

# Malpractice Prevention, Patient Safety, and Quality of Care: A Critical Linkage

L. Gregory Pawlson, MD, MPH; Margaret E. O'Kane, MS

There is growing evidence of a negative effect of the current American preoccupation with malpractice on efforts to reduce error, enhance safety, and improve other domains of quality. The use by some insurers of systems assessment and risk analysis programs, linked to rewards for performance—which, taken together, we term *proactive risk management*—offers an opportunity to enhance our focus on systems and to bring patient safety and malpractice risk reduction into close congruence with other quality improvement efforts. Given the increasing burden of malpractice, as well as the emerging concerns about patient safety, managed care organizations and their providers need to work together with malpractice insurers and quality improvement experts to refocus their efforts on creating systems improvement; driving measurement, analysis, and feedback; and developing incentives for performance that will align quality and risk management efforts and drive breakthroughs in quality, including patient safety.

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Two recent Institute of Medicine reports have increased our knowledge of the key issues related to patient safety and of the factors that lead to less than optimal quality of care in our healthcare system.<sup>1,2</sup> The latter of these reports, *Crossing the Quality Chasm: A New Health System for the 21st Century*, classified patient safety as 1 of 6 desirable attributes of our healthcare system (the other domains of quality were efficiency, patient-centeredness, timeliness, efficiency, and equity). Current efforts to include patient safety in quality improvement efforts have been overshadowed by the specter of malpractice litigation and hampered by a conceptual difference in approaches to quality related to patient safety vs other desirable attributes such as effectiveness or patient-centeredness.

Improvement and accountability in domains other than safety have been driven by the forces of professionalism and regulation and by a combination of these forces that underlies certification and accreditation programs.<sup>3,4</sup> In the past 2 decades, market-based interventions, including reporting and rewarding performance, have been introduced with varied degrees of success.<sup>3,5</sup> By contrast, before publication of the Institute of Medicine reports, patient safety was assumed by the public to be mitigated through the threat of malpractice, the efforts of providers to avoid malpractice, and the removal of “bad” physicians. Recent efforts by the

Institute for Healthcare Improvement, the National Patient Safety Foundation, The Leapfrog Group, and others have begun to bring quality improvement approaches, professionalism, and marketplace mechanisms into play in an effort to drive improvements in patient safety.<sup>6-10</sup> However, little attention has been paid to how to integrate these efforts to enhance patient safety with other efforts in quality improvement or with the persistent issue of avoiding malpractice litigation.

## MALPRACTICE AND PATIENT SAFETY

In contrast to the public's view, there is little evidence that malpractice, specifically litigation related to malpractice, acts as an impetus to improve patient safety or to deter unsafe practices or that it even compensates victims in a fair and equitable manner.<sup>11-15</sup> Moreover, malpractice litigation is based on the need to prove negligence and to place blame on an individual (or entity) and is antithetical to the systems and quality improvement focus of patient safety suggested by the Institute of Medicine report *To Err Is Human: Building a Safer Health System*.<sup>1</sup> Given our recurrent malpractice insurance crisis, it is likely that, without some shift in emphasis, more time, resources, and concern will be placed on efforts to avoid malpractice litigation in the future.<sup>16,17</sup>

Despite this overshadowing presence of litigation, a few malpractice insurers are increasing their emphasis on a set of programs that use a proactive, empiric, systems-focused approach to determining the causes of errors and their relationship to patient harm and subsequent litigation. These insurers use this information to create tools to assess and improve systems as a means to reduce the likelihood of future errors, patient harm, and litigation.<sup>18-22</sup> We have termed this set of activities *proactive risk management* and believe this emphasis mirrors in many ways the shift of clinical medicine during the past 4 decades from an almost exclusive focus on caring for acute events, such as heart attacks, to a com-

From the National Committee for Quality Assurance, Washington, DC.

Address correspondence to: L. Gregory Pawlson, MD, MPH, National Committee for Quality Assurance, 2000 L Street NW, Suite 500, Washington, DC 20036. E-mail: pawlson@ncqa.org.

plementary emphasis on the proactive identification and management of risk factors (hypertension, diabetes mellitus, and hypercholesterolemia) as means of preventing heart attacks.

