208), have increased their activity in recent years. Disciplinary actions increased from **1,540** in 1984 to 2,108 in 1985 (91) to 2,302 in 1986 (240). Nonetheless, the percentage of practicing physicians disciplined in 1986 (0.50 percent)[4] is significantly less than the 5 to 15 percent of physicians that some authors have hypothesized to be professionally incompetent to practice (169,208). Although the effectiveness of State medical boards in taking disciplinary actions is an important quality concern, the more specific intent of this chapter is to evaluate whether the disciplinary actions taken by State medical boards are good indicators of the quality of care.

Disciplinary actions taken by State medical boards are worth examining as a measure of quality, because they have face validity for average consumers. An average consumer would expect that limiting or withdrawing a physician's license to practice medicine indicates that the physician is professionally incompetent and would be concerned about using the physician for health care.

[4]**There were** 462,126 **physicians providing patient care in** 1986 (35).

[5]**In most** cases, revoking a **physician's** license prohibits **him** or **her** from **practicing medicine. There have** been **well-publicized** instances **in which physicians whose licenses** were revoked in one State **continued** to **provide medical care in other** States where they **held licenses.** Public **and private** efforts have **been** working to eliminate **this problem.**

Reliability of the Indicator

Nationwide consistency of disciplinary actions by State medical boards is not to be expected, because the granting and limitation or withdrawal of medical licenses are State responsibilities. The proportion of physicians who have had their licenses revoked or modified varies greatly among States (see table 6-l). Differences in medical performance, legal impropriety, and inaccuracy of reporting among the States can account for only a small fraction of the variation in the proportion. A greater part of the variation is attributable to differences in State laws and regulation, and, perhaps, the intensity with which State medical boards engage in disciplinary activities (499).

A State medical board's discipline of similar cases may differ because of factors that are not related to the quality of care. Important witnesses sometimes fail to appear, physicians' lawyers vary in expertise, and aggravating and mitigating factors, which are not defined in statute or case law but vary from case to case, must be weighed in disciplinary decisions **(389).** Consistency in decisions is particularly difficult to achieve in types of cases where physicians disagree about what constitutes acceptable practice. In some States (e.g., Colorado and Connecticut), a threat t. consistency is that more than one body is involved in disciplinary activities (206).

In general, the reliability of disciplinary actions as an indicator of quality within a State depends on the individual State. An investigation of 24 States by the Office of the Inspector General of HHS found "inconsistencies in the type of disciplinary actions taken in relation to the charges and even in the meanings of the different types of actions" (361), both among and within States. Whether disciplinary actions in other States are erratic, and if so, to what extent, is not known.

For the most part, the consistency of disciplinary actions taken within a State depends on the precision of the language specifying the grounds for discipline. The more vague the language, the greater the possibility for differing interpretations and applicability. Consistency of such actions is also related to the specific violation, since most States have precise grounds for some violations and ambiguous grounds for others. Most State medical practice acts list specific grounds for infractions dealing with drug prescription and use, fraud, and other violations (280,720). on the other hand, few of the States that specify incompetence in the practice of medicine or substandard practice as grounds for disciplinary actions define incompetence precisely. Illinois' Professions and Occupations Code defines "professional incompetence as manifested by poor standards of care" (111). In the face of such indefiniteness, consistency is difficult, and application of the rule requires a case-by-case interpretation of the applicable standard of practice.

A State medical board's composition and operating style also enter into the consistency of its decisions. Particularly if the grounds for disciplinary actions are vague, a State medical board could be arbitrary and capricious in its adherence to law and regulations and allow extraneous facts, such as the race, religion, or community standing of physicians, to enter into their decisions. In addition, most boards are voluntary and work long hours on difficult issues with little financial reward. Extensive caseloads are common **(658),** and the medical boards are usually limited in their disciplinary performance by staff and funds **(361).** As a result, the reliability of their decisions may be compromised.

In addition to taking formal disciplinary actions against physicians, State medical boards take informal disciplinary actions **(91).** The rationale and procedures for informal actions differ among the States. Boards take several times more informal than formal actions (91). In some States, informal disciplinary actions are taken because of a lack of investigatory resources and the backlog of unheard cases that most boards currently face (658). In other States, informal actions are used as a means of educating physicians. Even informal actions are often serious (91). The propensity for inconsistency among such actions could be high, because informal actions are confidential. Such actions could be used selectively to avoid disciplining some physicians and not others.

Validity of the Indicator

About one-half of the formal disciplinary actions taken against physicians by State medical

Table 6-l.— Physician Disciplinary Actions by State Boards, 1986[a]

	License revocation	Probation	License suspension	Other regulatory action	Total
Alabama	4	4	**0**	7	15
Alaska	**0**	1	1	0	2
Arizona	6		2	55	67
Arizona[b]	**0**	:	2	16	24
Arkansas	1	1	4	11	17
California	34	69	18	43	164
California[b]	1	3	0	1	5
Colorado	4	10	10	8	32
Connecticut	5	2	2	8	17
District of Columbia	7	2	0	**4**	13
Delaware	2	0	0	**0**	2
Florida	22	23	30	117	192
Florida[b]	4	4	3	7	18
Georgia	16	42	15	35	108
Guam	0	0	**0**	**0**	**0**
Hawaii	6	1	1	2	10
Idaho	2	2	**0**	1	5
Illinois	10	25	38	47	120
Indiana	9	18	30	38	95
lowa	16	7		9	35
Kansas	2	2	:	22	29
Kentucky	11	7	4	15	37
Louisiana	**0**	5	8	5	18
Maine	4	2	0	5	11
Maryland	1	5	5	15	26
Massachusetts	25	1	16	8	50
Michigan	3	**“o**	11	2	16
Michigan[b]	**0**	**o**	5	2	7
Minnesota	3	22	5	11	41
Mississippi	2	3	3	16	24
Missouri	32	6	0	48	86
Montana .....,	1	**0**	1	**0**	2
Nebraska	1	3	0	1	5
Nevada	2	1		3	7
FJevada[b]	**0**	0	:	**0**	0
New Hampshire	**0**	1	0	**0**	1
New Jersey	**10**	17	22	45	94
New Mexico	3	1	0	**0**	4
New Mexico	0	**0**	0	**0**	**0**
New York .....,...	64	**83**	20	31	198
North Carolina	12	13	1	25	51
North Dakota	1	1	0	3	5
Ohio	24	20	14	51	109
Oklahoma	3	15	3	16	37
Oklahoma	0	1	0	3	4
Oregon	2	19	7	20	**48**
Pennsylvania	9	7	11	34	**61**
Pennsylvania[b]	1	6	8	4	**19**
Puerto Rico	0	0	0	0	**0**
Rhode Island	2	0	1	4	7
South Carolina	6	5	5	10	26
South Dakota	1	0	0	8	9
Tennessee	6	3	1	11	21
Tennessee[b]	**0**	0	0	0	**0**
Texas	28	9	4	31	72
Utah	4	12	1	17	34
Vermont	0	0	1	6	7
Virgin Islands .,	0	0	0	0	**0**
Virginia State	15	18	6	51	90
Washington	**0**	8	3	22	33
Washington[b]	**0**	0	0	0	0
West Virginia	8	6	5	7	26
West Virginia	0	0	0	0	0
Wisconsin	23	2	1	20	46
Wyoming	**0**	0	0	0	**0**
Total for bear.	458	528	335	981	2,302

aExcept where designated, all boarcfs take disciplinzwy actions against both allopathic physicians **(M.Ds) and osteopathic @wkians@D s)**
bTtlis board takes disciplinary actions against osteopathic physicians (OD.s) onlY

SOURCE B Galusha and DG Breadon, “Official 1966 Federation Summary of Reported DIsciphnary Actlons.” *Federatiorr Bulletin 75(2)41.46, 1988*

boards are on the grounds of inappropriate writing of prescriptions. Such infractions are the easiest to prove because of the exactness of prescription laws *(658).* Inappropriate prescribing and a physician's personal drug or alcohol abuse are the grounds for three-fourths or more of the disciplinary actions taken by State boards. Conviction for felony and fraud is among the most common of the remaining grounds for license discipline. A relatively small number of disciplinary actions are based on incompetence—the ground for discipline that would most clearly indicate poor quality of care.

