Is it Effective to File Medical Malpractice Litigations and the Names of Hospitals and Physicians Involved on the Internet or not?

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Objective: **It was recently debated in the media that filing names of hospitals and physicians involved in medical malpractice suits on the Internet may create incentives for hospitals and physicians to improve their quality of care. Also, with improved quality of care, it may curb the need for expensive litigations.**
Method: **Different arguments pertinent to such a decision, in terms of effectiveness, efficacy, efficiency, and practicability, are considered.**
Results and conclusions: **The litigation system has been documently more adequate to determine injury than negligence, and so, making malpractice data and the names of those involved available on the Internet is a hazardous plan. In terms of effectiveness, efficacy, efficiency, and practicability, there are too many counter-arguments to warrant implementing this plan.**
Key words: *Malpractice, litigations, negligence, injury, internet.*

The litigation system for medical malpractice created incentives for hospitals and physicians to improve their quality of care (1-4), and tended to be effective for preventing unsafe practices (5-7), although several reports were inconclusive (8-13). It was recently debated in the media (14), that filing names of hospitals and physicians involved in malpractice suits on the Internet may further enhance such incentives and, in addition, may be helpful to prevent incompetent physicians from continuing their practices or starting at a different place. These effects would not only improve quality of care, but also, with improved quality of care, curb the need for expensive litigations. Even if these effects are true, other arguments pertinent to such a decision, in terms of effectivenes, efficacy, efficiency, and practicability, have to be considered. The current paper gives an overview of such arguments.

Is it effective for measuring medical negligence

Before we can effectively use malpractice litigations for estimating negligence on the part of the providers of health care, we have to know whether this approach is valid. Some specialized hospitals and physicians are particularly at risk of malpractice litigations, simply because they routinely treat patients with complex medical conditions, the treatment of which is likely to be partly unsuccessful and sometimes harmful. This, however, does not make them poor providers of health care. It follows that the providers' level of quality is not readable from his/her record of malpractice cases, and , conversely, that we can not prevent people from being treated by less competent physicians/ institutions. This point is more than just of a theoretical nature. E.g., the Harvard Medical Practice Study (15) showed that medical practice claims were frequently made after patients were injured or disabled, but that negligence on the part of the providers was rarely an issue. Similar results came from other studies (11,12). Alternatively, medical injuries caused by negligence of a physician did not results in claims (11-13), and claims were granted even when no medical injury, and particularly no negligence was demonstrable (11,13,15). E.g., an insurer in Massachusetts, USA, thought the court would compensate a patient with serious neurologic injury after vascular surgery, and then offered compensation even though the medical care met the required standard (15). It may be concluded that based on such short-term studies and case reports the relationship between malpractice litigations and actual negligence is rather loose, at least in the short-term. However, it has been recognized that in other litigation systems initial claims frequently did not reflect final settlements (7). What about final settlements for medical malpractice? Taragin et al (1), studying insurer's cases for a period of 10 years after they were started, found that, in the end, negligence did to some extent predict final payment. This result was, however, not confirmed by two other long-term observational studies (7,13). Obviously, the majority of the data currently available support that medical malpractice litigations can neither in the short-term nor in the long-term be effectively used for estimating negligence, and so filing them on the Internet cannot either.

Is it efficaceous for curbing medical negligence and litigations?

A real problem with making the files available to a broad audience is the possibility that numbers of litigation suits, rather than curb, will steeply rise, because more and more patients will recognize in filed cases something of their own quarrels with doctors and get the feeling they should not it let go. The past two decades already witnessed a similar phenomenon. When malpractice started to receive a lot of attention from the media, increasing numbers of suits with little regard to quality of care the plaintiff received were brought before court (9). Filing them on the Internet may very well increase this trend, as well as increase the risk of inaccurate claims. We do not see how

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such a development can be beneficial either to health care providers or to patients.

In addition, filing those cases and the names involved may, in the long-term, give rise to a rather awkward situation. E.g., Putting doctors who treat patients with complex illnesses, on a black list for not being able to cure such patients, jeopardizes not only them but also their institutions and colleagues. Internet filing might turn the highest quality hospitals into places crowded with black list physicians. It would wrongly give the impression that something deeply wrong is going on at places where actually the best standards of care are met.

On the long-term, extensive filing of malpractice cases and names on the Internet is also likely to lead physicians to overdiagnosing and overtreating, otherwise called defensive medicine, since they do not want to take the risk of being listed for missing a diagnosis or treatment option. Harmful diagnostic procedures and treatments are more likely to be given under the flag of giving the patient the "benefit of the doubt", neglecting the harm that such a "benefit of the doubt" decision may bring about, particularly for older and fragile patients. Also "saying no" to expensive and risky interventions for small illnesses will not be a desired approach anymore. In conclusion, the effect of filing may not only fail to improve health care, but also cause a real deterioration of health care due to increased numbers of futile treatments that are potentially harmful and that may leave little room for other important treatment modalities, e.g., preventive medicine, to be implemented.

Is it (cost-)efficient?

