Physician Responses to the Malpractice Crisis: From Defense to Offense

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Medical science brings innovations in patient care at an astounding pace today – new chemotherapeutic agents, coated stents, and minimally invasive surgery are just few recent examples. For physicians, though, the specter of malpractice liability can overshadow the marvel of practicing in this era. Many physicians are working in a volatile liability environment; they face spiraling costs for malpractice insurance, have difficulties purchasing liability coverage at any price, and see record payouts in a growing number of claims against their colleagues.[1] The American Medical Association (AMA) has declared that at least 20 states are currently in a malpractice "crisis," with another 24 states showing early signs of an impending crisis.[2]

There have been two comparable periods of instability in the last thirty years,[3] but these predecessor crises differ from the current one in important ways. First, while physicians mainly experienced dwindling options for obtaining coverage in the mid-1970s (i.e., availability) and exorbitant prices in the mid-1980s (i.e., affordability), the current crisis appears to have elements of both availability and affordability.[4] Second, in this time of increasing attention to patient safety and medical error, the public is more wary of reform that may protect providers from paying for injurious mistakes.[5] Third, reports show a growing physician discontent with practice.[6] A fourth distinction between the current and previous crises is beginning to receive increasing attention in media reports: some physicians are taking matters into their own hands and mounting aggressive responses in order to reduce malpractice risk and costs.

Traditional physician responses to liability concerns include advocacy and lobbying, relocation to areas with lower liability risk, curtailment of high-risk services, practice closures, and countersuits against frivolous claimants. There appears to be continuing interest among physicians in such responses. However, several novel reactions are stirring controversy; they include practicing without securing adequate malpractice cov-

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erage, conditioning the provision of care on patient waivers of the right to sue, and protesting via organized work stoppages. Depending on one's perspective, characterizations of these newer responses range from creative to overly aggressive. There are questions as to whether these reactions are rational strategies for achieving lower liability exposure and costs. But these responses also raise more fundamental concerns: Are they ethical? Are they acceptable from a public policy perspective?

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A combination of factors – the magnitude of the current liability crisis, a call by many for immediate medical liability reform, and the possible harm to patients' rights – demands a closer examination of some of the emerging physician responses. In this article, we review traditional physician responses briefly, and then move to the more controversial behaviors. We conclude that regardless of whether emerging responses are a rational means for lowering liability costs, they challenge, and perhaps even violate, the ethical obligations physicians owe to their patients and society at large. Consequently, they risk undermining the trust upon which patient-physician relationships are based. Importantly, these behaviors are also likely inefficient from a societal perspective.

Background

The Malpractice System

The medical malpractice system has two primary goals: to compensate injured patients and to deter physicians from careless behavior.[7] Patients who are injured by substandard medical care are entitled to compensation. If this compensation comes from the provider responsible for the error, fear of such penalties deters negligent behavior. Most would agree that two objectives are laudable, but physicians persistently question the ability of the malpractice system to achieve these goals. Notwithstanding evidence regarding the inability of lawsuits to compensate injured patients adequately (only a portion of negligent injury results in a claim),[8] physicians overestimate their risk of being sued and believe that their profession is sued too frequently.[9] The perception of excessive liability risk is perhaps fueled by the imprecision of malpractice suits (a substantial proportion of medical malpractice claims do not appear to have a basis of an injury due to negligence).[10]

Despite this imprecision, the widespread existence of liability insurance has traditionally tempered the economic repercussions of litigation for physicians.[11] Furthermore, when liability insurance costs rose, fee-for-service remuneration historically placed relatively few downward pressures on charges and enabled physicians to adjust fees to minimize any economic impact.[12] Today, reimbursement rates for professional services tend to be tightly controlled through fee schedules or capitation arrangements, hampering physicians' ability to raise charges to accommodate spikes in liability premiums.[13] In addition, even if physicians are able to afford coverage in the current environment, some may not find any offerings. Moreover, the non-economic costs of a suit – time spent in defense, anxiety of being sued, possible harm to reputation, and possible reporting to the National Practitioner Databank – remain significant and exert a psychological toll on physicians.[14] Thus, it is not surprising that physicians continually seek methods to reduce their liability risk.

Traditional Responses

Advocacy and Lobbying

To limit both the monetary and emotional impact of malpractice liability, physicians and the trade associations that represent their interests have long directed significant effort toward advocacy and lobbying.[15] The AMA, which was formed in the mid-1800s during one of the first medical malpractice crises in the United States,[16] has declared malpractice reform its top legislative priority.[17] Organized physician advocacy in this area has the potential to impair indirectly a patient's interest in obtaining compensation for medical injury, which arguably conflicts with physicians' fiduciary duties to patients. Perhaps because the United States government is built on the ability to freely advocate and lobby for change in the law, physician lobbying activity is rarely challenged on ethical grounds. However, if questioned, the response by proponents of reform is predictable: they argue that malpractice reform preserves access to quality and efficient health care; hence, physician lobbying efforts actually promote patient welfare.