If incompetence is strictly interpreted as the only violation that is a quality violation, disciplinary actions by State medical boards would not be a valid indicator of the quality of the medical care. A more liberal interpretation of incompetence to include inaccurate drug prescribing and drug and alcohol abuse is reasonable. The statistics just cited on types of violations present an incomplete picture of the importance of incompetence in disciplinary procedures. In addition, few medical practice acts identify incompetence as grounds for discipline, and the language of the acts that do is usually vague and difficult to interpret **(694).**[6] In addition, obtaining "clear and convincing evidence, " of incompetence in most States is extremely difficult, time-consuming, and costly *(239).* Boards often use overprescribing of drugs and drug and alcohol abuse, which they have found often coincide with incompetence, as grounds for action instead of trying to prove incompetence **(90,239,694,706,720).** In particular, alcohol and drug abuse, characteristic of the impaired physician, and physical and mental illness can result in substandard performance and avoidable medical injury **(636).**

Several grounds for disciplinary actions are related to law and ethics. Many of these may not affect the technical aspects of quality but may influence interpersonal relations. The grounds vary greatly in seriousness and include conviction of a felony, conviction of a crime or felony related to medical practice, fraud in obtaining a license, violations of narcotics laws, violations of child abuse reporting acts, betrayal of professional secrets or privileged communications, and making untruthful or exaggerated claims relating to professional excellence or abilities **(34,260).** Other grounds for disciplinary action relate to charges of essentially economic violations, such as fraud regarding fees, fee-splitting, false or deceptive advertising, and overcharging or making false claims for reimbursement *(34,260).* Whether any, some, or all of these violations affect medical decisionmaking is not known, but to the extent that a violation affects an individual's trust in a physician's care, the ability of a physician to provide competent interpersonal care is compromised. People have different expectations of their physicians, and, depending on the type and seriousness of the violation, many people would not be comfortable going to a physician who had violated the law.

If one accepts that all violations that lead to formal disciplinary actions are quality violations, then such actions appear to possess validity as a measure of quality. The burden of proof for taking formal disciplinary actions rests with the State, and such actions usually must be based on "clear and convincing evidence, " a difficult standard of proof. Due process safeguards are applied **(70** Corpus Juris Sec. 43), and procedural aspects are sufficiently rigorous that the decisionmaking process is unlikely to be affected by external influences and the decisions are based on the evidence presented *(260).* The time taken to complete a formal disciplinary action—about 3 years—is indicative of the carefulness of the process.

Other factors operate in favor of protecting physicians' licenses. Inadequate funding and staff often limit States' ability to prepare their cases as well as the physicians' paid legal counsels.[7] Testimony from expert witnesses against the licensee has often been difficult to obtain because of a fear of civil liability for defamation (260,694).[8]

[6] No **ground for discipline adequately describes the lack of professional ability or incompetence. The specific term varies among States and includes unprofessional conduct, gross incompetence, manifest incapacity, and malpractice and gross/repeated malpractice. All** of **these terms have no uniformly understood meaning.**

[7] **Andrew** Watry, **Executive Director of the Georgia State Board of Medical Examiners, reports that the Board's** annual **expenditures for legal fees for** 60 actions is $80,000 **to $100,000. A physician may spend as much** as $50,000 to $100,000 **in legal fees for one case** (694).

[8] Professionals' concern might decrease as a result of the recent passage of the Health Care Quality Improvement Act of 1986 (Public Law 99-660). **The act grants a limited immunity from damages** un-

(confinued on next page)

Thus, it is more than likely that physicians who have had formal disciplinary actions taken against them have violated State medical practice acts.

Nonetheless, the validity of formal disciplinary actions can be questioned, since the decisions of some boards have been overridden by the courts. Every State gives physicians the right to some type of judicial review of disciplinary actions taken against them to ensure that boards do not act in arbitrary, capricious ways or abuse discretion *(260)(70* Corpus Juris Sec. *51).* The courts have ruled against the boards in 30 percent of the cases brought before them *(168,342)*[9] on issues of constitutional rights, statutory interpretation, sufficiency of evidence, appropriateness of disciplinary action (260), and technical errors (169). Considering the number and range of reasons for overriding boards decisions, including technical errors, one can consider 30 percent a "fairly good record" (169).

Feasibility of Using the Indicator

Although information on formal disciplinary actions taken by State medical boards is available, consumers have limited access to it. Formal disciplinary actions are a matter of public record, and consumers can obtain information about actions taken against individual physicians by contacting State medical boards (190). Some boards even periodically report disciplinary actions to the news media (206), either directly or through newsletters, which almost a third of the boards now publish (206). Yet anecdotal information indicates that individuals and even representatives of health-related organizations are unaware of the availability of this information.

Another source of information on formal disciplinary actions by State boards, the Physician Disciplinary Data Bank operated by the Federation of State Medical Boards, is accessible only to organizations. The Federation's data bank includes information on formal disciplinary actions taken against physicians by its member State medical boards and other government authorities. The Federation of State Medical Boards sends monthly reports to its member boards and some private and public organizations on actions entered in the data bank during the preceding month *(205).* When the American Medical Association receives the Federation's monthly report, it informs all the State licensing boards under which a physician is licensed that the physician has been disciplined. The Federation also screens individual physicians' disciplinary histories upon request; in 1986 it answered 39,000 inquiries from member boards and other organizations (636). Organizations such as hospitals and insurance companies can contract with the Federation for information about disciplinary actions (90). Easier access to cross-State information will be available when the Federation completes a system for State medical boards to directly access the data bank *(636).*

(continued from previous page)

der Federal and State laws to individuals providing information to a professional review body regarding the competence or professional conduct of a physician unless they know the information is false.

'In a 1983 article, Derbyshire notes that the percentage was consistent for court decisions from 1902 to 1966 and from 1969 to 1979 (168). A similar percentage was found in an analysis of court decisions concerning actions taken against physicians who came before the Michigan Board of Medicine from 1977 to 1982 (342). More recent data are not available.

SANCTIONS RECOMMENDED BY PEER REVIEW ORGANIZATIONS AND IMPOSED BY HHS

In fulfilling its responsibility to assess and assure the quality of care provided to Medicare beneficiaries, HHS, upon recommendation of PROS, imposes sanctions on providers who fail to provide care that is medically necessary, appropriate, and of adequate quality.[10] The Secretary of Health and Human Services sanctions providers by imposing monetary penalties or exclusion from the Medicare program for specified periods of time.

The sanction process is initiated when a PRO physician finds that a quality problem exists and determines that a "substantial violation" or a

Ios$_{ee}$a$_{pp}$, D for „comprehensive description of *PROS.*

"gross and flagrant violation" may have occurred. [11] A "substantial violation" is a pattern of care over a substantial number of cases that is inappropriate, unnecessary, does not meet recognized standards of care, or is not supported by the documentation of care required by the PRO. A "gross and flagrant violation" is a violation that has occurred in one or more instances and that presents an imminent danger to the health, safety, or well-being of a Medicare beneficiary, or unnecessarily places the beneficiary in a situation of high-risk, for example of substantial and permanent harm **(638).**

If a PRO believes that a provider's alleged violation was a "substantial violation," the PRO must give the provider two opportunities to discuss the allegations (see figure 6-l). Since the basic purpose of PROS is intended to be educational, the PRO first proposes corrective actions (e.g., requiring the physician to update skills by further education). If the quality problem is not corrected, the PRO recommends a sanction to the Office of the Inspector General of HHS. If the PRO believes that the provider's violation was a "gross and flagrant violation, " the provider receives no opportunity to take corrective actions and only one opportunity for discussion before the PRO recommends a sanction (see figure **6-2).**

In the case of "substantial violations" and "gross and flagrant violations, " a provider is given 30 days notice and an additional opportunity to submit written comments before the PRO recommends sanctions to the Office of the Inspector General. The final decision about whether to sanction a physician is the responsibility of the Office of the Inspector General under authority delegated by HHS. The Office of the Inspector General decides if the medical evidence supports the decision of the PRO. If the decision of the Inspector General is to impose a sanction, a provider may appeal the decision to an HHS administrative law judge.

[11] In **addition** to **sanctions, PROS** may also deny payment to providers. The Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272) gave PROS authority to deny payment for quality of care violations, As of February 1988, the final regulations on these denial notices had not been released.