So far, the malpractice litigation system was generally more adequate at least on the short-term to determine injuries and disabilities than it was to determine negligence on the part of the providers (11,13,16). This caused Weiler et al (5) to ask why to persist on determining negligence when compensation for injury is obviously at issue in the malpractice sytem. According to this concept the determination of negligence might be considered no more than an expensive side-show, and malpractice suits probably would be far less costly if negligence would not have been assessed at all. The State of New York, e.g., handled 67,900 claims between 1975 and 1989 most of whom involved payments between $ 100,00 and 249,00. This is, however, only a small fraction of the real costs, as it does not count legal aid insurance policy payments and reimbursements of lawyers and employees of the courts (5,13). With increasing numbers of litigations, costs will further rise. But costs will also further rise due to the mechanism of overtreating and overdiagnosing, which is a pity even more so because it leads to deterioration of individual health care, futile diagnostic and therapeutic interventions.

Is it practicable?

When using malpractice files on the Internet as a tool to beneficially influence both health care providers and patients, we have to be sure about the practicability of such a measure. As malpractice cases vary from very serious to very mild, weighing procedures are required. Since the weight of a particular malpractice case is frequently largely determined by factors of ethical, psychological, and social nature, a simple weighing procedure is impossible. E.g., the emphasis given to such factors by individual judges may be quite different, dependent upon their own individual values. As jurisprudence in many cases of malpractice is lacking, judges frequently depend upon expert opinions and verdicts are rather arbitrary. As a criterium for severity of malpractice, studies frequently used retrospective financial settlements, or made their own weighing scales using independent assessments by reviewers. However, the former approach is not feasible while the latter approach is based on the analysis of homogeneous samples of comparable data, and such approaches are thus impossible for the complex task of weighing malpractice files from different corners of the world on the Internet. This means that we simply have no means to attach a reliable and reproducible level of severity to cases listed. Given this lack of reproducibility criteria to assess severity of malpractice it is impracticable to use files of malpractice cases for the purpose of improving health care.

Second, it is impracticable in many situations of supposed malpractice, to find out from patients' and hospital files, whether there is actually question of an intentional error, or just inattentiveness in keeping records and checking equipment out of adjustment, or even just an accident.

Third, even in the situation where the body of arguments supports that a true negligence is obvious, it is ethically and legally hardly fair to put physicians on a black list, since such a thing has not been done with professionals from other disciplines, e.g., lawyers, notaries etc. Based on the principle of equal rights, physicians can be punished for inappropriate behavior but such punishment does not include a black list.

Discussion

Both institutions and physicians are increasingly involved in civil liabilities and lawsuits because of supposed malpractice. The current trend of taking legal actions is further enhanced by the treshold lowering effects of legal aid insurances as well as financially driven activities of malpractice lawyers (17). The litigation system has been documently more adequate to determine and compensate injury than negligence (1-4,7,8,10,13), and so, making malpractice data and those involved in malpractice available on the Internet for purposes of minimizing future negligence, is a hazardous plan. We argue that in terms of effectiveness, efficacy, efficiency, and practicability, there are too many counter-arguments to warrant implementing this plan.

The current paper also addresses the more general issue of the appropriateness of trying to solve medical malpractice problem in a court room or not. A common aspect of malpractice cases is, unlike other civil lawsuits, that on the whole defendants did not intentionally do the wrong thing, as providers of health care are traditionally

driven by a strong desire to do the right thing. This intrinsic strong desire is probably the reason that, traditionally, law has had a limited impact on medicine. Many providers of health care believe that, rather than in terms of legislation, medicine must be assessed in terms of appropriate behavior. Trying to enhance appropriate behavior by legislating medicine would accordingly be essentially wrong.

Actually, the word malpractice may be considered as a wrong word in the first place, because it suggests that something intentionally wrong has been going on. Obviously, however, the large majority of malpractice cases involve injuries and disabilities from medical interventions, that meet appropriate medical standards, and lack any element of negligence on the part of the providers. A parallel problem of wrong wording is currently recognized to be true for the notion "informed consent" (18,19). This notion suggests that patients without any medical training or skill must be capable of judging the implications of complex medical interventions being given to them. It is currently increasingly being recognized that the informed consent rule does not mean too much. The medical community knows how easily patients can give informed consent and contend that the patients' best protection is not it but rather the conscientious physician him/herself. This may be considered a paternalistic statement. One should, however, not fail to appreciate, that physicians' training and skill- the reason after all that people consult them- creates an inequality in the physician-patient relationship that no informed consent regulation can erase. The medical community increasingly believes that there are better ways to protect the patients' best interests, including ethic committees, monitoring groups, and other circumstantial organs safeguarding the patients. This discussion about the protecting of the patients' best interest and the informed consent, parallels in many ways the discussion about the quality of health care and the issue of malpractice. And similarly to better alternatives for the informed consent rule, there may be better alternatives to enhance standards of high quality health care than persuing malpractice on the Internet. E.g., some countries are undertaking no-fault compensation for medical injuries and systems for rewarding high quality hospitals, as methods to prevent patients from injuries (20,21). Rather than through ratings of malpractice, quality of care may be assessed through different approaches some of whom are sufficiently reliable for current use (22,24). E.g., ratings by nurses and physicians of adequacy of the diagnostic and therapeutic process (25) provided reproducible results and already showed that teaching hospitals scored better for providing quality of care while the opposite was true for handling patients'emotional needs and giving information (26). Both hospitals and physicians are beset nowadays by a litany of complaints. Hospitals are large and unpersonal, physicians often disregard patients'dignity. Waiting time to see a doctor is often excessive. Obviously, both parties must improve their efforts to give optimal care. However, we believe that filing malpractice litigations on the Internet for the purpose of improving such efforts is not effective and may even become rather counterproductive to such efforts.

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