The last 3 years have seen many governmental attempts to control the perceived excesses of the malpractice system, moves which echo those made in earlier crises.[18] Popular tort reforms include statutory caps on damages, mandatory arbitration requirements,

heightened qualification requirements for experts, periodic payments for damages, attorney fee limitations, and collateral source offset rules.[19] Recently, most legislative activity has been centered on creating or amending caps for malpractice awards, a reform that is strongly endorsed by organized medicine.[20] Yet none of the lobbying efforts and legislative interventions appear to have stemmed the rapid rise of premiums that marks the current crisis.[21] Accordingly, debate over the ability of advocacy and legislative interventions to achieve long-term stability in the liability environment continues, as do concerns about whether such interventions undermine the malpractice system's goals of compensation and deterrence.[22]

Defensive Medicine

To reduce liability risk, physicians may choose to alter their practice in directions that are clinically unnecessary or inappropriate.[23] This type of response is often labeled "defensive medicine" and may involve assurance-type behaviors (i.e., providing additional tests or care to patients to assure them they have been properly evaluated or treated) or avoidance-type behaviors (i.e., avoiding treatment of patients that may be at higher risk for adverse outcomes, and thus, at higher risk for filing lawsuits).[24] For example, to reduce risks of being sued, a surgeon may stop accepting trauma cases or a family practitioner may stop providing obstetrical care, referring it elsewhere instead. Alternatively, physicians may decide to relocate their practice to another state where the liability environment is more hospitable.

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In the current climate, both assurance and avoidance behaviors are expected responses. Provided that proper informed consent is given for the additional tests and treatments associated with assurance behaviors (and these tests and treatments do not breach the standard of care), and avoidance behaviors do not involve abandonment of patients, physician practicing defensive medicine are likely not violating ethical responsibilities to individual patients. From a population perspective, though, both types of behaviors can bring unwanted consequences. Assurance behavior generates inefficiencies for the health care system. Notwithstanding the fact that they may sometimes entail small marginal benefits to patients, over-ordering and overtreating are costly, and also increase the risk of iatrogenic injury. The cost impact of assurance behaviors has thus been touted as a reason for liability reform in current debates.[25]

Avoidance behavior will have minimal impact on access if it is not widespread and patients continue to have alternative sources of care. However, as in previous crises, numerous reports of doctors limiting services, moving from a high-premium state to a lower-premium state, or quitting practice altogether because of liability costs are readily available.[26] A recent survey of specialist physicians found that nearly two-thirds were either changing their scope of practice or considering a move out of state.[27] Some geographic areas lack physicians or necessary medical services, with liability as the cited reason cited by physicians.[28] To ascertain whether defensive responses have affected access to health care, the General Accounting Office (GAO), now the General Accountability Office, conducted a study in ten states. It reported that in some circumstances, access to specific services might be limited because of malpractice risk – obstetrical services in central Mississippi or on-call orthopedics in Pennsylvania – but that access was already an identified concern in these areas (both of which are rural) prior to the recent volatilities in liability insurance markets. The GAO concluded that, in the states studied, worries of widespread impaired access due to malpractice risk may be overstated, and a clear link between liability risk and access did not exist.[29] The generalizability of these findings was disputed by the AMA, which contended that that access shortages due to avoidance behaviors may still exist.[30] A recent study in Florida concluded that the liability insurance crisis is exerting a detrimental effect on the availability and delivery of health care services in rural areas.[31] Disagreement about the overall effect of the malpractice crisis on access to medical services will likely continue.

Countersuits

When subjected to unreasonable litigation by a patient and/or a patient's attorney, physicians may countersue. The frequency of countersuits is unknown, but it is apparent that physicians are willing to pursue them.[32] Private organizations offer physicians assistance in filing countersuits.[33] In Pennsylvania, the state medical society also provides such assistance.[34] Grounds for countersuits vary and include malicious prosecution (for frivolous suits), abuse of process (for use of the judicial process to coerce unduly), and defamation (for undue harm to reputation).[35]

Importantly, countersuits are not designed to provide compensation for every suit filed against a physician that is ultimately unsuccessful. They require proof that initiation of the suit was unreasonable. To countersue

for malicious prosecution, the underlying claim must first be resolved in the physician's favor.[36] The physician must then demonstrate that the original plaintiff or attorney could not have reasonably believed there existed a good chance of establishing a successful suit to the satisfaction of a court or jury.[37] Claims of abuse of process require a finding that that judicial process was used for the wrong reasons.[38] To illustrate, if an attorney files suit against a physician and a hospital solely for the purpose of securing a settlement and does not first conduct a reasonable investigation, a court may find that an abuse of process has occurred, regardless of the validity of the underlying suit.