The intent of the discussion here is not to evaluate the effectiveness of the sanctioning process in identifying all providers of poor-quality care, but to evaluate whether PRO-recommended sanctions imposed by HHS are indicators of poor quality. As is true in the case of disciplinary actions taken by State medical boards, sanctions are expected to measure the overall performance of a provider. The hypothesized relationship, that PRO-recommended sanctions imposed by the Office of the Inspector General of HHS indicate providers of poor-quality care, has face validity. Since the Secretary of HHS is responsible for protecting the health and safety of Medicare beneficiaries, it is likely that beneficiaries and other consumers would consider physicians whom HHS fined or excluded from practicing in the Medicare and Medicaid programs [12] to be providers of poor-quality care.

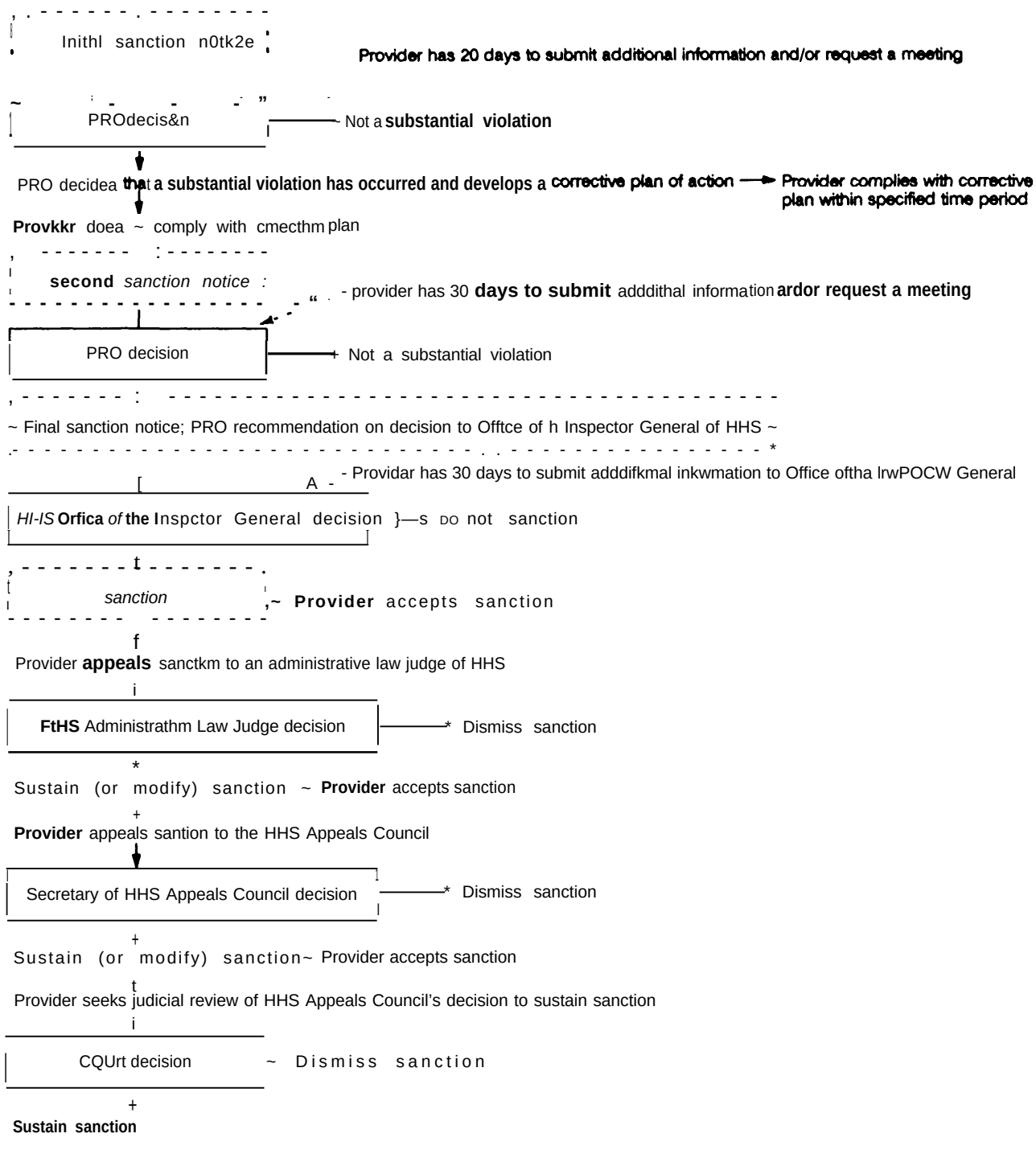
Reliability of the Indicator

Sanctions result from actions taken by two different organizations, a PRO and the Office of the Inspector General of HHS. Because of variations in the process and criteria used to initiate sanctions among the 54 PRO programs, recommendations for sanctions by PROS on a national basis as an indicator of quality are not reliable *(622).* Furthermore, the criteria of "professionally recognized standards of care" that PRO reviewers use to assess the appropriateness and quality of providers' care are based upon typical patterns of practice within the PRO's geographic area or national criteria where appropriate **(638).** To the extent that PROS use local and regional standards of care in initiating sanctions, the **criteria for** assessing care can vary among areas. Since different criteria are likely to be used, the possibility of replicating sanction recommendations among PROS is low.

To the extent that a given PRO reviews similar cases in a similar manner, the PRO's recommendations for sanctions to the Office of the Inspector General may have a considerable degree of consistency as an indicator of quality. PRO rec-

[12] Public Law 100-93, th, Medicare and Medicaid Patient and Program Protection Act of 1987, excludes physicians from Medicaid if they have been excluded from Medicare.

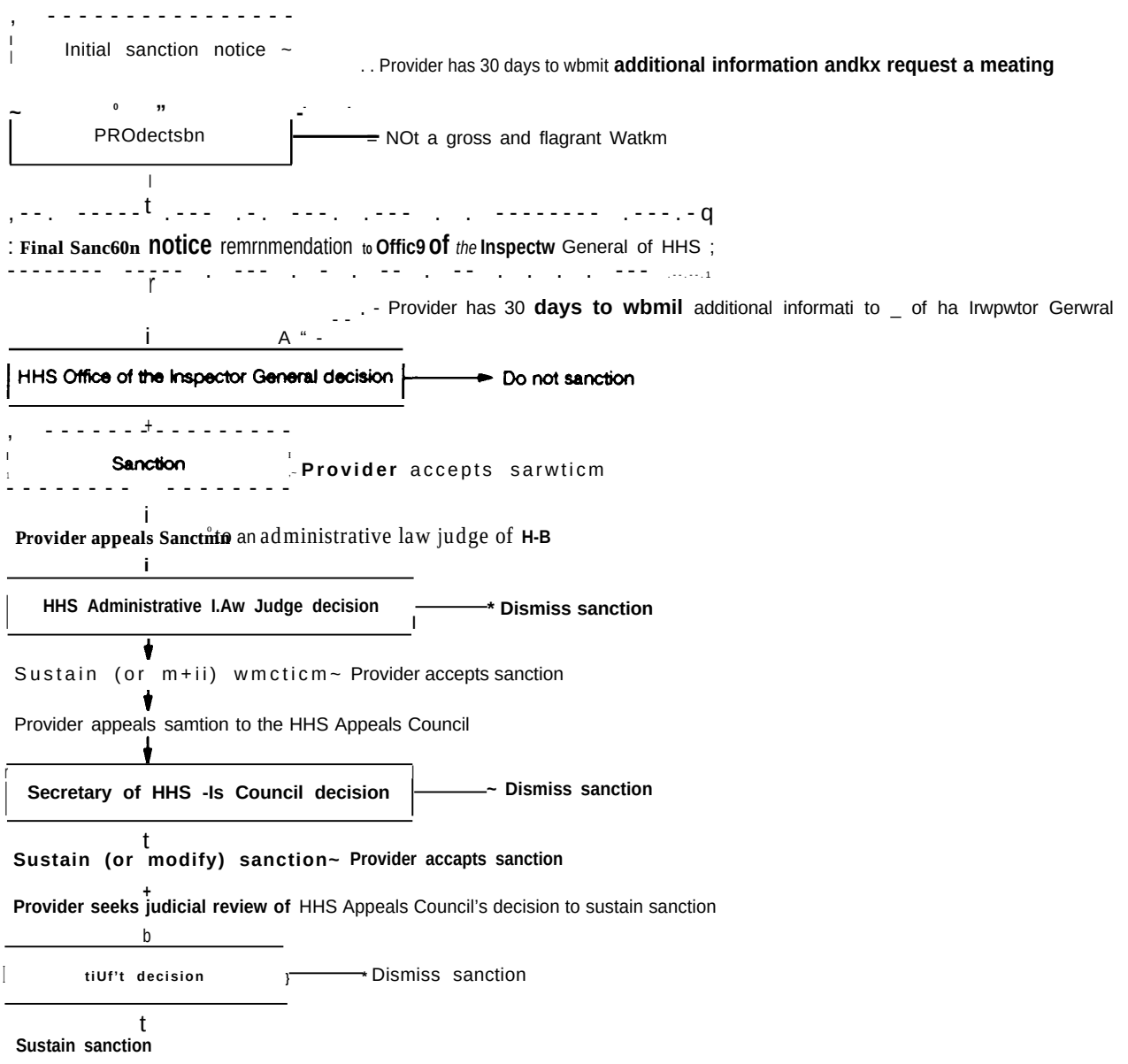
Figure 6-1.—Overview of the PRO/HHS Sanction Process for Substantial Violations[a]