### **Example of a Systems-Oriented, Risk Management Approach to Malpractice**

The set of programs used by COPIC Insurance Company, Denver, Colo, is offered as an illustration of the firms that use proactive risk analysis and systems assessment to reduce malpractice occurrences. COPIC (originally an acronym for Colorado Physicians Insurance Company) is a physician-sponsored malpractice insurer that insures about 75% of the eligible physicians practicing in Colorado.<sup>23</sup> Although the COPIC program is among the most highly developed, we would note that there are other insurers, such as Medical Mutual, Hunt Valley, Md,<sup>24</sup> and the malpractice subsidiary (CRICO) of Partners Healthcare, Boston, Mass,<sup>25</sup> that place a major emphasis on proactive risk management. Key elements of the COPIC program are described.

*Focus on Incident Reporting and Using Data to Foster Prevention.* Physicians and organizations insured by COPIC are encouraged to report, via telephone, any incident that they believe might result in a malpractice claim. Although nearly all malpractice insurers invite reporting of incidents, COPIC provides encouragement through active outreach and repeated reminders to providers to report even minor adverse events. When an incident is reported, it is coded into the COPIC database. Risk managers and claim adjusters review the report in the context of information provided by the database of prior incidents. The physician or organization and insurance company work together to understand and address the likely cause and course of events resulting from the incident.

The incident database is structured through the use of a coding system developed by COPIC that categorizes reported incidents using multiple characteristics, including the setting, providers involved, and type of occurrence. COPIC then uses the data to analyze and understand “near misses” and which incidents are most likely to lead to malpractice claims and payouts. These data are also used to help structure the systems analysis and feedback, as noted in the next subsection.

*Practice Systems Assessment and Feedback.* A major point of the Institute of Medicine report *To Err Is Human: Building a Safer Health System*,<sup>1</sup> and of much of the literature on safety in general, is that errors and adverse events are more often due to system design flaws than to individual culpability.<sup>26</sup> As noted by Leape et al,<sup>10</sup> systems produce the results they are designed to produce, including errors that arise. Several ways of

analyzing systems problems related to patient safety concerns have been proposed, including root-cause analysis and applying the concepts of continuous quality improvement.<sup>27-29</sup> A subsidiary of COPIC (Practice Quality LLC) employs nurses with specialized training in the assessment of risks to patient safety that may be present in practice settings. The nurses use a standard survey protocol to evaluate office systems and practices in each insured physician’s office and hospital at least once every 2 years. The overall protocol and assessment instrument were developed using information from incidents, claims filed, and a payout database developed by COPIC. **Table 1** provides a synopsis of the areas assessed. Results of the practice risk assessment are shared with the office practice leadership at the end of the survey, along with a variety of suggestions and options for improving areas identified as being at risk. In addition, the program links the providers to “tool kits” and other educational programs that are designed to help in correcting problems identified by the audit, as well as providing clinicians with examples of best practices that can enhance safety and other domains of quality. This focus on systems assessment and improvement provides an important linkage between patient safety and other domains of quality, which we will subsequently explore in more detail.

*Collaboration and Rewarding Results.* The third major component of the COPIC proactive risk management program involves the use of an incentive system that rewards physicians for adopting safe and effective practices. COPIC has created a system by which practices are awarded points based on their adherence to COPIC guidelines to improve performance, ranging from attendance at educational seminars to online educational opportunities to implementing changes suggested by COPIC’s practice evaluations. Malpractice premium rates are tied to baseline levels of performance on the survey, adherence to suggested corrective actions, and participation in risk reduction programs. In addition, if COPIC’s total payouts for claims are lower than expected, the savings are shared retroactively with insured physicians and organizations in the form of premium credits. Therefore, individual and collective performances are rewarded.

Those individuals and practices that are identified as consistently poor performers are given repeat surveys, with opportunities for remediation. If the problem appears to lie with an individual practitioner rather than the practice systems, referrals are made to programs (separate from COPIC) that provide in-depth assessment of clinical performance, individually tailored skills training, and, if needed, counseling services for physicians who are identified as having personal

health issues, chemical dependency, or other problems that adversely affect their clinical performance. If all of these attempts fail, a last resort is the nonrenewal of COPIC insurance. Although this is rarely used, it carries great weight in Colorado, because the state requires proof of insurance for physician licensure.