Countersuits are legal, but is it ethical for physicians to pursue them? Physicians owe their patients a fiduciary duty to put their patients' interests first, and cannot advance their own interests at the expense of their patients.[39] By countersuing in situations where the patient is abusing the legal process, physicians are not advancing their interests at the expense of their patients, but rather recovering interests that were improperly taken from them. Countersuits brought against clearly vexatious claimants are, thus, not likely to run afoul of physicians' ethical responsibilities. However, the use of countersuits in inappropriate circumstances would be a violation of ethics; for example, using a countersuit, or the threat of one, to deter patients from seeking due recovery would be contrary to ethical obligations (see also waivers of liability section below). Countersuits pursued against attorneys are less likely to raise concerns about physicians acting directly against the interests of patients. But again, if they are used for an illegitimate purpose, such as reducing the number of attorneys willing to take reasonable cases, then they may indirectly violate physicians' ethical responsibilities to their patients.

Even though countersuits provide legitimate and valuable remedies for aggrieved physicians, their use may nonetheless undermine patients' trust in their physicians. Furthermore, countersuits may be inefficient by adding to the administrative costs of the malpractice system and consuming significant opportunity costs. Time and attention spent by physicians in preparation for litigation and in court is time lost from the clinical setting. This lost time may have implications for patient access to care. More broadly, countersuits may also affect quality of care if they disrupt physician ability to focus on their work.

Recent Aggressive Responses

As liability costs continue to increase in the face of traditional responses, physicians have resorted to other strategies to limit their liability exposure and costs. A wide range of responses has drawn much attention and controversy in the press. In one case, a physician recommended that the AMA pass a resolution not to treat plaintiffs' attorneys and their families, except in emergency circumstances.[40] In other instances, physician groups have started actively campaigning for certain political candidates, as opposed to advocating to and directly lobbying elected officials. For example, during a 2004 presidential election rally in Pennsylvania, physicians dressed in their white coats took to the stage with George Bush, who was advocating for malpractice reform.[41] Other physician groups have sought to elect U.S. Senators that support malpractice award caps.[42] In the state of Washington, an organization chose to appeal to the public by placing an advertisement in the newspaper highlighting the exodus of physicians from the state because of liability costs.[43] Many of the newer responses have been either short-lived or raised minimal controversy, but others, which we describe below, appear to have garnered more dedicated physician activity and public interest. In particular, two physician responses – practicing without adequate liability coverage and requesting waivers of the right to sue – have received a heightened level of attention and press and, therefore, are explored in greater detail.

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Going Bare

A physician who "goes bare" has chosen to practice without securing sufficient professional liability insurance coverage. Ostensibly, this equates to choosing to self-insure instead of purchasing commercial insurance. However, self-insurance differs in several important ways. When a physician (or other health care entity) chooses to self-insure, the implication is that the physician has secured enough assets to cover, at a minimum, typical on-going liability and defense costs. This involves setting aside monies on a recurrent basis to guard against the possibility of expensive litigation. Conventional self-insurance also involves the purchase of "stop loss" or umbrella coverage to limit exposure above a certain level. In contrast, the physician who goes bare will generally have some assets (or insurance) available to provide for defense costs and satisfy judgments, but above this level of assets (or coverage), the physician will not have any assets or umbrella coverage available to satisfy unanticipated judgments.

Going bare is not an unprecedented physician response, nor is it a practice limited to the medical profession.[44] A number of practicing lawyers are thought to be underinsured,[45] and occasionally, companies, due to soaring product liability costs, have opted to do without insurance coverage.[46] During the malpractice crises of the 1970s and 1980s, there was increased interest in this strategy in medicine.[47] However, practicing without liability insurance today is not an option for all physicians. Some states require physicians to obtain malpractice coverage as a precondition to medical practice.[48] Many hospitals and health plans also require contracted staff to carry sufficient malpractice insurance coverage.

Despite practicing in an era of rising jury verdicts, physicians who are able to go bare may elect to do so for rational and legitimate reasons. They may have no choice but to go bare if all available insurers refuse to provide coverage.[49] In a more common scenario, coverage options may be available but at so exorbitant a price that acquisition would either eliminate all profits from medical practice or reduce them sufficiently to make continuing practice an unreasonable option. Forgoing malpractice coverage and prohibitive premium expenses may thus be needed to maintain a practice's viability. In lieu of paying the premiums associated with full coverage, physicians going bare may either purchase minimal insurance and/or set aside a reasonable amount of assets to cover defense and liability costs. Others may opt to borrow funds when and if the need arises. Of course, there is the risk that a plaintiff may secure a judgment for more assets than the physician has allocated or can obtain; in the context of reasonable planning, this situation is analogous to a plaintiff securing a larger judgment than insurance policy limits. The lower the amount of assets or insurance coverage a physician has available, the higher the risk of overruns. Thus, physicians who go bare may be at significant risk of overruns and losing personal assets. However, the strategy of going bare itself may help to curtail the risks of large payouts.