[a]A substantial violation is a pattern of care over a substantial number of cases that is inappropriate, unnecessary, does not meet recognized patterns of care, or is not supported by the documentation of care required by the PRO

SOURCES: Adapted from U S Department of Health and Human Services, Health Care Financing Administration, "Pear Review Organization Manual," HCFA Pub No 19, Transmittal No 15, Baltimore, MD, May 1987, and R P Kusserow, Inspector General of the U S Department of Health and Human Services, testimony on the Peer Review Organization Process before the Subcommittee on Intergovernmental Relations and Human Resources, Committee on Govern ment Operations, House of Representatives, U S Congress, Washington, DC, Oct 20, 19137

Figure 6-2.—Overview of the PRO/HHS Sanction Process for Gross and Flagrant Violations[a]



[a]~goss and flagrant substantial violation is ● violation that has occurred in one or more instances and presents an imminent danger to the health, safety, or well-tang of a Medicare beneficiary

SOURCES: Adapted from U S Department of Health ● nd Human Services, Health Care Financing Administration, 'Peer Review Organization Manual, 'HCFA Pub No 19, Transmittal No 15, Baltimore, MD, May 1987, and R P Kusserow, Inspector General of the U S Department of Health and Human Services, testimony on the Peer Review Organization Process before the Subcommittee on Intergovernmental Relations and Human Resources, Committee on Government Operations, House of Representa-I-, U S Congress, Washington, DC, Oct 20, 1987

ommendations for sanctions go through a number of reviews before they are sent to the Office of the Inspector General. The first round of physician review offers chances for great inconsistency. Similar cases could be reviewed by different physicians who for the most part use implicit criteria in deciding to initiate a sanction. Furthermore, some PROS have expressed concern that inadequate funding makes them unable to recruit, train, and retain qualified physician reviewers (491).

Nonetheless, subsequent reviews can increase the chances that a recommendation for a sanction for a similar violation is replicable within a PRO. The number of additional reviews varies among the PROS. In Iowa, for example, before a sanction is recommended to the Office of the Inspector General, the case is reviewed by a 15-member quality assurance committee; a 15-member comprehensive review committee; and the board of directors of the PRO, composed of 29 physicians, a business representative, a dentist, a nursing home owner, an administrator of a small hospital, and an administrator of a large hospital (405). Before a sanction recommendation is made to the Office of the Inspector General, the California PRO involves a regional medical director, the associate medicaI director, the medical director, the monitoring committee, the chief executive officer, and the board of directors (435). In all PROS, final review by the PRO's board of directors is required before a formal recommendation is made to the Office of the Inspector General.

To the extent that a PRO's board of directors is stable in membership, that a consensus process is used in arriving at decisions, and that members are consistent in their rulings, reliability is increased. If precise guidelines were used by boards of directors in arriving at recommendations for sanctions, the replicability of their decisions could be increased. More exact guidelines were provided in May 1987 as the result of an agreement among the American Association of Retired Persons, the American Medical Association, the Office of the Inspector General, and the Health Care Financing Administration (HCFA) to specify and standardize the procedures PROS use in recommending sanctions (164).[13]

Since the imposition of sanctions is, for the most part, a function of the Office of the Inspector General of HHS, the additional reviews the Office conducts before a provider is sanctioned are crucial in establishing the reliability of sanctions. Federal regulations are specific about what steps the Office should take in arriving at a sanction decision, but do not describe how the steps should be executed (42 CFR 1004.90 [1986]). The same small number of Office personnel, representing the medical and legal professions, are involved in considering whether a provider has violated his/her obligations and in determining an appropriate sanction, and a single individual within the Office of the Inspector General is responsible for the final determination to sanction a provider **(375).**

Validity of the Indicator

It is not clear whether all sanctions are initiated on the basis of quality-related problems. 14 Recommendations for sanctions are initiated by PROS when a provider's services: 1) are not provided economically and are not medically necessary, 2) are not of a quality that meets professionally recognized standards of health care, and 3) are not properly documented (638). Although pro-

[13] The recommended procedures include specifying model letters that **PROS will send to physicians and hospitals during the sanction process; ensuring that no physician member of a** PRO making a final sanction determination against a physician has a bias against or *is* **in competition with the subject physician; permitting an attorney to accompany a physician to certain meetings required during the process; permitting the attorney to make opening and closing remarks and to assist the physician in presenting the testimony of expert witnesses who may appear on the physician's behalf; making a verbatim record of such meetings with a copy made available to the physician: and permitting the physician to submit additional relevant information to the PRO within 5 working days after the meeting (164).**

[14] The Health Care **Financing Administration** collects **data on the number of sanctions initiated by PROS because of potential "substantial violations" and "gross and flagrant violations," but does not have information on the grounds for the initiation of sanctions** (228). **The Office of the Inspector General does have the information but does not generally distribute it. The Office of the Inspector General has provided the information to at least one consumer advocacy group.**

vision of unnecessary services could be classified as a quality issue, insufficient documentation is most likely due to inadequate recordkeeping, which may or may not be associated with poor-quality care.

Of more importance is the fact that, if unnecessary and inappropriate services and premature discharges are perceived as quality concerns, almost all of the sanctions imposed by the Office of the Inspector General upon recommendation of PROS have been for quality violations. In fact, **78** of the **79** sanctions the Office imposed by September 1987, were on quality-based grounds. One sanction was based exclusively on grounds of improper documentation (375).

Furthermore, the possibility of sanctioning physicians who do not provide poor care is slight, an observation that suggests that PRO-recommended sanctions imposed by HHS are valid indicators of quality. An extensive weeding-out process takes places before PRO-recommended sanctions are imposed by HHS, and only a few sanctions have been imposed. From the **30** million hospital discharges involving Medicare beneficiaries from the beginning of October 1983 to the end of December 1986, PROS identified **6,500** discharges involving **2,500** providers as having potential quality-of-care or utilization problems **(360).** The great majority–over 97 percent–of the cases were resolved at the PRO level by PROS working with providers during the steps of the process and were not referred to the Office of the Inspector General. Most deficiencies were corrected by educational or corrective actions, and through December 1987, only 151 cases were referred to the Office for review and final action. Not all of the 151 cases that were referred were held to be sustained in law or by medical evidence. Only **61** resulted in exclusion from the Medicare program (60 physicians and 1 hospital); 26 cases resulted in a monetary penalty; 8 cases are now under review; and 2 physicians have died (661). Many of the sanctions that the Office rejected were rejected because of procedural issues (e. g., the PROS were late in submitting documentation or the documentation was not complete) (360).

Physicians who are sanctioned are often cited for multiple violations. One physician, for example, was sanctioned on the basis of **22** cases of deficient care (713). Indeed, the 11 physicians who were sanctioned by exclusion from Medicare in the period February 8 to July 2, 1987, were responsible for "gross and flagrant violations" in the care of 48 patients. Physicians who are fined are also likely to have committed one or two serious violations (501).