**Linking Patient Safety and Effectiveness of Care at the Conceptual and Practice Level**

*Focus on Risk Factors and Fostering Prevention.* The use of proactive risk management (incident analysis and prevention, systems assessment and feedback, and rewarding performance) is similar in many respects to the focus in managed care related to enhancing quality in the domain of effectiveness of care. Most managed care organizations structure their clinical quality improvement efforts in effectiveness of care around measurement and interventions related to primary and secondary risk prevention. Some examples of this focus include programs related to primary immunizations in childhood and adolescence, screening for cancer in adults, the use of  $\beta$ -blockers and controlling cholesterol in patients identified as being at high risk for cardiovascular events, and screening and control of glycosylated hemoglobin in patients with diabetes mellitus. There is a congruence of this approach with that of malpractice insurers like COPIC with their focus on measurement and analysis of incidents to guide preventive efforts in safety.

*Practice Systems Assessment and Feedback.* In terms of assessment of systems as a quality measure beyond the domain of safety, investigators have developed and demonstrated the use of a model that identifies, using existing empiric evidence, systems that are linked to higher quality processes and outcomes of care in prevention and chronic illness.<sup>30-33</sup> The model, variously referred to as the “chronic care” or “planned care” model, has been translated into several instruments, including one developed by the National Committee for Quality Assurance that measures the presence, content, and use of office systems in physician practices (available from L.G.P.). Although these instruments are in the developmental stages, the basic domains and some of the subelements of the overall model are shown in **Table 2** (more information is available from L.G.P.). Note the high degree of overlap in content with the office system assessment used by COPIC (Table 1) to assess the presence or absence of systems critical to patient safety. This overlap suggests the possibility that a single assessment tool might provide information to practices related to multiple desirable attributes, including patient safety and effectiveness.

**Table 1.** Domains of COPIC Office Assessment\*

Patient registration
Access and security
Summary of patient record
Documentation of clinical encounter
Letter and transcription
Orders and results
Medications
Signatures
Patient follow-up
Patient registries and database
Records retention
Equipment and computer systems

\*For more information, contact COPIC.<sup>23</sup>

**Rewarding Performance**

An additional factor present in the COPIC model is the provision of incentives that reward the implementation of systems that are linked to improved safety. Purchasers and health plans, in some cases encouraged by a grant program “Rewarding Performance,” funded by the Robert Wood Johnson Foundation, have introduced financial and other incentives based on clinical performance, including effectiveness and patient-centeredness. If these efforts at rewarding performance could be coordinated with those of malpractice insurers like COPIC in reducing premiums for malpractice insurance for improvements in safety, the combined market levers might be sufficient to drive substantial improvement in multiple domains of quality.

**Integrating Risk Management and Quality**

The final common pathway of most quality improvement activities is the direct participation of clinicians and practices in systems and behavioral changes that bring about improvement. However, safety risk management programs in most hospitals and group practices are often a defensive response to malpractice concerns and are located and staffed by the hospital or physician group legal office. These programs are often not effective in gaining the involvement of clinical leaders with the knowledge, experience, and influence necessary to foster the needed improvement in clinical practice systems and provider behaviors. Combining efforts in risk management with those in quality enhancement may create a critical mass of focus and personnel that could drive systems and behavioral change. The literature supporting integration of patient

**Table 2.** Domains of Practice Systems Assessment Instruments**Clinical information systems**

Patient registries  
 Measurement-feedback (populations)  
 Systematic monitoring (individuals)

**Decision system support**

Provider reminders  
 Guidelines incorporated in practice  
 Safety alert systems

**Patient self-management support**

Patient reminders  
 Patient behavioral change support  
 Active patient education

**Delivery system design**

Care management  
 Planned visits  
 Coordination of care  
 Continuity of care  
 Effective use of team

safety with other quality assessment and improvement efforts spans more than 2 decades but provides little evidence of progress.<sup>34-41</sup>

**Policy Implications and Future Directions**

Despite the barriers to wider dissemination of proactive risk management—increasing our efforts in systems improvement, integrating patient safety with other domains of quality, and rewarding performance—we believe that these efforts, taken together, are close to creating a synergy that could positively affect health-care quality and safety. Although none of the activities we note are easy to implement, there are examples of cutting-edge organizations that have successfully implemented most or all of these practices. We believe it is time to develop policies and interventions that would encourage widespread use of these practices. The alternative of following the traditional path of paying claims or relying on isolated, disjointed risk management programs is likely to be increasingly costly and dysfunctional to all parties.

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