Some assert that the availability of assets (deep pockets of the insurance companies) and the relative ease with which they are available have driven the increasing number of lawsuits and sizes of verdicts. By removing high insurance limits from the equation, settlement negotiations may be conducted at reasonable dollar amounts, commensurate with the value of the assets available.[50] This viewpoint is not without some empirical justification. There is some evidence that plaintiffs and payouts in civil litigation are sensitive to both perceptions and realities about the defendant's wealth.[51] The risk of overruns can be further minimized by utilizing homestead protection laws that permit some or all of the assets that are part of a primary residence to be protected from creditors.[52] Other methods, such as creating life insurance trusts, offshore trusts, and signing over one's assets to a spouse can provide similar protections from creditors.[53] Of note, the transfer of assets within a protection strategy must be carefully planned; if an asset transfer is judged to hinder or defraud creditors or potential creditors, it can be deemed a fraudulent transfer and ineligible for protection.[54]

Hence, three factors appear to make forgoing insurance, or underinsuring, a tenable and alluring strategy: high or rapidly escalating liability premiums; the absence of statutory or other requirements that physicians carry sufficient liability coverage; and laws that permit divestment and asset protection. Florida is a jurisdiction that fits this description. Soaring practice premiums have incentivized physicians to find ways to lower or avoid needing coverage. The AMA has declared Florida a malpractice crisis state and for some physicians, premiums rose 25-40% in 2003.[55] Favorable Florida bankruptcy laws permit effective asset protection and the state does not mandate that practitioners carry liability insurance coverage beyond $250,000 per claim and $750,000 per year.[56] Physicians can bypass insurance requirements by placing $250,000 in an escrow account (or obtaining a letter of credit for that amount) and posting a sign informing their patients that they do not maintain malpractice coverage.[57] The result is quite striking. It is reported that approximately 5% of physicians in Florida go bare, a proportion that has increased dramatically in recent years; in South Florida, approximately 30% to 40% of physicians reportedly go bare.[58] The Florida legislature is considering enacting laws that would increase the escrow or letter of credit requirement for physicians going bare to $750,000, but is meeting opposition.[59]

Patient advocates and trial attorneys argue that practicing without adequate insurance vitiates one of the cornerstones of the malpractice system – ensuring a reliable pool of resources to compensate patients who sustain negligent injury. Proponents of going bare may counter that it is permissible to limit compensation because access to medical care may otherwise be impaired due to the malpractice crisis. Although such limitations may feel unfair to injured plaintiffs, the law has recognized that competing interests may sometimes justify limiting patient compensation. For example, damages caps to keep insurance premiums affordable and limit unreasonable verdicts, charitable immunity to foster care for the poor, and a statute of limitations to bound litigation windows and protect the evidentiary process are all regular features of tort litigation. But there is an important distinction between these types of limitations on compensation and going bare: the decision to

limit compensation in these situations is either judicial or legislative, not a private one made at the level of the individual physician. Opponents of going bare thus argue that the focus of inquiry must remain on the rights and duties that stem from the patient-physician relationship.

Because the fiduciary duty that physicians owe their patients is not created until the patient-physician relationship has been established, physician responsibilities to potential and current patients differ.[60] From a legal point of view, the formation of the patient-physician relationship is quasi-contractual in nature – the physician must agree to render care and the patient must accept the physician's terms.[61] When a physician opts to go bare, terms offered to a potential patient would include acceptance of limited physician liability. Historically, courts have been reluctant to enforce complete liability waiver agreements in the health care context (see waivers section below). Some physicians that go bare may functionally be seeking a complete waiver, but it is very likely that many are seeking to limit liability to a certain level – the amount of assets set aside or insurance coverage purchased. Agreements that limit liability must be explicit and the party accepting the limitation must be (or reasonably expected to be) aware of it. In practice, patients establishing care with a physician rarely ask how much compensation is available in the case of malpractice. To expect such an inquiry would place an additional burden on patients at an inopportune time.

Even if a physician makes going bare an unambiguous and explicit condition for treatment, in order for an agreement limiting liability to be valid, bargaining between parties must not be so unfair that it rises to the level of unconscionability or essentially puts one party at the mercy of other's negligence.[62] Notwithstanding circumstances in which patients would be able to bargain (e.g., a healthy patient seeking to establish care with a physician), patients frequently are effectively unable to negotiate because of the need of urgent, local, or specialized care. Moreover, physicians have often asserted that their profession is one with special talent and skills.[63] For example, a patient referred to a neurosurgeon for evaluation of a possible brain tumor may have a difficult time negotiating liability limits because the physician could simply refuse to provide care. Finding another neurosurgeon may not be feasible due to the possible delay in treatment associated with such a search. Even if care were elective, the neurosurgeon may be the only one available in a local market. Thus, expecting patients to bargain over liability terms might be unrealistic, if not unreasonable, in many instances. Interestingly, even though the existence of such unequal bargaining power argues against permitting physicians to go bare with new patients, bankruptcy and asset protection laws may still permit physicians to successfully go bare. Consequently, the legal and ethical considerations are not the same. Physicians may go bare within the bounds of the law but may still violate ethical standards if they exploit a bargaining superiority in doing so.