Another way to determine if physicians who provide standard care are being safeguarded from sanctions is to examine if they are given appropriate due process. The sanction process attempts to balance the interest of HHS in protecting the health and safety of Medicare beneficiaries with the due process rights of providers. As a peer review process, the system does not have the extensive safeguards characteristic of the judicial process. Nonetheless, physicians have the opportunity of submitting information, being heard before two administrative bodies (the PRO and the Office of the Inspector General) before a sanction is imposed, and of appealing the imposition of a sanction.

As noted earlier, regulations require that PROS allow physicians to submit information and meet once with the PRO if they are alleged to have committed a gross and flagrant violation(s) and twice if the violation is a substantial violation. After the PRO recommends a sanction, the Office of the Inspector General conducts an independent review of the PRO report and any additional information submitted by the physician under consideration. If the Office agrees with the PRO and also finds the physician unwilling or unable to comply with statutory obligations,[15] it will sanction the physician, [16] either by excluding the physician from the Medicare program or by imposing a monetary penalty. The Office's decision

[15] The "unwilling and unable" condition **has been questioned as being ambiguous and an impediment to protecting patients from providers of substandard care** *(360).*

[16] The Office **of the Inspector General of** HHS **has** 120 **days to accept or reject the recommendation, or a sanction is imposed. To date, the Office of the Inspector General has always acted on recommendations within the allotted time (375).**

can be appealed, in which case a hearing is held before an administrative law judge of HHS. This hearing is the first time in the process that a full evidentiary hearing is held (360). This decision may then be reviewed upon request by the HHS Appeals Council. If dissatisfied with the result, physicians have the right to seek further review of their cases in the court system (see figures 6-1 and 6-2).

A few cases have gone to district courts, and some of them have been appealed. The appeals courts have upheld the adequacy of due process in the PRO sanction process (125,276,674). In its ruling, the 4th Circuit Court noted that the PRO-initiated sanctions process affords providers appropriate due process, since the Government's need to protect Medicare beneficiaries from poor-quality care is compelling. Disagreement with the adequacy of the process continues, however, in both the medical and legislative communities. Some accommodation was made in the Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203), which allows physicians in certain underserved areas to continue to practice, although sanctioned, during the administrative review process.[17]

Feasibility of Using the Indicator

Although sufficient data exist for purposes of formulating PRO-recommended sanctions imposed by HHS as an indicator of the quality of care, many consumers may find it difficult to gain access to the information. If the Office of the Inspector General imposes a sanction, a notice is published in a newspaper in the PRO area advising the public of the Government's action .[18] The May *1987* agreement between the Office of the Inspector General, the American Medical Association, the American Association of Retired Persons, and HCFA, discussed earlier, included a stipulation, subject to regulatory change, that physicians and other providers are to notify their Medicare patients that they have been sanctioned in lieu of newspaper publication of this fact. As of February 1988, the regulations were under development.

Anecdotal information indicates that the current publishing requirement has not been implemented in a way that provides easy access for consumers to information about sanctioned physicians. It is said, for example, that newspapers with small circulations are often used, and notices are placed in small type, often in the public notice section. There are potential problems with the new method as well. It is not clear that having physicians privately inform their current or potential Medicare patients that they have been sanctioned will increase the effectiveness of providing consumers with information on sanctions. On the one hand, Medicare beneficiaries would not have to seek out the information. On the other hand, sanctioned physicians will have conflicting interests between defending their practices and their legal obligation to provide information. Thus, Medicare beneficiaries may not receive as complete an explanation about the grounds for a sanction from the sanctioned physician as from a newspaper notice. In addition, automatic notification concerning sanctioned physicians will not be available to non-Medicare consumers *(501).*

[17] **The Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) made some changes in the review process. The act provides that in rural health areas with health manpower shortages and in counties with fewer than 70,000 people, physicians seeking to overturn a decision that excludes them from Medicare for failure to furnish medical care of acceptable quality may continue to practice during the administrative review process, unless an administrative judge determines that continued practice would pose a serious risk to Medicare beneficiaries.**

[18] **Regulations require that the Office of the Inspector General "notify the public by publishing in a newspaper of general circulation in the PRO area a notice that identifies the sanctioned practitioner or other person, the obligation that has been violated, the sanction imposed and if the sanction is exclusion, the effective date and duration"** (42 CFR Sh. V (10)-1986 cd.).

MALPRACTICE COMPENSATION

A malpractice suit indicates that a patient is dissatisfied with care received from a provider. There is some evidence that patients who are satisfied with interpersonal aspects of care are less likely to sue their physicians than patients who are dissatisfied with these aspects. 1[9]The analysis in this chapter assumes that a malpractice suit suggests that the physician has some deficiency in interpersonal aspects of care. The question explored here is whether malpractice compensation is a reasonable indicator of poor technical performance.

Patients usually use the tort liability system to obtain monetary compensation for medical injury. The process of determining liability is initiated when a patient or provider identifies a medical, possibly negligently induced, injury. Sometimes a "warning" file maybe opened by an insurer on the basis of a report from an insured provider. The next step is likely to be a claim received directly from an injured claimant or claimant's representative, which may accompany or soon be followed by a lawsuit. The lawsuit may or may not be resolved in favor of the patient. If the lawsuit is resolved in favor of the patient, the patient may receive medical compensation either through a jury verdict or through negotiated settlement with the physician's insurance company, usually prior to an actual courtroom proceeding. Even after a jury verdict, the trial judge may alter or overturn the verdict, and appeals may be made. Many awards are reduced before actual payment is made (159).

Only some medical injuries, or adverse medical outcomes, that occur are the result of providers' failing to conform, through omission or commission, to current standards of medical care (449,636). Other adverse medical outcomes are unavoidable results of insufficient medical knowledge about the natural course of some conditions and unexpected effects of diagnostic and therapeutic procedures (449,636).

Few studies have attempted to determine the occurrence of medical injuries and fewer still the proportion that are possibly negligently induced. A pilot study in 1973 found that medical injuries occurred in nearly 8 percent of the cases reviewed and estimated that medical injuries due to medical negligence occurred in 2.3 percent of cases reviewed (494). A study of about 21,000 hospital records of California hospitals performed in the mid-1970s concluded that 1 out of every 20 admissions (5 percent) resulted in an injury caused by medical treatment (114). Seventeen percent of the injuries caused by medical treatment, or 1 out of every **126** hospital admissions (0.8 percent), were estimated to be caused by legally provable negligence. A more recent analysis found that almost 1 percent of hospital admissions are associated with poor care that results in temporary or permanent disability or death (159).

The discussion here will focus on the reliability and validity of court awards as an indicator of the quality of care, in part because from a consumer's perspective such awards would have face validity. In order for medical malpractice to be established in court, one must prove the existence of a duty of the physician to the patient, the existence of an applicable standard of care, negligence or the failure of the provider to meet the standard of care, injury or damage to the patient, and the determination that the proximate cause of injury to the patient was the physician's failure to meet the standard of care **(636).** Most people would consider a physician who has been found liable of malpractice in a court action, par-

[9]**"Obstetricians/ gynecologists and medical specialists who report spending more time with their patients per office visit than similar physicians, on average, incur fewer claims than physicians who spend less time** (6).

ticularly for a number of cases over a period of time, to be a provider of poor-quality care.

The other major form of malpractice compensation is negotiated settlements, that is, payment without a judicial determination. Malpractice settlements are often made for reasons unrelated to quality that are usually unknown to the general public.[20] The lack of information does not mean that any claim for which settlement was negotiated is not without meaning as an indicator of quality. Indeed, it can be argued that cases with large settlements are settled out of court because negligence can be proven. It is likely that cases involving small settlements of $20,000 to $40,000 may not go to trial for reasons of efficiency as well as reasons of negligence. Furthermore, negotiated settlements are the more important form of claims settlement, since 90 percent of medical malpractice claims are settled before trial, and of those settled with payment approximately 97 percent are closed as a result of a negotiated settlement (625). The reliability and validity of negotiated settlements as indicators of the quality of care cannot be evaluated, however, because the negotiation process is confidential .21

Reliability of the Indicator

The many variations across the country in the tort system governing malpractice cases—including variations in laws, judges, and juries—make it unlikely that court awards are reliable as an indicator of quality on a national level. There are fewer variations within States, because medical malpractice claims are resolved through State court systems and under State statutes. Even within States, however, many judges and juries are involved in malpractice cases, and not all judges place the same interpretation upon the law.

