OUR HANDS ARE TIED

Legal Tensions and Medical Ethics

Marshall B. Kapp

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To the Memory of H. R. K. and B. B. K.
"You shouldn't make excuses."

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Preface

"The practice patterns of individual clinicians are fundamental determinants of the quality, ethical standards, and cost-effectiveness of health services" (Logan & Scott, 1996, p. 595). Physicians' practice patterns are influenced by a wide variety of factors, both conscious and subconscious. For at least the last century and a half, physicians have insisted that one of those factors—mainly negative in effect—is the pervasive anxiety and apprehension physicians experience about potential malpractice litigation and legal liability connected to the care that they provide to their patients (Mohr, 1993, pp. 109–121; Wachsman, 1993, p. 161).

Physicians as well as other health care professionals in the United States are constantly complaining about lawyers and the persistent possibility of being held legally liable for decisions made and actions taken in the course of caring for patients. The vast majority of practicing physicians have long told anyone who would listen that apprehension about potential litigation and liability influences medical professionals to practice "defensively," and therefore wastefully in an economic sense.

Although they are nothing new, these complaints lately have intensified in bitterness and broadened in scope. The primary claim used to focus on the financial waste entailed in practicing defensive medicine.

More recently, though, one is likely to hear the lament that binding legal dictates (that is, the need for physicians as well as other health care providers to specially tailor their conduct to avoid litigation and liability) often act in opposition not only to cost containment precepts but to good clinical judgment and accepted principles of medical ethics also.

THE ETHICAL LOBOTOMIZING OF THE HEALTH PROFESSIONS

As an attorney working in a medical education setting, I am exposed to these laments frequently. As I contemplate their significance, I have grown increasingly disturbed about the medical paradigm of "ethical lobotomy" in which too many physicians appear influenced in their daily decisions and actions far less by a thoughtful consideration of ethical principles and consequences than by calculations for avoiding regulatory and judicial sanctions. This ethical lobotomy is an essential part of the "our hands are tied" syndrome from which a growing segment of the medical profession seems to suffer. The result can be a "deprofessionalization" of medicine in which medical judgment is willingly forfeited in return for protection against public accountability (Annas, 1996).

The relationship between law and ethics as applied to medical practice varies depending on the particular circumstances involved. In specific cases, law and ethics may be synonymous, distinct, at odds, complementary, or overlapping. An analysis of the law-ethics relationship is complicated markedly by the often enormous chasms between three distinct approaches to the law, namely: (a) the law "in books" (how law professors and appellate judges describe the law); (b) the law "in the mind" (how physicians imagine, fear, and frequently caricature the law); and (c) the law "in action" (the way in which clinicians actually practice because of or in spite of their perceptions about the law) (Schuck, 1994, p. 903).

When the law in the physician's mind conflicts or is inconsistent with her concept of what is ethical under the circumstances, almost always the legal concerns crowd out the ethical ones when the physician's calculations are translated into action (De Ville, 1994a). Physicians believe (most of the time erroneously) that the law provides definitive guidance in concrete situations, unlike "soft" and "fuzzy" ethics. Further, physicians believe that they may be forced to endure bad, tangible, concrete consequences if second-guessed legally but not if criticized on ethical grounds.

Unfortunately, this displacement of ethics by perceived risk management needs occurs regularly in actual practice, despite the poor capacity of legislatures and courts to guide participants about, let alone satisfac-

torily resolve, ethical dilemmas. As one commentator has noted, "By their nature, courts [and legislators often, too] deal with medical relationships gone wrong. This raw material for medicolegal doctrine engenders a frame of reference and precedents that frequently misapprehend the nature of the medical relationship" (De Ville, 1994a, p. 479). The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research concluded that "its vision of the patient-professional relationship" cannot be achieved "primarily through reliance on the law" (President's Commission, 1982, p. 152).