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When a physician with an established panel of patients opts to practice while underinsured, the analysis is slightly different. The physician in this case is choosing to modify the terms of the patient-physician relationship after it has already started. From this viewpoint, going bare may be both legally and ethically impermissible. Nevertheless, there is another possible justification for permitting a physician to go bare with established patients – preserving continuity of care. If the dilemma confronting the physician is to go bare or to dissolve the practice, the advantages for patients in maintaining the established care relationship may outweigh the possible threat to adequate compensation in the event of an injury. The above calculus hinges on an understanding of the physician's "true" motivation in going bare, which will be very difficult to determine from the outside.

Intentional underinsurance can also create other undesirable results. Patients receiving care from underinsured physicians have sought to seek compensation for injury expending resources to reach protected assets.[64] They may claim that they did not know the physician was bare or that even if they knew, effective bargaining was not possible. This hunt for compensation creates greater inefficiencies in the administration of the malpractice system and likely furthers physician apprehension surrounding liability. In addition, if physicians

are successful in going bare, a greater number of patients negligently injured may not be able to secure adequate compensation.

Right to Sue Waivers

To lower liability exposure, some physicians have asked patients to sign agreements that seek to bind the patients: to submit all claims to mandatory arbitration, not to sue for frivolous claims, or to waive the right to sue for claims of negligence.[65] These agreements, implicitly or explicitly, condition the provision of medical care on a patient's waiver of the right to a civil trial. They differ by making available varying degrees of recourse in the event of injury and, thus, carry different policy and ethical implications.

Mandatory arbitration agreements aim to reduce litigation costs and speed resolution of disputes while still providing an impartial judgment.[66] They offer injured patients the ability to seek compensation, but change the means or process by which to obtain it. Partly because they still offer a remedy, these types of agreements have been ruled constitutionally permissible in many contexts, provided that traditional contract principles are not violated.[67] Opponents of mandatory arbitration agreements in health care argue that most consumers are not sufficiently empowered to reject arbitration agreements. In the office setting, when individual physicians offer arbitration agreements as a condition for care, patients in need of treatment may not have the ability to bargain or find another physician. Also, when the agreement is made as part of an employer-sponsored health plan, consumers may not be able to make an informed choice. A binding arbitration clause may state: "By enrolling in this plan, you are agreeing to have certain disputes decided by neutral binding arbitration. Both the health plan and health plan members waive their right to a jury or court trial for these disputes."[68] The disclosure is clear, as required by state law, but some enrollees may not appreciate the implications of this clause. What types of disputes will be subject to arbitration, and on what conditions can arbitration judgments be appealed? Furthermore, if an employer offers only one plan, enrollees will be forced to choose this one or opt for very costly health care on their own.

These patient concerns can be outweighed by the societal goals of administrative efficiency furthered by alternate dispute resolution methods. Agreements mandating the arbitration of health care injury have thus received legislative sanction in some states, such as California and New York.[69] Courts have affirmed the validity of mandatory arbitration agreements – whether executed by a physician and patient at the site of care or as part of an agreement negotiated between an employer and health insurer.[70]

In *Buraczynski v. Eyring,* a consolidated appeal of two cases with essentially identical arbitration agreements, one of the plaintiffs had received a total knee replacement from her physician.[71] Approximately two months later, as a condition for continued treatment, her physician asked her to sign a retroactive mandatory arbitration agreement that covered the knee surgery. The plaintiff subsequently developed difficulty with her new joint, required re-operation, and sued for negligence. The defendant filed a motion to compel arbitration. The Tennessee Supreme Court found that the arbitration agreements in this case were contracts of adhesion but did not rise to the level of unconscionability, and were thus valid. The court first reviewed prior cases in which arbitration agreements had been held invalid and found that courts may be reluctant to enforce such agreements when: they are presented in such a manner that patients do not have the opportunity to question their terms or purpose (for example, when presented within a clinic admission form); the arbitration process provides a health plan with an unfair advantage, such as giving it the right to unilaterally reject an arbitrator's decision or require a patient to pay one-half the costs of arbitrators; or the agreement unfairly limits a patient's choice of arbitrators.[72] In the case at hand, the mandatory arbitration contracts were found to do none of these things. They were presented clearly and as a separate document, provided for a fair procedure for selection of arbitrators, contained a 30-day clause in which a patient could revoke the agreement, did not limit liability, and did not alter the physician's duty to provide non-negligent care.