Within a judge's courtroom, a judge's awards may be consistent. In addition, indirect evidence suggests that jury awards might have some reliability as an indicator of the quality of care. Although the consistency of verdicts among juries has not been studied, the consistency in verdicts between judge and juries has been examined in both criminal and civil cases. In *3,576* criminal trials and about 4,000 civil trials, both judge and jury agreed on the verdict 78 percent of the time (338). These findings might have positive implications for consistency among juries. In general, studies find that the rate of agreement among participants in complex human judgments, such as scientific peer review panels and decisions of practicing physicians and judges, ranges from 55 to 80 percent (see table 6-2). Nonetheless, the limited boundary of one judge's courtroom, within which jury awards might have some consistency, works against the usefulness of jury awards as an indicator of the quality of care.

Validity of the Indicator

Individual Awards for Malpractice

Court awards for malpractice as a measure of the quality of care would appear to have some validity as indicators of quality in that compensation is supposed to be awarded for negligence only. Other concerns, such as fraud and abuse, are not at issue. In addition, a judgment in favor of a patient, in theory, means that a physician's negligence has been proven. Nonetheless, in weighing the evidence it appears that—except in extreme cases, such as amputating the wrong limb—individual jury awards are not indicators of a physician's performance.

On the one hand, the difficulty and length of time involved in filing and resolving malpractice claims, the formal process of the litigation, and the small number of cases that are resolved in favor of the patient/claimant appear to support the contention that physicians who have been found liable of malpractice are providing poor-quality care. Although these features have to do with

[20] Settlements are usually agreed to in cases whose resolution is clear *(88).* **They are often made for reasons other than physician negligence, including court congestion, variation in the interest of liability insurance carriers in settlements, probability of success in a particular court before specific judges, credibility of both plaintiffs and defendants as witnesses** (461), the cost of protracted litigation **compared to early settlement, the ability of the plaintiff's counsel, the sympathy aroused by the plaintiff, aggravated fact situations that would inflate the award, the amount of the awards for a similar injury in the jurisdiction, the personalities of the key witnesses, the desire to avoid publicity of a trial, and the existence of a statutory requirement to submit the claim to a pretrial panel** (636). **Indeed,** *some* **experts contend that settlements are not directly related to a finding of malpractice, i.e., negligently induced medical injury** (636).

[21] The section does not consider malpractice claims that have not **been resolved, because such claims represent an accusation of wrongdoing with no knowledge of the truth or falsity of the claim.**

Table 6.2.—Interjudge Consistency in Complex Human Judgments

Decisionmakers	Stimulus	Decision	Rate of agreement between 2 judges (%)
National Science Foundation vs. National Academy of Sciences peer reviewers	150 Grant proposals submitted to the National Science Foundation	To fund or not to fund (half funded by the National Science Foundation)	[illegible]
7 Employment interviewers	10 Job applicants	Ranked in top 5 or in bottom 5	70
4 Experienced psychiatrists	153 Patients interviewed twice, once by each of 2 psychiatrists	Psychosis, neurosis, character disorder	70
21-23 Practicing physicians	3 Patients-actors with presenting symptoms	Diagnosis: correct or incorrect	66, 77, 70
		Probability of agreement (both correct or both incorrect)[a]	55,65,57
3,576 Judge-jury pairs	3,576 Jury trials	Guilty or not guilty	78
12 Federal judges	460 Presentence reports (at sentencing council)	Custody or no custody	80
8 Federal judges	439 Presentence reports (at sentencing council)	Custody or no custody	79

[a]Inflated because physicians could also be inaccurate in different ways.

SOURCE S.S Diamond, "Order In the Court: Consistency in Criminal Court Decisions," *The Master Lecture Series Vol. //: Psychology and the Law,* C.J Schelrer and B.L Hammonds (eds) (Washington, DC: American Psychological Association, 1983) Copyright 1983 by the American Psychological Association Ada~ted by permission of the publisher and the author.

adherence to procedural requirements rather than with the substance of claims, one could argue that they diminish the possibility that physicians who are found liable will not in fact have been negligent. Of course, some of the physicians who are not found liable of malpractice may in fact have been negligent.

The fact that very few injured people bring a malpractice claim (87) illustrates the difficulty of the process. A recent pilot study of the prevalence of public perceptions of medically induced illness in Maine concluded that of the **42** respondents that had reported that they or a close relative had a medically induced injury, 2 discussed the incident with an attorney and only 1 initiated a suit (430). A more comprehensive analysis estimated that claims are filed for only a small percentage of negligently induced injuries. Extrapolating from a 1977 California Medical Association / California Hospital Association study and 1974-76 data collected by the National Association of Insurance Commissioners, the researcher estimated that about 1 malpractice claim was filed for every 10 potentially valid claims (159).

An attorney has to be convinced of the merits of a case to take the case, because most attorneys in malpractice litigation cases are paid only if their client wins (i. e., they work on a contingency fee basis). Since attorneys generally receive a percentage of the award, most are concerned with potentially successful claims that are likely to result in a substantial award. Although it is obvious that the number varies among lawyers, a dated survey found that a claimant has less than one chance in eight of convincing an attorney to take a medical malpractice case (449).[22]

The extensive time required is another illustration of the rigor of the claims resolution process. The median length of time from claim filing to complete disposition against all the providers involved is 19 months: the median time for paid claims is 23 months. In general, the more severe and the more costly cases take a longer period to resolve *(623),*

Furthermore, during litigation, the substantive and due process rights of participants are protected. Formal rules of evidence control the admission of unreliable or prejudicial testimony, and compensation depends upon proving the provider at fault (449). Standards of care are generally in favor of the defendant (87). Providers are judged by peer standards, and juries are instructed to as-

[22]Newer quantitative **data are not available**

sess and choose among the medical opinions presented and not impose their own opinion of the care. Finally, only a small percentage of claims filed are closed with a court award. A study of 73,500 claims closed in 1984 found that 24,630 (43.7 percent) were closed with payment; of the 24,630, only 608 (2.5 percent) were closed with a court verdict either before or after appeal (622).

On the other hand, in reality, numerous other factors not related to the quality of medical care influence jury awards. Such factors include the effectiveness of the attorneys (611); the ability of the jury and expert witnesses to assess medical responsibility (611,636); the effect of race, sex, and perceived economic status on the jury (486); the effect of the passage of time from incident to verdict on the quality of the evidence (317); and the selective recall of witnesses (486); the effect of the extent of the injury and its obviousness (e. g., when surgical instruments are left within a body) (159); and the effect of the number of defendants (the chance of a physician's receiving an adverse judgment approximately doubles when a case involves multiple defendants) (159). It is not known whether some of these factors lead to increased or decreased accuracy in the outcomes of medical malpractice litigation.

In addition, individual jury awards are inaccurate indicators of specific physicians who provide substandard care, because multiple physicians may be defendants in any one case. Physicians who have had only peripheral involvement with a supposed negligently induced injury may be involved in the jury award. Heads of departments, for example, are often held legally responsible for the actions of the residents in their department, even though they were not present at the time of an incident; the same may be true of residents who played only a small part in a complex procedure.

Another challenge to the validity of malpractice compensation as an indicator of the quality of medical care is that malpractice litigation depends to a large extent on the lack of criteria regarding poor-quality care. The disagreements about what constitutes real malpractice are longstanding and serious and need extensive research before resolution.

Physician Profiles

A successful malpractice suit might indicate that a physician made an inadvertent error that had serious consequences for the patient or it might be one instance of a dangerous practice pattern of a physician that poses a risk in future patient encounters. There is a lack of empirical evidence to indicate which applies. Some would argue that findings of negligence in a number of malpractice cases indicate that a physician is delivering substandard care. Although this argument may seem intuitively correct, evidence to disprove it is also lacking.