Bioethics pioneer Daniel Callahan has suggested that the greatest obstacle to outright and serious public moral debate in this country is "the hovering presence of the law." He warns, "The danger in our country of opening moral discussions about private matters is that some one or other is likely to have the idea that 'there ought to be a law.'" Callahan attacks "legalism," which he defines "as the translation of moral problems into legal problems; the inhibition of moral debate for fear that it will be so translated; and the elevation of the moral judgments of courts as the moral standards of the land" (Callahan, 1996, p. 34).

In commenting on the dynamics between law and ethics in the crucible of medical care, one observer has perceptively concluded that ultimately "one's choice of protective measures is itself a vexing ethical problem" (De Ville, 1994b, p. 193). It is the problem that forms the core of this book.

WHY AND HOW?

Provoked by the sort of claims just described, and with the financial support of the Greenwall Foundation, I decided to investigate in depth the defensive medicine phenomenon, concentrating particularly on the influence that apprehension about litigation and legal liability exerts on ethical medical practice today. I wanted to pay special attention to the real and perceived tensions between risk management and defensive medicine, on one hand, and good (i.e., ethical) patient care, on the other. The aim of this book is a critical examination of the "our hands are tied" syndrome, not for the purpose of defending lawyers or the current legal system in the United States, but rather to place in some realistic perspective the impact—actual and ideal—of legal principles on modern medical decision making and treatment.

Among the specific questions I set out to explore through literature review, personal interviews of physicians and observers of the medical profession, and primarily reflection on lessons learned during my more

than decade and a half working and teaching in medical environments, were the following:

What is the etiology of the anxiety about litigation and liability that appears to pervade American medical practice in the 1990s? Put differently, where do modern physicians get their notions about what the law forbids, requires, and punishes?

How much physician apprehension in this sphere is well-founded and how much emanates from misunderstanding or mythology? Is the apprehension free-floating or predicated on specific, real experiences? What particular beliefs do physicians hold about the legal environment, versus a generalized feeling of malaise?

How do physician perceptions about legal requirements, prohibitions, and potential adversities manifest themselves in patient care situations? Do physicians perceive these behavioral manifestations as positive or as interfering with their ability to practice ethically?

If a tension exists between defensive medicine and ethical medical practice, what can be done to mitigate or resolve that tension? What changes would encourage medical practice that more closely incorporates the ethical values that are now sometimes jeopardized by that tension?

This volume represents the fruits of my investigation. In Chapter 1, physician attitudes toward the law, and especially regarding the current system for handling medical malpractice lawsuits, are analyzed. This includes discussion of the origins of physicians' legal fears, the expectations of certainty and infallibility that physicians impose upon themselves, and what physicians believe the public wants of them and the health care enterprise. Chapter 2 outlines both salutary and deleterious effects of defensive medicine on the ethical quality of care provided to patients, primarily in the context of medical decisions about the use of various diagnostic and therapeutic interventions. The concept of "defensive medicine as pretext for something else" is raised at this juncture.

Chapter 3 comments on physician perceptions about the roles and influence on clinical practice of health care risk managers and legal counsel. The relationship between risk management and institutional ethics committees and ethics consultants is also broached here.

Chapter 4 looks specifically at the ways that provider apprehension about civil, criminal, and regulatory liability often encourages tragic overly aggressive, even cruel, interventions to be inflicted on seriously ill and dying patients. Chapter 5 contains a discussion of paternalistic defensive medicine as it limits patient prerogatives in such areas as assisted living, guardianship, and involuntary commitment. Chapter 6 assesses the likely impact of managed care and other emerging changes in the American health care financing and delivery system on the defensive medicine / medical ethics interface.

The book concludes with a look at possible solutions to the problem of defensive medicine interfering with ethical medical practice. Proposals for initiatives in public policy (e.g., tort reform), professional education, and organizational activity (e.g., the development and dissemination of clinical practice parameters) are set forth for consideration.

This volume articulates my own conjectures and conclusions, supported where possible by references to the professional and popular literature. Statements denoted by quotation marks represent, unless otherwise noted, direct quotes from individuals with whom I have spoken about the topics discussed herein.

