

Bioethics Notes



a newsletter from the Bioethics Review & Advisory Committee

March, 2004

"Good is good, and that is the end of the matter."

George Edward Moore, Principia Ethica, 1903

Consult Services

We would like to remind you that the Bioethics Review and Advisory Committee in Danville provides ethics consultation services. We have an alphanumeric pager (2229). Anyone can request an ethics consultation. Page directly by phone, or leave a text message using the Infoweb Phone Directory. Enter "2229" in the Directory Search and then click on the "Quick Page" button.

Bioethics Committee

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Case Study

In association with the forthcoming Bioethics Conference on the Ethical Implications of the Medical Liability Crisis on March 12, 2004, the following overview is offered.

Tillinghast-Towers Perrin's "U.S. Tort Costs: 2003 Update" found that since 1975, (the first year that insured medical malpractice costs were separately identified), medical malpractice has risen at 11.9% annually versus 9.3% for all other tort costs. In other words, medical malpractice costs have increased by a factor of 21 since 1975 versus a factor of 11 for all other torts. Direct costs of medical malpractice were \$85 per U.S. citizen in 2002 versus \$5 in 1975 (\$17 in 2002 dollars).

The Congressional Budget Office report of January 2004 on "Limiting Tort Liability for Medical Malpractice" found that average premiums for all physicians rose by 15% between 2000 and 2002, with greater increases for obstetricians and surgeons. Average claim payment likewise rose from \$95k in 1986 to \$320k in 2002 (annual growth rate 8%). Between 1996 and 2002, the median medical malpractice jury award in Pennsylvania was \$840k. The following table describes the allocation of these tort costs:

Cost	Percentage
Claimant attorney fees	19%
Awards for non-economic loss	24%
Awards for economic loss	22%
Defense costs	14%
Administration	21%

The American Medical Association now identifies 19 states where medical liability has reached crisis proportions, including Pennsylvania. The above and additional data may be accessed [here](#). Specifics of malpractice law in Pennsylvania can be reviewed [here](#).

Many observers have commented on approaches to address the medical malpractice insurance crisis, including the [National Governors Association Center for Best Practices](#). The Geisinger Health Systems has developed a [position paper](#).

However, it is not our intent to review the legal and economic issues relevant to the medical malpractice crisis, but rather to focus on ethical issues. Generally, moral theories may be considered as (a) consequentialist or (b) non-consequentialist depending upon whether actions, persons or motives are morally judged according to (a) the nature of results or consequences or (b) by conformity to moral rules. Egoism and utilitarianism are examples of consequentialist moral theories. Natural law and respect for persons are

Events

6th Annual Bioethics Conference

Friday, March 12, 2004
Susquehanna University

"Ethical Implications of the Medical
Liability Crisis"

7th Annual Palliative Medicine Conference

Thursday, March 18, 2004
Bucknell University

"Issues Discussed and Issues Never
Discussed"

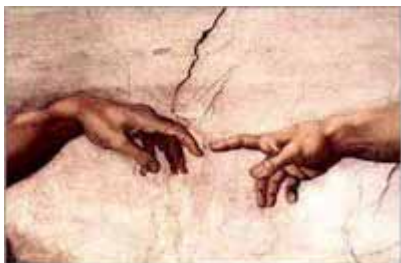
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examples of non-consequentialist moral theories.

A biomedical ethics derived from Aristotelian notions of virtue aims to minimize cultural and religious biases. The four principles include: respect for autonomy, nonmaleficence, beneficence and justice.

Three social goals of malpractice have been delineated: to deter unsafe practices, to compensate persons injured through negligence, and to exact corrective justice. (Studdert DM et al Medical malpractice [N Engl J Med 350:283, 2004](#)). Thus, both medical practice and the tort system are based upon the principle of "not doing harm" to patients. However, the tort system, unlike administrative remediation of injury or the patient safety system, is punitive, individualistic and adversarial, being dependent on a finding of negligence. It is thus paradoxical that the only statistically significant predictor of payout to plaintiffs has been found to be the degree of disability, not the presence of negligence (Brennan TA et al [N Engl J Med 335:1963,1996](#)).

In the absence of these other developed mechanisms, tort law has been the primary mechanism in a capitalistic society to protect injured patients. Schoenbaum has argued for malpractice reform, but only if it includes steps to prevent medical injury ([Ann Intern Med 140:51, 2004](#)). Ethically, in the absence of such measures, it is difficult to argue that persons injured through medical error should be no less protected than if they were injured by other means. What is special about medicine to ascribe to it a greater moral good or moral role to protect it from the societal developed basis for injury compensation—tort law? Some would argue that the social goal (justice) of access to medical care, including specialty care, warrant additional limitations on medical tort law to insure that current and future talented physicians will provide such patient care, especially in areas of medicine where there are increased risks.

Provision of fair compensation for disability (beneficence) and limitation of patient injury (nonmaleficence) ought to be our goals. Brennan has argued that to support these goals there are three options for a "new paradigm" for health care safety: (a) maintain the status quo, but simultaneously push the safety agenda harder, (b) take legislative steps to curb the frequency and economic effect of malpractice litigation, (c) no-fault compensation for avoidable injuries. ([Ann Intern Med 139:267,2003](#)).

We invite your attendance at the conference on March 12 as a panel of experts discuss these issues.

Respectfully submitted,
Joel Berberich

The Bioethics Review and Advisory Committee gratefully acknowledges *The Degenstein Foundation*,
whose funding helps support the educational activities of our committee.



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