A report of an analysis of Maryland data from 1960 to 1970 noted that a physician's being sued more than once could be attributed as much to chance as to poor practice, but the authors warn against generalizing the data to the entire country **(101).** A hypothetical informal statistical analysis confirmed the above finding (443). The analysis assumed that all physicians were similar and all patients were similar and that all cases were independent of each other. Yet in practice, physicians practice in different specialties and even, within a specialty, see different types of cases and different numbers of patients. Physicians who are frequently sued may be technically excellent but may be treating difficult cases and using high-risk procedures. In the absence of knowledge about patient and practice characteristics, the relationship of a physician's quality of care to multiple malpractice suits cannot be determined.

It is clear, however, that liability experience is not random with respect to specialty, and that some specialties have more malpractice claims than others. The specialists most often named in malpractice actions are obstetricians/gynecologists, general surgeons, and orthopedic surgeons; the percentage of claims paid is highest for pathologists, urologists, otolaryngologists, and obstetricians/gynecologists *(623).* These specialties employ invasive technologies with greater chances of doing serious harm. The many suits against obstetricians may also reflect heightened expectations on the part of consumers about what can be done with procedures such as fetal monitoring or amniocentesis rather than anything to do with the technical aspects of quality.

Studies also show that fairly few physicians account for a large share of medical malpractice claims. One study reported that 1 percent of physicians were responsible for 25 percent of paid claims and 20 percent of physicians had three or more paid claims in 10 years (301). Another study found that about 42 percent of physicians with claims in one year had previous claims against them (623). Since such percentages reflect the differences in malpractice experience among specialties, they do not necessarily mean that these physicians are providing substandard care,

Certain physicians in certain specialties have more claims than expected by chance (301,529, 675). In looking at large claims, researchers found that in some specialties, some physicians did not have more claims than expected **(675).** In other specialties, including internal medicine and anesthesiology, some physicians had disproportionately more claims than others; however, the difference could be accounted for by differences in practice level. This finding indicates that the past experience of individual physicians in certain specialties may be a valid measure of the individual's exposure to claims in the future and may be used to set malpractice premium rates. The lack of information about the characteristics and numbers, however, of the patients and cases seen by physicians compromises the ability to use medical malpractice experience as a valid indicator of substandard care provided by individual physicians.

Currently, the frequency and severity[23] of claims against individual practitioners are taken into account in quality-of-care evaluations carried out by certain hospitals for the purposes of peer review and by certain State licensure and credentialing organizations. The impetus for this new practice can be traced to lawsuits in Arizona and California, where hospitals had been held responsible to patients when lawsuit information of attending physicians was not considered when medical staff committees determined whether to grant hospital privileges **(197,504).** The frequency and severity of claims are also used by certain insurance organizations to evaluate physicians who are applying for malpractice insurance coverage or renewal and to identify physicians for risk management and quality assurance review and remediation (30).

Feasibility of Using the Indicator

The remarkable limitations of available data on malpractice litigation contravene the feasibility of using medical malpractice compensation as an indicator of the quality of care. The major source of data on settlements and jury awards is claims closed by insurers writing malpractice insurance,[24] and data from this source are expensive to collect and limited in usefulness. One reason that the usefulness of the data is limited is that insurers do not have a standard definition of claims and count claims differently.

Systematically collected data on the number of paid malpractice physician claims are not readily available; also not readily available are data on the frequency of malpractice claims that involve multiple providers and the identity of the defendants in multiple-defendant malpractice suits. Health insurance data that link procedures performed to individual physicians would be helpful in addressing the issue of the relationship of multiple settlements to extent of practice. In most instances, such information is not available. Data that identify physician performance that results in negligent actions and malpractice claims are not available. Without such information, it is not possible to relate malpractice compensation to negligence. To obtain such information, costly medical record reviews would be needed in addition to malpractice claims information.

Incomplete information on medical malpractice judgments is compiled at present, but even this information is not readily accessible to consumers. A malpractice judgment is a final court decision, and like any other court record, it is public. Some State laws require reporting of malpractice judgments to medical licensing boards. If the State has a Freedom of Information Act, the information

[23] **Severity is related to frequency. Potentially high damages are more likely to prompt a claim than are low ones, and anyone specializing in high-damage cases, such as obstetricians** /gynecologists, **is likely to generate higher frequency claims than other specialists.**

[24] The last study of national claims **identified a universe of** 102 **malpractice insurers in the United States in** 1983 (623).

is available through a Freedom of Information request *(578).* Although an ongoing source of data *on* jury verdicts is the privately published Jury Verdict Reporter Newsletters, which cover many metropolitan areas, such publications are expensive, and it is unlikely that individual consumers subscribe to them. Information on out-of-court settlements is not publicly available.

CONCLUSIONS AND POLICY IMPLICATIONS

The causal relationship between license discipline, sanctions imposed by HHS upon recommendations by PROS, and malpractice compensation on the one hand and quality of care on the other has not been the subject of scientific examination. Since the interpretation of such relationships relies on deductive reasoning from descriptive information, findings are not firmly conclusive. Nonetheless, tentative conclusions can be made and directions for policy and research offered.

Disciplinary Actions by State Medical Boards

Of the three potential indicators examined in this chapter, formal disciplinary actions taken by State medical boards can currently be used with the greatest degree of confidence in identifying physicians who provide substandard care. Although the reliability of disciplinary actions is not clear, the deliberateness of the disciplinary process and the safeguards of physicians' rights to legal due process appear to ensure that the actions indicate infractions of State medical practice acts. Some people do not consider all infractions of State medical practice to be quality problems, however, because the scope of medical practice acts is broad and infractions of the acts include inaccurate drug prescribing, substance abuse, and criminal actions as well as incompetence. For those consumers who believe that quality in providing medical care is affected by a physician's character and not confined to the physician's technical skills, formal disciplinary actions taken by a State medical board would be a fairly good indicator of poor-quality care. For those consumers who limit their assessment of the quality of medical care to how physicians provide medical care, formal disciplinary actions generally would bean inexact indicator of poor-quality care. For all consumers, formal disciplinary actions that are taken on grounds of incompetence are adequate, albeit not perfect, indicators of substandard care.

If the reliability of formal disciplinary actions were better established, individuals and organizations could use this indicator with greater confidence. In order to increase reliability, an essential step would be to open up to public examination the processes that State medical boards use in disciplining physicians. Public scrutiny would also permit a better understanding of informal disciplinary actions and exactly when, why, and how they are taken and enforced. Their relationship to formal disciplinary actions and to poor care has not been examined. The validity of disciplinary actions as a quality indicator could be improved if all State medical practice acts included incompetence as a ground for disciplinary action, precisely defined the meaning of the term, and supplied guidelines for the actions applicable to the violation.

Although consumers can obtain information about formal disciplinary actions taken against individual physicians by contacting State medical boards, most consumers do not know this. Information would reach more consumers if more State boards would publicize their actions widely, and if State boards that currently supply information would increase their dissemination activities. Without additional funding, most State medical boards would have difficulty assuming the additional costs associated with providing information to the public. Most of the boards are under extreme financial constraints due to increasing investigatory and disciplinary activities (361). If dissemination of such information is a desirable government responsibility, additional State funding is needed. Federal funding is another possibility, although many concerned individuals believe that it would interfere with States' prerogative to license physicians *(190).*

Another source of information on formal disciplinary actions taken by State medical boards is the Physician Disciplinary Data Bank operated by the Federation of State Medical Boards. Reporting of disciplinary actions by State medical boards to the Federation is voluntary, but all States participate in the Federation's data bank. Through monthly reports and through direct access to the data bank, the information is disseminated to State medical boards and other organizations; it is not disseminated to individuals. Some would argue that the usefulness of individual access to the information in the Federation's data bank is questionable. Although organizations such as third-party payers require updates on disciplinary actions taken against many physicians, most individuals are interested in information concerning one or more physicians at one point in time, and that information can be obtained from State medical boards. The Federation charges for its services, and the charges might be high for most people. In addition, the Federation does not verify the accuracy of the information that the States report. Organizations are expected to use the information in the Federation's data bank as a starting point for more intensive inquiry—a course which many individuals might not be willing or able to pursue.

The national data bank mandated by the Health Care Quality Improvement Act of 1986 (Public Law 99-660) is a potential source of information on disciplinary actions .25 State medical boards are to report disciplinary actions to the data bank, but are not mandated to actively obtain information concerning other boards' disciplinary actions. It appears the data bank will include the same license discipline information now available in the Federation's Physician Disciplinary Data Bank, but will add new information on malpractice compensation and adverse actions taken by hospitals regarding physicians' privileges. National confidentiality requirements will not override State legislative requirements of confidentiality (706).

