What Is So Good About Being the Best?

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In this issue of the *Journal*, Ely and colleagues ask: Are the best doctors sued more? *(J Fam Pract 1999; 48:23-30)* If this statement is true, it will be a charming irony. The notion that lawsuits identify bad doctors has always been simplistic and dubious, and the authors give us evidence against it. But, how far should we extrapolate? Should we now direct patients to the most sued physicians? Imagine a resultant seminar titled "Tips on How to Get Sued More Often" or a slogan for Yellow Pages ads, "The most sued practice in town!"

Of course, this is not the lesson we should learn from their study. Just because lawsuits do not identify the worst doctors, does not mean they identify the best. Therefore, it is worth exploring what "being the best" really means.

The goal of the work by Ely and colleagues was to dispel the common stereotype, proposed by the American Medical Association as a credentialing screen, that good physicians have little or no experience with malpractice litigation. This is a respectable goal, but a tough assignment. We have this great mythic weight of tradition, supported both in the professional standards and in the popular consciousness, that bad doctors get sued and good ones do not. The authors provide evidence that — at least for Florida family physicians — this is not always true. This result is intuitively appealing, but have the authors really shown it? And what if they have?

The article uses industrial-strength statistics to show that doctors with better academic credentials are sued more. If the authors had left things at that point, we would still have some interesting issues with which to grapple. We would need to look for flaws in our recruitment processes, training programs, credentialing system, and tort system, and we would find plenty.

But it is a leap from this point to the idea that the best doctors are sued more. Ely and colleagues appear to be aware of the difficulties in defining who the best doctors are. They reduced "best" to having medical knowledge, and medical knowledge was determined through academic credentials. Both propositions are problematic.

Plato,[1] convinced that virtue is a matter of knowledge, understood that simple cleverness or book learning was not enough to make someone "good." Classical philosophy draws distinctions between different types of knowledge. There is the knowledge of the words to a song, the knowledge of the number of degrees in a circle, the knowledge of which road leads home, the knowledge when to shut up and listen. So, what kind of knowledge makes us "better?" Can we measure it? Can it be taught?

Ely and coworkers apparently define knowledge to be things learned in residency and continuing medical education courses measured on standardized tests. This may not define the best physicians, but at least it defines the best trained. Why would these physicians be sued more?

The 2 explanations we are offered are that medical knowledge is incompatible with interpersonal skill and the more competent physicians take care of tougher patients.

The first explanation may be a cliché, but it is unfortunately somewhat true. Academic performance is achieved through different talents than success with people. And, while knowledge encompasses more than what is written in books, we do not measure the unwritten parts very well on standardized tests. (Nonetheless, standardized tests do measure some relevant things and should not be casually disparaged.) Still, even if knowledge and niceness compete, we need both in a complete health care system.

Whether this weak inverse relationship is lucky depends on whether you graduated in the top half of your class. And there is compelling evidence that dissatisfaction with the physician is the seed of many suits. But this syllogism alone is not persuasive enough to explain the findings of Ely and coworkers.

The second explanation suggests that the more competent family physicians may treat sicker patients. While it is difficult to see how patients would sort this out for themselves, there may be a tendency for better-trained family physicians to hang on to tougher problems longer. In any case, they perform more procedures, and procedures themselves breed litigation. Proof of this can be found in liability insurance rates. Patient factors are more difficult to analyze. It is worth asking whether something else about the "likely to be sued" doctor attracts the "likely to sue" patient.

There is also the more ominous possibility that we are training family practitioners to overreach their skills. The most important predictor of lawsuits is adverse outcome. These data might indicate that better-credentialed family physicians have more adverse outcomes. But these physicians tend to win their cases. This implies that their adverse outcomes are defensible and effectively refutes this concern.

A swarm of other tempting questions arises. The study does not attempt to ask how the qualities of the best family physicians compare with those of the best pathologists, pediatricians, or oncologists. And though the authors raise the question, they could not find data to show a relationship between patient volume and lawsuits. Nor were there any data about group practice compared with solo practice, multispecialty arrangements, or the use of information technology. And, what is so good about being the best, anyway? Is there a place for pretty good doctors?