In *Engalla v. Permanente Medical Group,* a plaintiff sued the Permanente Medical Group and the Kaiser Foundation Health Plan (Kaiser) for a failure to diagnose lung cancer in a timely fashion.[73] On appeal, the California Supreme Court addressed the validity of the mandatory arbitration contracts widely used by the

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health plan. In contracting with the plan to provide insurance to its employees, Mr. Engalla's employer, a tire company, had agreed to the provision. The court recognized that the company probably did not have sufficient bargaining power with Kaiser to alter the terms of the contract that contained a mandatory arbitration clause. Mr. Engalla also had limited choice; his employer had made only one other health plan available. Nevertheless, the court held that the system of arbitration set up by the contract, which included the appointment of a neutral arbitrator, "did not lack minimum levels of integrity." The court thus found that even though the agreement did have some attributes of adhesion, it was nonetheless valid, and was not unconscionable on its face. The court went on to state, though, that otherwise valid arbitration agreements can still be declared unenforceable if manipulations in the arbitration process occur (which, it was determined, had in fact occurred in *Engalla*).

The above cases demonstrate that even though mandatory arbitration agreements that seek to intervene in medical malpractice litigation have received explicit judicial and legislative sanction, courts will still scrutinize them to ensure that they are equitably employed. Moreover, the legal permissibility of these clauses does not remove a physician's ethical obligation not to take advantage of a patient's limited bargaining power, which may stem from lesser knowledge or constraints on alternatives sources of care. Therefore, the ethical concerns here are similar to those that apply when physicians go bare. However, one important difference exists if an ethical violation occurs. If a physician engages in unfair bargaining and goes bare, the physician may still receive liability protection due to bankruptcy or asset protection laws. In contrast, physicians using mandatory arbitration agreements cannot perform this type of an end run around contractual obligations. If a mandatory arbitration agreement is held invalid for any reason (including unfair bargaining), the physician can then be taken to court for a negligence claim.

Instead of pressing mandatory arbitration agreements, some physicians have simply conditioned treatment on waiving the right to sue. In these situations, the patient is explicitly asked to give up the right to bring a frivolous suit or to completely relinquish recovery rights for negligent acts.[74] Use of these waiver agreements appear to offer few, if any, legitimate benefits to physicians. Even though the initiation of frivolous suits is already actionable, violation of a waiver agreement not to bring a frivolous suit could theoretically create an additional claim for breach of contract. However, evidentiary standards for these two types of claims are not likely to be dramatically different, as both claims will likely require a showing that the original suit was frivolous. In addition, even though complete waivers of liability may pass constitutional muster,[75] they face a large challenge in the context of health care delivery. Because a potentially essential service (medical treatment) is involved and unequal bargaining power can exist, complete waivers of the right to sue for negligent care have traditionally and consistently been struck down by the courts.[76] Today, because many patients theoretically have a greater choice of physicians (and greater access to information about their physicians),[77] it is possible that a complete waiver could be upheld by a courts, but realistically, the chances are slim.

Due to the small incremental benefit that these waiver agreements probably provide, their use by physicians may suggest unethical motives. Physicians could use their superior bargaining position to negotiate away exposure to liability for negligent care, removing physician accountability and leaving patients without compensation. Furthermore, waivers may erode the trust in the patient-physician relationship. In addition, patients may misinterpret the frivolous suit waiver agreements as complete waivers to suit and/or may mistakenly believe that complete waivers are enforceable. The high potential for misuse of these waivers, coupled with the chance of patient misperception of their enforceability, argues against the use of liability waivers.

From a policy perspective, liability waivers fail to advance the malpractice goals of compensation of negligently injured patients and deterrence of unreasonable harm. Waivers do not help correct for the fact that more patients are injured by negligent care than file claims (compensation) nor do they further public accountability or promote quality of care (deterrence); indeed, by insulating physicians from liability, they may actually worsen the performance of the system in both regards. As with going bare and mandatory arbitration agreements, litigation over the validity of liability waiver agreements is inevitable and will increase the administrative costs of the malpractice system.

Protests and Walk Outs

Protests and work stoppages, like those recently conducted in New Jersey,[78] Pennsylvania,[79] and West Virginia,[80] have received significant public attention. During these protests, physicians have called for malpractice reform with the hope of effecting quick, if not immediate, change. Collective physician activity is not new; physicians in other parts of the world have gone on strike over terms of employment.[81] Due to the importance of medical treatment to patients, strikes arguably breach the ethical requirement that physicians put patients' interests first. On the other hand, precisely because physicians provide such an essential

skilled service, it is argued that they also bear responsibility for ensuring that their work environment (or other obstacles) does not obstruct their capacity to provide this service. The ethics of physician strikes and walkouts continues to be debated along these lines.[82]

An important distinction can be drawn between strikes for wages and working conditions and the protests over malpractice liability in the United States. Protesters may argue that their actions are not necessarily (or only) directed at improving physician income or benefits but rather at correcting a malpractice system that is failing patients and physicians. Critics may counter that the protests are a pretext or veil for increasing profits, but that argument tends to ignore the fact that they may well have the opposite effect on income given that protesting takes time of out of practice and runs the risk of alienating the public. Perhaps the most telling aspect of the controversy surrounding this practice is that medical societies disagree on the ethics of protests and strikes over liability reform.[83]

