IMPLEMENTING HEALTH REFORM

Medical Malpractice

Physicians have long sought an overhaul of the nation's tort system in the hope of reducing the financial and emotional costs involved with medical malpractice. The Affordable Care Act took a small step by funding demonstration projects to develop litigation alternatives. The law provides $50 million to states for 5-year grants in fiscal year 2011, which began on Oct. 1, 2010. The Obama administration said it will give preference to states that develop programs that improve access to liability insurance and improve patient safety by reducing medical errors.

Dr. Albert L. Strunk, deputy executive vice president of the American College of Obstetricians and Gynecologists, discusses the current malpractice environment and the impact of health reform.

OB.GYN. NEWS: Does ACOG consider this proposal a step in the right direction?
Dr. Strunk: Any step that is undertaken to reduce the cost of litigation and improve determinations of good vs. bad medical care is a very good idea. Whether you think medically related litigation costs $11 billion or $22 billion or $60 billion a year, the figures are substantial, so we're very anxious to have trial or pilot programs go forward.

We are grateful for any impact from the Affordable Care Act, but I think that real innovation also is occurring apart from the grants. There is an increasing institutional and practitioner awareness that the way in which less-than-optimal outcomes occur requires attention to a constellation of factors. Personnel is only one element.

More and more, we accept the notion that we have to, in a way, pull ourselves up by our own bootstraps. While the 112th Congress may be more receptive to tort reform, primarily, we have to look to the states for legislative solutions.

OB.GYN. NEWS: Some studies have suggested that the cost of medical malpractice is a fraction of overall health spending, and that tort reform would do little to bring down total health care spending. How does the cost of medical malpractice impact the practice of obstetrics and gynecology?
Dr. Strunk: The ob.gyn. specialty is somewhat unique within the context of the current tort system, in part because of the size of awards attached to neurologically impaired or neonatal encephalopathy types of cases. Because those cases allege primarily economic damages based on the life-care of an impaired infant, traditional tort reform involving caps on noneconomic damages are of little assistance.

In addition, there has been a good deal of judicial nullification of statutes of limitations in cases involving infants. So obstetricians today face a practice environment whereby simply being at the wrong place at the wrong time can literally cause economic ruin.

We know from survey results that the anxiety associated with this risk greatly influences the behavior of obstetricians and gynecologists, as does the cost and availability of liability insurance. The anxiety causes our physicians to leave obstetrics in their 40s, so there is a significant impact on the workforce. So we believe that defensive medicine and fear of litigation does add to our total health bill.

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DR. STRUNK

OB.GYN. NEWS: Is ACOG working to reform tort laws at the state level?
Dr. Strunk: We are, and it's quite a different approach that one takes. Most of the state initiatives tend to relate to traditional California MICRA (Medical Injury Compensation Reform Act)–style tort reform, addressing noneconomic damages through caps, as well as limiting contingency fees, for instance. The most successful initiative has been in Texas. The impact of the state cap on noneconomic damages – coupled with a constitutional amendment that prevented the courts from overturning the legislation – has resulted in a huge influx of doctors. Access to care, particularly in low-income populations, has been dramatically increased.

In the short term, caps on noneconomic damages are helpful in selected state environments. Some states are also exploring a contractual arrangement between the patient and the physician to provide for predispute voluntary binding arbitration. Another long-term goal would be the implementation of health courts.

OB.GYN. NEWS: What would ACOG ideally like to see happen with the malpractice reform demonstration projects?
Dr. Strunk: In terms of the grants that have been made, we are very supportive of a project in Missouri, which is going to focus on the quality of perinatal care and the way adverse perinatal events are managed in five Missouri hospitals. They are going to establish an evidence-based obstetrics practice model. We believe that the use of evidence-based guidelines and checklists increases patient safety and reduces risk.

