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PERSPECTIVE

Who Is **Supervising** The **Supervisors**?

Tort reform is unsafe.

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NURSE PRACTITIONERS and midwives can "treat" patients only if they have physician supervision.[1] The media has recently reported a "turf war" dispute between physicians and these non-physician health care providers. One non-physician maintained doctors do not like having to compete for the business.[2]

The Medical Society of the State of New York (MSSNY) has supported the position of physician organizations such as the American Congress of Obstetricians and Gynecologists (ACOG) in opposing legislation that would allow these non-physicians to practice without written agreements requiring supervision because, physicians maintain, such autonomous unsupervised care would be unsafe for patients.[3]

Dr. Leah S. McCormack, current president of MSSNY, in opposing such non-physician autonomy said that "it's a question of patient health and safety,…[they] should have gone to medical school and then residency" if they "wanted to practice medicine."[4]

Nurse practitioners maintain they want only their "piece of the health care pie" and that "any illness that requires a specialist… is immediately referred to one." Dr. McCormack replies that "they don't know what they don't know."[5]

A discussion of these "turf war" disputes from the patient's perspective should include an understanding of how tort reform influences patient safety. The Institute of Medicine (I.O.M.), in its landmark report, stated that designing a better system does not mean that individuals can be careless and that "people still must be vigilant and held responsible for their actions."[6] Further, the report states that "unsafe care is one of the prices we pay for not having organized systems of care with clear lines of accountability."[7]

The premise of this article is that tort reform advocates seek changes that will produce partial or even complete liability immunity. Immunity erodes accountability and is therefore unsafe.

MSSNY has supported broad-based tort reform initiates on behalf of its physician members and supported ACOG's program for complete immunity from claims made against its obstetrical members by brain injured children.[8] ACOG continues to urge a no-fault system because allegedly a brain injury occurring while the fetal patient is being monitored in the hospital is rare and not preventible.[9]

Yet, ACOG opposes home births managed by midwives because "the hospital setting is the safest place to have a baby" and "home birth midwives are not accountable to the public."[10] Midwives in support of autonomy contend that written physician supervision agreements don't create or provide real supervision as supervision is "nowhere in current law." Midwives add that opposition to home births is "…a fear-based position not

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supported by data" because "…home birth is safe with the proper candidate." One midwife stated that even without a written agreement, she will continue to consult with physicians and refer tough cases to them.[11]

Midwives assure us they can safely do home deliveries "with the proper candidate." Midwives and nurse practitioners assure us that their practice of medicine without physician supervision will be safe because they will immediately refer when indicated. Dr. McCormack's pointful comment is that they "don't know what they don't know" because they have not had equivalent years of physician training.[12] Meaningful supervision exists only if the supervision makes care safer. If current midwife supervision agreements have no true function, as midwives contend, then midwives and the obstetricians who have agreed to supervise them have been engaged in a charade.

Home birth unequivocally is unsafe. Midwives are unequivocally wrong that they can safely choose the proper candidate. Even if midwives always would identify the "proper candidate," a complication still can arise during the birth process requiring physician and hospital response.

Equally wrong are ACOG endorsed claims that monitoring the fetal patient in the hospital cannot influence the outcome. Thus, ACOG correctly is on the side of their patient for safer care in the context of a "turf war," but opposed to the right of their fetal patient to sue for preventable brain injuries.

Patient safety has been defined as the prevention of health care errors, and the elimination or mitigation of patient injury caused by errors. A healthcare error has been defined as an unintended outcome caused by a defect in the delivery of care to a patient.[13]

Immunity is unsafe because it erodes accountability. Patient-safety discussions degenerate into lip-service if patients do not have an unfettered right to sue when malpractice occurs.

Troubling Positions

The inconsistency between the pro-safety positions taken by Dr. McCormack, supporting for example, the idea that unsupervised home deliveries are unsafe (which they are) and the anti-safety position MSSNY takes in supporting ACOG's quest for immunity when in fact, contrary to ACOG's claim, proper in hospital care unequivocally can prevent catastrophic harm to mother and baby, is particularly troubling.[14]

Methods used by the American Society of Anesthesiology (ASA) to dramatically improve patient safety and lower liability costs have not been used by ACOG.[15]

In resisting autonomy for non-physicians, Dr. McCormack asks "why are they so bound and possessed, so adamant to get the right to practice independently? Is it really so onerous to have a physician checking on them? I would think they would want that."[16]