Amid work stoppages in their respective states, the medical societies of New Jersey and Illinois appeared to reach opposite conclusions on the ethics of the work stoppages. The New Jersey Medical Society was instrumental in organizing the work stoppage in its state.[84] In Illinois, the state medical society stated that it would not stop an organized protest, but that it was against the action in principle.[85] The AMA Code of Ethics recognizes that although collective activity may violate ethical responsibilities to patients, it may be permissible in rare circumstances.[86] For example, collective action may be appropriate as a means of calling attention to needed changes in patient care. The varying positions on the ethics of work stoppages by the medical societies demonstrates the difficulty of determining both their ultimate effect on patient interests and the motivations behind them.

From a public perspective, prolonged physician protests may prevent patients from getting care from their usual physician for both ongoing and urgent needs. Patients may thus be forced to seek their care from an emergency department (assuming that emergency physicians are not also protesting), which could lead to emergency department crowding. In the short run, unavailability of office-based physicians and the increased patient volume in the emergency departments may impair access to care for patients. If emergency department physicians were to join in a work stoppage, patient may lose access to essential care at times of critical need. On the other hand, work stoppages appear to have catalyzed legislative action in some states. Shortly after a protest in Nevada, lawmakers passed malpractice legislation creating damages caps.[87] In New Jersey, a cap for which physicians had lobbied hard was not passed, although a state fund to subsidize malpractice premiums was.[88] However, as previously noted, the long-term effects of tort reform on patient access and liability premiums remains unknown. In sum, protests lead to short term inefficiencies, with potentially adverse consequences on the continuity and quality of care for patients.

Targeting Expert Witnesses

A number of tort reform packages over the years have included provisions that raise the standards required of physicians who testify as expert witnesses.[89] In a recent twist on activities in this area, some physicians and organizations are now seeking redress against experts that testify falsely.[90] For example, the American Association of Neurological Surgeons has created a professional conduct review board that examines expert testimony given by its members. The board strips physicians of society membership if they violate the society's ethical standards when providing expert testimony. Such action has withstood a legal challenge, with an appellate judge commenting: "[T]his kind of professional self-regulation rather furthers than impedes the cause of justice. By becoming a member of the prestigious American Association of Neurological Surgeons, a fact he did not neglect to mention in his testimony in the malpractice suit against [the physician], the [expert] boosted his credibility as an expert witness. The Association had an interest – the community at large had an interest – in [the expert's] not being able to use his membership to dazzle judges and juries and deflect the close and skeptical scrutiny that shoddy testimony deserves."[91]

In a similar vein, some organizations offer to take legal action on behalf of sued physicians against expert witnesses who have delivered false testimony.[92] For example, an organization offers countersuit assistance for frivolous suits and will also help seek disciplinary action against "unscrupulous" experts.[93] Support is offered by lodging formal complaints against experts to the appropriate medical society, state licensing board, hospital credentialing committee, or even criminal courts of law. The Pennsylvania Medical Society has determined that testimony in medical liability actions must be in accordance with acceptable standards of medical practice.[94] For cases that are particularly egregious, the society will encourage the medical boards to take appropriate action against the hired expert.

From an ethical perspective, the arguments are similar to those that attend countersuits. Circumstances matter. Just as it is permissible for physicians to seek redress for patent misuse of the legal system against them, initiatives that seek to restrict false testimony are ethically acceptable, even laudable. However, injudicious

constraint of expert testimony, including intimidatation of expert witnesses who are qualified and testifying in good faith would not be ethical, nor would efforts to reduce the pool of available experts.

From a policy perspective, even though higher standards may reduce the number of frivolous suits and improve the reliability of expert testimony, the impact of a potential reduction of experts available for a plaintiff should not be underestimated. Plaintiff's attorneys already claim that finding a physician expert to testify against another physician is extremely difficult.[95] The danger of further shrinking the supply exists, regardless of method chosen to elevate the standards of expert testimony, if prospective experts decide that the cost and risks of testifying are simply not worth it. If the resulting by-product is to shrink the pool of legitimate experts to the extent that meritorious and needy plaintiffs cannot bring forth claims, the problem of undercompensation in the malpractice system will worsen.

Surcharges also raise ethical concerns. Patient-physician relations may be strained by the perceived or real lack of choice some patients will have when asked to pay this surcharge.

Surcharges

Another physician practice that has surfaced is levying surcharges on patients to cover rising malpractice premiums.[96] Physician rationale for surcharges is straightforward: if tightly regulated fees or capitation make it difficult to meet the costs of rising premiums, it is reasonable to pass these costs directly on to patients. Although the surcharge can be mandatory in some instances, it is often voluntary, because federal regulations stipulate that patients covered by Medicare cannot be required to pay extra fees for their care.[97] Provider surcharges may also violate health plan contracts that prohibit the collection of additional fees for covered services.