[c] The national data bank did not receive funding for fiscal year 1988, although it is in the President's budget for fiscal year 1989.

Sanctions Recommended by PROS and Imposed by HHS

It is likely that sanctions imposed by the Office of the Inspector General of HHS on the recommendation of PROS are indicators of substandard quality of care. Available evidence about the sanctioning process suggests that recommendations for sanctions are consistent within a PRO area and are imposed consistently by the Office of the Inspector General. Such sanctions are valid indicators of physicians and hospitals that provide unnecessary services and substandard care. But evidence is very scanty and the sanctioning process is new and evolving. Although consumers could use such sanctions as an indicator of poor-quality care at this time, the indicator needs continuous evaluation.

The reliability and the validity of sanctions as an indicator of quality could be assessed with greater accuracy if information about the processes used by PROS and the Office of the Inspector General were available. It is clear that there is great variation in the approaches used by PROS in assessing quality, the number of groups within a PRO that review a case, and the number and types of intervention steps and amount of time between the identification of a quality problem and sanctioning (623,661). Yet little is known about how individual PROS make sanction recommendations and how the Office of the Inspector General executes the steps in arriving at a sanction decision. It would appear that the use of precise guidelines by the boards of directors of PROS in recommending sanctions to the Office of the Inspector General and the standardization of professional guidelines of care would allow consumers to rely more heavily upon PRO/HHS sanctions as a quality indicator.

The potential usefulness of this indicator of the quality of care suggests that a policy requiring oversight of the effectiveness of actions to disseminate information on sanctions is warranted. A new method has been agreed upon, and once regulations are promulgated, providers will have to notify their Medicare patients of sanctions. Sanctioned physicians may be hesitant about providing complete information to their Medicare patients, and their non-Medicare patients may not be informed at all. Although private publications,

specifically the newsletter published by the Public Citizen Health Research Group, periodically publish the names of sanctioned physicians and analyze the grounds for sanctions, these publications do not reach all Federal beneficiaries.

A serious gap in availability of information is the lack of a central source for obtaining information about physicians who have been sanctioned by HHS as a result of PRO recommendations. As mandated by the Health Care Quality Improvement Act of 1986 (Public Law 99-660), the proposed national data bank is not intended to include information on sanctions imposed by HHS that result from PRO recommendations. In any event, the information in the data bank will not be publicly available.

Malpractice Compensation

Medical malpractice compensation cannot currently be used as an indicator of poor quality of care because of the many variables other than the merits of the case that affect the resolution of individual malpractice court trials and of negotiated settlements. Although it is clear that more and higher payments are made against some specialties than other specialties, there is insufficient evidence to evaluate whether multiple awards against an individual physician indicate poor quality.

Given present information, malpractice litigation information could possibly be used as a screen or trigger for further investigation into a physician's performance by patients, hospitals, liability insurers, and third-party payers. The screen would be weak, since so few people file malpractice claims and resolution often occurs years after the triggering incident (548). Questions of the type of malpractice information (claims, settlements, or jury awards) to be used for screening purposes would need to be decided, as well as how many claims, settlements, and jury awards over what time period would initiate the trigger action.

Before malpractice compensation can be considered an indicator of quality, much more needs to be learned about standards of care. There are disagreements about what constitutes real malpractice, and establishing standards of care might help remedy the problem. Information is needed on the relationship between physician characteristics and medical malpractice claims, judgments and settlements and on physician malpractice profiles and negligently induced adverse outcomes. To understand the relationship between multiple payments and negligence, more needs to be known about the relationship of patient and practice characteristics (e.g., the number of procedures performed) to multiple claims and payments. The Harvard Medical Practice Group is starting to examine medical care and medical injuries in the State of New York. Similar national information is needed on the incidence, severity, and pattern of injuries of negligently induced adverse outcomes. The Harvard group also intends to determine the relationship of adverse outcomes to subsequent tort or disciplinary actions, and the relationship between the probability of suits and the distribution of adverse events and of substandard care.[2b]

Government agencies have not traditionally collected data on malpractice. Recently, however, the Health Care Quality Improvement Act of 1986 established a mechanism in Federal law for collection and limited dissemination of information on malpractice payments as well as formal State disciplinary actions, adverse hospital privilege information, and adverse membership actions taken by professional societies. The 1986 act provides that any entity that makes payment under a policy of insurance or self-insurance or in settlement or satisfaction of a judgment in a medical malpractice action or claim must report that information to the Secretary of HHS or the Secretary's designee. The penalty for failure to report malpractice information is a substantial fine. The information that is to be reported includes the physician's name, the amount of payment, and a description of the acts and omissions or injuries upon which the action or claim was based. This information would dramatically improve what is known about malpractice litigation and may offer an opportunity for reexamining the validity of malpractice information as an indicator of the quality of care.

The Health Care Quality Improvement Act may also considerably improve the dissemination

[2b] The Robert Wood Johnson Foundation has funded 13 other projects to increase current understanding of what constitutes medical malpractice, what causes it, and how it can be prevented (522).

of information on malpractice litigation. Currently, dissemination of information on malpractice compensation is limited to information on court awards, which like any other court record is public. The information is published sporadically in costly private newsletters that cover metropolitan areas. The 1986 act requires HHS to make physician-identified information collected in the national data bank available to health care entities and licensing boards. Hospitals are required to obtain the information from HHS, and will be presumed to have the information in any medical malpractice action. Information in the data bank will not be available to individuals. Given the problems of using malpractice compensation as an indicator of the quality of care, publicizing such information to consumers requires further examination.

Combinations of Indicators

A centralized system that includes information on formal disciplinary actions taken by State medical boards, sanctions imposed by HHS upon recommendation of PROS, malpractice compensation, and information on other disciplinary actions taken by medical entities could }Lelp to identify recurring problems in the care provided by physicians and perhaps improve the validity of each of the actions as an indicator of quality. Shared information could improve the level of decisionmaking by all concerned bodies. If different, independent bodies censure a physician, the probability that the physician is providing substandard care increases.

A combination of indicators might be a more valid indicator of substandard care than a single indicator. The information could assist in improving future care by making it more difficult than it is now for physicians who have been demonstrated to provide substandard care to continue to practice. However, extreme caution would be needed in using this particular combination of indicators. As discussed above, the validity of medical malpractice claims and compensation as an indicator of the quality of care is not clear. Recent data from the New York State Department of Health indicate that there is a linkage between multiple malpractice claims and disciplinary actions taken by the State medical board (460). Physicians who have had 6 or more medical malpractice claims made against them are likely to be disciplined by the New York State medical board: the State medical board took disciplinary action against 17 percent of such physicians. Further work is needed, since only 181 physicians were studied. The validity of adverse actions taken by hospitals and professional societies also needs to be examined.

The national data bank mandated by the Health Care Quality Improvement Act of 1986 is unique in that malpractice judgments on individuals can be compared with the type of disciplinary actions taken by State medical boards and the adverse actions taken by hospitals and professional societies. Since PRO / HHS sanctions will not be included, the usefulness of the data bank will be limited. Information on such sanctions does not appear to be widely disseminated. The Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) requires that PROS share, when requested, information related to substandard care with State medical boards and others, but final regulations had not been released by March 1988.

Interest in greater cooperation and sharing of information is seen in the Medicare and Medicaid Patient and Program Protection Act of 1987 (Public Law 110-93). That law strengthens the provisions in the earlier Health Care Quality Improvement Act and requires States to make available to the Secretary of HHS information concerning disciplinary actions taken by State medical boards against a range of health care practitioners. The 1987 law also requires that the Secretary of HHS disseminate information on these actions to State medical licensure boards and to other State and Federal officials.

As noted earlier, information in the data bank mandated by the Health Care Quality improvement Act will not be available to individuals, and this situation might be reasonable. A prudent course of action in establishing the data bank would be to begin with fairly detailed data but very limited distribution, and then to test the seeming credibility and usefulness of the data as they begin to accumulate for statistical power or actuarial credibility. The data bank will need to be continuously analyzed and revised with continuing experience.