Ethics and Growing Legal Crisis in Medicine

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Abstract

This essay presents a preventive ethics to hidden aspects of the professional liability crisis, which is now affecting physicians throughout the world. It draws on the concept of fiduciary responsibility and its four professional virtues of integrity, compassion, self-effacement, and self-sacrifice to identify preventive ethics approaches to the professional liability crisis for practicing physicians and physician leaders. Physicians should adhere to integrity in clinical practice and testimony, to compassion and self-sacrifice by focusing on patients rather than their own needs, and to self-effacement by not allowing risk of litigation to influence patient care. Physician leaders should create organizational cultures to support physicians in this important work. Fiduciary responsibility and professional virtues should guide practicing physicians and physician leaders in creating best-practice models to improve organizational culture and influence health policy.

The legal crisis concerning malpractice and professional liability affects physicians and physician leaders in many countries around the world either as an existing or emerging issue. Much attention has appropriately been given to public policy issues such as tort reform and insurance reform. At the level of clinical practice, proposals have been made about improving communication, documentation, adherence to practice guidelines, consultation, and even weeding out bad doctors (1). Such policy and clinical proposals will not in all cases be implemented and those that are will take considerable time to have an effect. Meanwhile, as recent work stoppages in the United States indicate, among physicians and physician leaders there is great frustration, anger, and even despair about the future of medicine.

At this time of crisis, economic survival has become paramount for many physicians. Older physicians are considering whether early retirement is as attractive as or even more attractive than continuing to practice. Younger physicians worry that insurance costs may not permit a fiscally viable practice. Physician leaders wonder whether medicine is entering a world in which there is no margin and therefore no mission.

As a result of these responses to the professional liability crisis, economic and other forms of self-interest can become dominant and displace fiduciary professionalism from its central place in the moral lives of physicians and physician leaders. The purpose of this paper is to provide physicians with preventive ethics tools to deal effectively in their own practices and in organizational culture with this hidden ethical professional liability crisis (2-4). This paper draws on our previous work on this topic (5). The historical, sociocultural, and economic circumstances of different countries will shape this emerging crisis in distinctive ways but the ethical challenges, we believe, are transcultural.
Fiduciary Professionalism

Origins in Eighteenth-century British Medical Ethics

In contrast to most work in bioethics, which draws on contemporary sources as if there were no relevant historical sources, one of the novel features of our approach is to turn to the history of medical ethics. We therefore take these tools from the medical ethics of Dr John Gregory (1724-1773), who first developed the concept of fiduciary professionalism in the modern period (6,7). Gregory’s Lectures on the Duties and Qualifications of a Physician from 1772 are now available in a contemporary edition (5). While it is sometimes thought that the history of medical ethics was mainly concerned with matters of decorum and deontology, this is not the case for Gregory. He wrote his medical ethics with a reforming purpose, to correct the dominance of self-interest in the highly competitive, market-driven world of eighteenth-century medical practice in Britain. Gregory’s concept of fiduciary professionalism has three elements. First, physicians should accept the intellectual discipline of science so that theories of health and disease are as free of bias as possible. Following Francis Bacon’s (1556-1626) philosophy of medicine, Gregory called for what has become known in our time as evidence-based medicine. Second, physicians should make the protection and promotion of the patient’s health-related interests their primary consideration. Third, physicians should keep economic and other forms of self-interest in a systematically secondary position. In practice, this means that physicians must be able to justify any decision to place their own self-interest, e.g., reducing liability for malpractice actions, before their obligation to care for their patients.

Four Professional Virtues

Four virtues put the concept of fiduciary professionalism into medical practice as well as medical leadership (3,4,8). The first and most fundamental virtue in medical ethics is professional integrity. For Gregory, and therefore for us, this means practicing medicine according to standards of intellectual and moral excellence. Gregory argues that integrity protects patients and underscores the profound sense of wholeness and satisfaction that comes from a life of intellectual and moral excellence in medicine (6,7). Integrity should never be compromised. One of the best ways to ensure integrity for physicians and physician leaders is to create organizational cultures that support and reward adherence to high quality practice guidelines and other disease management strategies that support a life of service to patients rather than the pursuit of self-interest.

It has been suggested that doing so might reduce the risk of malpractice litigation, an added bonus (9). In other words, the pursuit of intellectual excellence both enhances patient care, by reducing unnecessary clinical variation and its risks, while at the same time promoting self-interest as a happy side-effect of a primary focus on good patient care. There is a general ethical lesson here for physician leaders in response to the professional liability crisis: the best way to keep economic self-interest in its proper place is to make it a function of excellence in patient care, not an independent goal. Failure to do so will contribute to the destruction of professionalism in medicine, which is not as robust as physicians sometimes like to think (10).

The professional virtue of integrity has important implications for physician expert testimony by defense and plaintiffs’ expert physicians in malpractice actions. Expert testimony by physicians should in all cases be directed to identification of the range of the standard of care on the basis of the best available evidence at the time of the case in question. This approach will serve as an antidote to slanting testimony in favor of the party who has hired the expert on testimony based only on the witness’s personal experience.