Critics of surcharges raise concerns about hampering access to care by raising out of pocket patient expenses (even though the surcharge may be small).[98] Moreover, the degree to which the surcharges are genuinely "voluntary" may be questionable, given the inherent asymmetry in bargaining power between patients and physicians. The California Medical Association has opined that this practice is legal and recommends notification prior to rendering services.[99] The AMA is studying the practice and planning to issue guidelines.[100]

Surcharges also raise ethical concerns. Patient-physician relations may be strained by the perceived or real lack of choice some patients will have when asked to pay this surcharge. The motive of some physicians for adding surcharges may not be recovery of liability premium expenditures but rather to raise attention to malpractice issues, and this arguably comes at the expense of patient interests. There also exists the potential of gaming as many questions surrounding this new practice remain unanswered. If these surcharges are being collected to cover malpractice insurance premiums, should they be set aside from general operating revenue and earmarked solely for premium payments? What should be done if physicians collect more in surcharges than the cost of premiums? Because the collection of surcharges can serve many physician motivations at once, it may create ethical questions when employed, and may further undermine the trust on which the patient-physician relationship is based. At this point, it is difficult to determine whether surcharges are an appropriate response by physicians to their perceived malpractice woes. What is clear is that they will add to patient health care expenses without directly addressing the key problems of undercompensation and imprecision in the current malpractice system.

Plaintiff Database

One of the more sensational physician responses in the current crisis was the creation of a subscription database designed to track patients that had filed suit against a physician.[101] The stated purpose for compiling and circulating this information was to allow physicians to identify patients who repeatedly brought unsubstantiated claims against their physicians. Regardless of the database's possible legitimate use, potential abuse of the database frightened many and caused uproar. Concern arose about the prospect that physicians may blacklist or refuse patients who had filed suits, regardless of their legitimacy, and what effect the database would have on patient's ability to seek compensation and medical care after bringing a malpractice claim.

We will not learn the actual use and impact of this database. Public outcry quickly led to its shutdown.[102] Despite its demise, this database further demonstrates potential downstream effects that newer and more aggressive physician responses can have. Had the database continued, subscription to it would have raised questions regarding physician motivation in using it. Subscription could have been seen as a method to ensure that fewer patients would sue for malpractice. Such a perception could have caused patients to question the ethical behavior of their physicians. From a societal view, subscribing physicians would have been investing

time and resources on screening patients for their litigation history, rather than on providing high quality care. In addition, no matter how legitimate the purpose of the database, the mere possibility of becoming blacklisted could have theoretically exerted a tremendous chilling effect on patient decisions about whether to seek compensation for negligent injury, thereby feeding the undercompensation problem.

Conclusion

Physicians work today in the midst of a malpractice crisis of rising insurance premiums and insurance availability of coverage. Physicians' reactions to this crisis demonstrate the extreme nature of feelings provoked. Many physicians and physician groups continue to advocate and lobby legislatures for reforms that will lower liability exposure. Some have availed themselves of legal remedies via countersuits; others have opted for defensive measures that include curtailing, relocating, or leaving practice. Novel and more aggressive measures are cropping up and raising controversy. These newer measures seem to be rationally related to physicians' goals of reducing liability expense and exposure. Physician behavior, however, must also meet ethical and fiduciary standards. When treating patients, physicians should place patient interests ahead of their own. Physicians also have an ethical responsibility to ensure access to quality care. However, ethical principles do not, in general, mandate that physicians continue to practice to the point of financial or psychological ruin.

When evaluating newer aggressive responses from an ethical perspective, the question thus becomes one of balancing competing interests. One view of these novel responses is that they ensure greater stability in provider services, thereby bolstering or improving access to care that is high in quality and affordable. Another view is that the means do not justify the ends because the cost to patients, in terms of obstructing access to compensation and introducing adversarialism into the patient-physician relationship, is too great. Sharper versions of this opposing view are that the physician activism at issue is motivated by selfish goals, such as income maximization. Due to the difficulty in determining which interests are actually advanced, whether many of these activities violate ethical standards remains subject to reasonable disagreement. What is clear, though, is that the use of these measures is causing the public to question the ethics of physician behavior and potentially undermining the trust placed in the profession.

These measures share another common theme: even if they reduce the costs of high premiums, they may generate a variety of additional costs and inefficiencies. Some novel responses, such as surcharges, may directly raise the cost of health care for patients. Disputes contesting the validity of suit waivers, or attempts to reach the protected assets of "bare" physicians, will generate additional litigation expense. Protests and litigation for countersuits may cause the loss of physician clinical time. Such costs may be acceptable from a societal perspective, if they sufficiently advance the core malpractice goals of compensation and deterrence or improve access to quality care. However, many of these activities may actually threaten the goals of the malpractice system and there exists no evidence or clear indication that these activities improve the public's access to quality medical care.

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