The Carilion Roanoke Memorial Hospital Center has a planning grant to enhance teamwork and systems management, the goal being to improve the quality of obstetrical care and patient care, and reduce risk and liability. Team-based care, systems analysis, and systems solutions are essential. Most of the mishaps that occur in the delivery of care don't really relate to the negligence of a single person, notwithstanding what the tort system would have us believe. It is generally a constellation of factors. ■

POLICY & PRACTICE

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Surgeon General: Breast Is Best

In a "Call to Action," U.S. Surgeon General Regina Benjamin identified ways that physicians and others can help new mothers stick with breastfeeding. For example, clinicians can get training in how to care for breastfeeding mothers and babies and then give mothers proper how-to advice. About 75% of mothers breastfeed their babies initially, but that number falls to 43% at the end of 6 months, according to 2010 data from the Centers for Disease Control and Prevention. "Many barriers exist for mothers who want to breastfeed," Dr. Benjamin said in a statement accompanying the report. "They shouldn't have to go it alone. Whether you're a clinician, a family member, a friend, or an employer, you can play an important part in helping mothers who want to breastfeed." But Dr. Benjamin said that breastfeeding is a personal decision and that women shouldn't be made to feel guilty if they choose not to.

Law Eased Medicaid Expansions

The Affordable Care Act made it easier for states to expand their Medicaid family planning services, according to the Guttmacher Institute. Previously, that could be done only through a waiver process that typically took 2 years to complete, according to the Guttmacher report. But under the health reform law, states have the authority to expand Medicaid without a waiver. "A strong body of research demonstrates the significant impact of these programs in enabling women to avoid unintended pregnancies and the abortions and births that follow," said Adam Sonfield, the report's lead author, in a statement. New York, for example, could save $1.6 million a year by avoiding some unintended births, according to the report. The research was supported by a grant from the Centers for Disease Control and Prevention.

New Laws Restrict Abortion

State laws passed in 2010 were far more restrictive of abortion than in favor of abortion rights or access to contraception, according to NARAL Pro-Choice America. Last year, 16 states passed 34 measures that NARAL deemed "antichoice," the organization reported. For example, Arizona, Louisiana, Mississippi, Missouri, and Tennessee enacted laws that ban abortion coverage in the state-based insurance exchanges set to launch in 2014 under the Affordable Care Act. In contrast, nine states enacted measures that NARAL categorized as "prochoice." California, for instance, increased protections for the confidentiality of reproductive-health professionals and patients. NARAL President Nancy Keenan said she is concerned that more abortion restrictions will emerge in the coming years because many abortion opponents were elected to Congress, state legislatures, and governorships last fall.

Medicaid Hospital Admissions Rise

Medicaid hospital admissions rose 30% from 1997 to 2008, while admissions of privately insured patients rose only 5%, the Agency for Healthcare Research and Quality found in another analysis. By 2008, Medicaid paid for 18% of the nearly 40 million hospital stays by U.S. patients, with maternity-related and newborn care accounting for about half of the Medicaid-financed hospitalizations. In that year, the public insurance program spent $51 billion on hospital care, compared with $117 billion paid by private insurers and a cost of $15 billion for the care of uninsured patients.

Federal Abortion Law Introduced

Abortion opponents in the House have introduced the "No Taxpayer Funding for Abortion Act" (H.R. 3) to both further restrict abortion funding and outlaw discrimination against providers who refuse to perform abortions. The bill states that no federal funding can go to any health-benefits plan that includes abortion coverage and that federal tax credits can't be claimed for a health plan that covers abortion, except in cases of rape, incest, and where the life of the mother is in danger. But abortion-rights supporters say the legislation goes too far. Nancy Northrop, president of the Center for Reproductive Rights, said the legislation would create "new tax penalties" aimed at making abortion coverage unavailable even under private health insurance.

AMA Issues Social Media Policy

Physicians using social media sites such as Facebook and Twitter should carefully guard patient privacy while monitoring their own Internet presence in order to make sure it is accurate and appropriate, the American Medical Association said in a new policy statement. During its semiannual policy meeting in San Diego, the association called for physicians to "recognize that actions online and content posted can negatively affect their reputations among patients and colleagues, and may even have consequences for their medical careers." The AMA urges physicians to set privacy settings on Web sites at their highest levels, maintain appropriate boundaries when interacting with patients online, and consider separating personal and professional content online.

–Mary Ellen Schneider