One of the goals of physicians is to engage in effective peer review activities to avoid oppressive regulation and to allow physicians to maintain control over the standards of their own profession.[17] Yet prominent physicians have noted that with regard to medical error and its prevention, the profession has, with rare exceptions, adopted an ostrichlike attitude.[18]

If good doctors speaking through their general medical organizations like MSSNY and specialty organizations like ACOG would embrace the idea that all of their patients should have full access to attorneys, who would pursue meritorious cases, that would promote the idea that doctors accept accountability even from unpleasant liability cases. This would be consistent with their ethical mandates and would prove that doctors can be trusted to promote patient safety. That would truly be a win-win scenario in which injured patients have full appropriate redress and the medical profession would use the information from each case as an important part of the process to make future care safer.

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The ethics of the medical profession require physicians to "participate in the process of self-regulation" including reporting colleagues who they know are impaired or incompetent to practice medicine. Yet a recent survey revealed that one-third of physicians disagreed that reporting should be their obligation, and a significant percentage of physicians did not report incompetence or impairment of colleagues despite personal knowledge that such existed.[19]

What does this survey tell us about patient safety, when the ethics of the profession also mandates that physicians objectively evaluate their own practice and then mandates a truthful disclosure to their patients regardless of the legal consequences?[20]

Who is supervising the supervisors? Can we trust physicians as a group to have their own autonomy so they can decide what is safe for their patients? A malpractice crisis is something terrible happening to a patient, not to the physician/health care provider who could have prevented the crisis. When MSSNY and physician specialty organizations like ACOG abandon tort reform efforts and fully accept the accountability that comes with their patients' unfettered rights, that will signal a giant patient safety breakthrough.[21]

1. Education Law §6542 and §6951.
2. Delthia Ricks, "Medical Melee: Bill Would Allow Nurse Practitioners to Practice on Their Own; Doctors Object," Newsday, June 13, 2010; Claude Solnik, "Midwives See More Autonomy, Docs Push Back, Claiming Patients Would Be Put At Risk," Long Island Business News, June 18-24, 2010; Delthia Ricks, "Independence Bill For N.Y. Midwives," Newsday, July 2, 2010.
3. Solnik, supra note 2; Ricks, supra note 2, Newsday, July 2.
4. Ricks, supra note 2, Newsday, June 13.
5. Id.
6. Inst. Of Med., "To Err Is Human: Building a Safer Health System" (Linda Kohn, et. al., Eds. 2000) at p. 5.
7. Id., at 3-5.
8. See: MSSNY, Submissions to the New York State Medical Malpractice Liability Task Force (Oct. 16, 2007 and Dec. 19, 2007) (on file with the author).
9. Richard L. Berkowitz, et. al., "A Proposed Model For Managing Cases of Neurologically Impaired Infants," 113 Obstetrics and Gynecology 683 (2009) and Alastair Mac Lennon, et al., "Who will Deliver our Grandchildren? Implications of Cerebral Palsy Litigation," 294 JAMA 1688 (2005).
10. ACOG Press Statement on Midwifery Bill, July 1, 2010.
11. "Midwives See More Autonomy;" "Independence Bill For N.Y. Midwives," supra note 2.
12. "Medical Melee," supra note 2.
13. Definitions Approved by the National Patient Safety Foundation (NPSF) Board, July 2003.
14. See Robert Conason and Steven E. Pegalis, "Perspective: Avoidable Brain Damage and Medical Liability," New York Law Journal, April 22, 2009.
15. Id.
16. "Medical Melee," supra note 2.
17. Ronald L. Goldman, "The Reliability of Peer Assessments of Quality of Care," 267 JAMA 958, 958-60 (1992).
18. David Blumenthal, "Making Medical Errors Into 'Medical Treasures,'" 272 JAMA 1867, 1867-68 and n. 23.
19. C. Desroches, "Physicians' Perceptions, Preparedness For Reporting, and Experiences Related to Impaired and Incompetent Colleagues," JAMA, 2010; 304(2): 187-193.
20. AMA Code of Med. Ethics: Patient Information, at E-8.12
21. See Steven E. Pegalis, "A Proposal to Use Common Ground that Exists Between the Medical and Legal Professions to Promote a Culture of Safety," New York Law School Law Review, Vol. 51 - 2006/2007.