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HOW SHOULD PHYSICIANS BE JUDGED?

Like the electron cloud around an atom, good doctoring may be impossible to pin down, but its effects are palpable. We need to discover how to take pictures of it. Being judged makes everyone squirm. We are quick to point out all the foibles: retrospection, adverse selection, subjectivity, conflict of interest, faulty data, prejudice, legitimate clinical controversy, happenstance, human nature. But we cannot hide from these demons. Accountability is one of the pillars of our profession.

But should we be judging persons at all? It is tricky and creates discomfort, as well as injustice and hard feelings. It supports the idea, reinforced by this paper, that it is the doctor who is good or bad, rather than the results of the encounter. In contrast, comparing abstract quantities like outcomes comfortably depersonalizes the evaluation, allowing us to congratulate doctors with fewer postoperative infections, better mammography rates, and more flu shots, without actually implying they are better people. It also lets us refine our judgment somewhat, in semiquantitative terms rather than polarized concepts of good and bad.

At the other end of the judgment scale, in terms of objectivity, is patient satisfaction. Granted, allowances need to be made. (But what patient wants a doctor who is 3 standard deviations below the satisfaction mean?) At first glance, knowledge of how to satisfy patients would intuitively correlate with a lower lawsuit risk. However, it is unclear whether a high satisfaction rating is protective in the face of a severe adverse event.

Or, we could be empirical. It is likely that a meaningful percentage of Americans measure the quality of physicians by their incomes. ("This group must be great. Look at their waiting room!") Why scoff at this as a benchmark? It is an old Calvinist standard that many subscribe to implicitly, though few acknowledge it publicly, and it applies to other professions as well. It might have been fascinating to look at the lawsuit and knowledge data from this angle.

Ironically, the most subjective standard described is the most professional. *The Best Doctors in America: Southeast Region*[2] relies on reputation among one's peers. For physician-directed referrals, this standard probably carries more weight than any other. However, reputation is mostly a measure of public visibility, generally not a good discriminator of anything but itself, and it does not signify anything about either lawsuits or knowledge.

The physician-patient relationship still rests largely on trust. At some level, we are going to be judged as people, along with our actions and outcomes. If there is one thing we should teach in medical school and residency (and elementary school, as well), it is how to deserve the trust of other people. Test scores, honor societies, and board examinations may be part of it; interpersonal skills may also play a part.

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Ultimately, the best doctors are the ones to whom the broadest range of patients can come, with the broadest range of needs, and then leave with the greatest chance of being better off than before. Where are these physicians? They are not necessarily found where test scores are highest, empathy is the most touching, or waiting rooms are the most plush. They will be where brilliant protocols are combined with intense human interest, vigilant error trapping, meticulous monitoring, and endless learning. There is ample evidence that malpractice suits not only do not identify bad doctors, they do not even identify malpractice.[3,4] Hopefully, the contribution from Ely and associates will help remedy this. But the vacuum left by the old, broken system for measuring competence needs filling with something greater than individual performance.

Solving this problem requires a broader and better perspective. The *ad hominem* approach to quality—judging it one doctor at a time—embraces a quaint delusion about how health care works. Patient care involves much more than 2 people communing in the isolation of an examining room. The better measures of quality pertain more to system design than to individual talent. The 160-acre farm is no model for feeding an industrial nation. Barnstorming in a biplane is no model for an airline. Wyatt Earp is no model for a police department. Medicine is slowly evolving in the footsteps of institutions that have needed to be organizationally smarter, better capitalized, more coherent and coordinated, and better managed, with up-to-date information and communication systems and more effective measures of success. The path toward quality improvement does not abandon individual honors; it augments them with the organizational ones we are still discovering. We have to learn to speak in terms of the best treatments rather than the best doctors.

We do not need to discard individual merit. The world will always recognize virtue and wisdom. But a better understanding of what it means to be the best would increase the opportunity for all of us, as patients, to expect good care without our physicians having to be heroic. In America today, receiving good care still involves a lot of chance. There is plenty of room for good physicians to get better, without worrying about being the best.

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