The second professional virtue is compassion. According to Gregory, this virtue obligates the physician to recognize when the patient is experiencing pain, distress, or suffering and to act promptly to relieve them (6,7). Compassion prohibits physicians from burdening patients with his or her complaints about the professional liability crisis, because doing so is inconsistent with the obligation to relieve pain, distress, and suffering. Work stoppages that ensure that patients’ urgent needs are met are less ethically problematic because they do not interfere with the individual doctor-patient relationship. In contrast, adding to the distress of elected officials who are unresponsive to serious social problems such as the professional liability crisis is a time-honored civic duty in democracies (10,11).
The third professional virtue is self-ef- facement. Gregory held that this virtue requires physicians to put aside and not be influenced by irrele vant differences with patients such as race, gender, sexual orientation, and socio-economic status (6,7). When in an emergency encounter, a patient threatens to sue the physician, he or she should respond in the subsequent management of the patient just as required by standards of clinical excellence and not on a personal basis. Similarly, the fact that the patient has brought legal actions in the past or is a plaintiffs’ malpractice attorney should have no effect on the physician’s management of the patient.

The fourth professional virtue is to self-sacrifice, which requires the physician to take reasonable risks to self-interest in patient care (6,7). The resurgence of life-threatening infectious diseases from such pathogens as HIV and HBV has resulted in physicians routinely taking risks to health care and life in meeting patient care responsibilities. With the encouragement and role-modeling of physician leaders, physicians should always keep in mind that while financial risks are real, they are not as important as risks to health and life.

Keeping economic self-interest such an ethically proper perspective is a powerful antidote to economic conflicts of interest that can under lie professionalism by making self-interest in avoiding malpractice liability an overriding consideration and motivation. Physicians should assess conflicts of interest using four criteria, which have been recently articulated (12). The first is how intense the conflict of interest is. This concerns the percent of one’s total earnings represented by a particular financial incentive, e.g., performing a non-indicated surgical procedure. The second is how immediate the conflict of interest is. This concerns whether the first thing the physician thinks about in patient care is the well being of the patient or the impact on the physician’s economic interests of decisions the physician is about to make. The third is how systematic the conflict of interest is. This concerns how many decisions are strongly influenced by self-interest. The fourth concerns whether an individual is dealing alone or with like-minded colleagues to address and manage conflicts of interest. The more intense, immediate, systematic, and individual the conflict of interest is, the more likely even the most conscientious physician will be to manage it poorly. The task is to bring conflicts of interest into a more manageable range under these four criteria. The result is that physicians will responsibly manage conflicts of interest without having to become martyrs or masochists.

Considered together, the professional virtues require physicians to judge as unethical strategies that physicians can sometimes employ in the clinical setting to reduce the risk of litigation. For example, physicians should not engage in “crepe-hanging,” i.e., distorting the informed consent process by accenting potentially adverse outcomes of very low incidence in order to decrease expectations and the risk of litigations. This practice, which can occur in many specialties, violates the integrity of the informed consent process, as well as self-sacrifice (13). Similarly, if an uncertain obstetric ultrasound finding is found in the second trimester, a physician who steers a patient toward abortion, either explicitly or implicitly, may do so to prevent the potential liability that occurs with the birth of an anomalous child. This strategy violates the integrity of non-directive counseling (3), as well as self-sacrifice. Lastly, an obstetrician who performs an unindicated cesarean delivery, in the attempt to reduce liability for birth injuries to the infant, violates integrity, self-effacement, and self-sacrifice. It should be plain that the professional virtue of compassion is violated in all three examples.

Ethical Obligations of Physician Leaders

Expecting physicians to maintain fiduciary professionalism in response to the professional liability crisis, on their own, is unrealistic. A supportive organizational culture is of paramount importance (14). Physician leaders are responsible for shaping organizational cultures and therefore have a critical role to play in the hidden ethical professional liability crisis. They should create organizational practices and policies that acknowledge and reward physician behavior based on the professional virtues. In our judgment, some behaviors such as adherence to practice guidelines, can be reliably measured and assessed. For example, continuous quality improvement should be utilized as a preventive ethics tool for maintaining both individual and organizational integrity. Physician leaders should be explicit about the preventive ethical significance of this and other manage-
ment tools so that survival for its own sake does not become the overriding consideration.

Some behaviors, such as inappropriate counseling of patients, are not easily measured and assessed and present more difficult preventive ethics challenges to the physician leadership. This is because there is no "canary in the mine" to warn a physician leader that the professional virtues and the organizational culture are in ethical peril from these hard-to-detect physician behaviors. We believe that strengthening the fiduciary professionalism of an organization’s culture will also serve to strengthen individual fiduciary professionalism, especially in these hard-to-assess areas. Physician leaders should emphasize that maintenance of individual fiduciary professionalism is essential for maintaining organizational fiduciary professionalism.

Conclusion

In conclusion, an inadequate response to the hidden ethical professional liability crisis is to focus only on macro-level policy changes and therefore fail to acknowledge that the micro-level decisions of individual physicians and physician leaders are essential for responsibly managing that crisis. The professional liability crisis needs not only a “top-down” but also a “bottom-up” response. The concept of fiduciary professionalism and the professional virtues that put it into practice and organizational culture should be used by physicians and physician leaders to create ethical best-practice models that can improve organizational cultures, and therefore guide macro-level tort and insurance reform by legislature and courts. This micro-level response, over which physicians and physician leaders continue to retain effective control, will serve as a powerful antidote to the dominance of survival and economic self-interest in organizational and public policy discourse and action.

A worse and ultimately ineffective response to the hidden ethical professional liability crisis is to give oneself over to anger and despair. This is a simple but dangerously seductive alternative. However, the reader should remember the ancient wisdom: “Whom the gods would destroy, they first make angry.”

References


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