Careful study and dissection of the defensive medicine phenomenon in the United States have been woefully inadequate to date. In the course of assembling this project, I interviewed the coauthor of one of the few nationally recognized legitimate analyses in this field. In reply to my query about how he had become an expert on defensive medicine, he joked, "It was easy. I wrote an article on the topic twenty years ago, and every night I reread it." Defensive medicine and its impact on medical ethics is no joke, however; it is a serious matter compelling serious attention.

Nobel Prize winner Aleksandr Solzhenitsyn lectured the 1978 Harvard graduating class. He said that although a society without an objective legal scale is terrible, "a society with no other scale but the legal one is not quite worthy of man either":

> A society that is based on the letter of the law and never reaches any higher is taking very small advantages of the high level of human possibilities. The letter of the law is too cold and formal to have a beneficial influence on society. Whenever the tissue of life is woven of legalistic relations, there is an atmosphere of mediocrity, paralysing man's noblest impulse. (Solzhenitsyn, 1978, p. 22)

In the context of medical care, it is the noblest impulse of human nature to treat the patient and family with dignity, respect, and loving kindness. Many physicians believe that "[t]he law, however, has no philosophical construct for kindness and is, therefore, unable to provide for the logical incorporation of kindness into its formulations and promulgations" (Frengley, 1996, p. 1126). Although that sentiment overstates the case a bit, its author is correct in exhorting, "It behooves physicians to challenge our legal colleagues and to insist that kindness be one of the values that guide the practice of medicine" (Frengley, 1996, p. 1126).

Effective risk management and legal prophylaxis need not necessarily conflict with medicine's noble impulse. This book is my modest

attempt to contribute to a better understanding of the impact of defensive medicine on ethical practice and to the identification of effective strategies for accomplishing the valid goals of legal regulation of health care delivery without impairing the ability to respect fundamental ethical values.

I have suggested in some earlier writings that the law, as the current best expression of society's values and authority regarding specific issues, may not be ignored, but neither should it automatically dictate disregard of other important sources of those values. It is the constellation of values from a broad range of perspectives, law included but by no means alone, that ought to guide those who have undertaken the awesome clinical and ethical obligations of patient well-being. It is the goal of this book to make physicians feel safer to recognize and respect that rich constellation of values, and thereby to practice medicine more ethically. It is my hope that "[f]or a change, law may be the handmaiden of ethics and ethics served by the law rather than vice versa" (Abrams & Veenhuis, 1986, p. 9).

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Losing at the Lottery: Physician Perceptions of the Legal Environment

INTRODUCTION—PHYSICIAN ATTITUDES TOWARD LEGAL RISK

Legal tensions profoundly affect physicians' ethical conduct in everyday medical practice. To comprehend this dynamic, one must begin with some understanding of physician attitudes toward their own legal risks. These attitudes are best summed up as a professional ethos of zero legal risk tolerance, reinforced continually by an almost "Pavlovian hostility toward [the] law" (Williams & Winslade, 1995, p. 783). Physicians' view of the universe as a scary and dangerous legal place for them and their patients has become such a commonplace and automatic assumption (Ferguson, 1993; Wolter, 1993) that I half expect tomorrow's newspapers to trumpet the discovery of an "anti-lawyer" gene that predisposes carriers to pursue medical careers.

Repeatedly and vigorously, physicians indicate that their primary anxiety about legal system entanglement is fear of the traumatic experience of being civilly sued for malpractice,[1] an event which they interpret as a deeply personal and intimate, yet simultaneously an embarrassingly public affront against their very integrity and worth as professionals and as people. In terms of the psychological and financial

trauma that they fear, few physicians seem to distinguish (in other than purely intellectual terms, perhaps) between the experience of being sued, on one hand, and the ability to defend successfully against a malpractice lawsuit, on the other. Put differently, most physicians feel that they have already "lost" the sense of self-confidence and peer respect that they value most highly upon the mere filing of a malpractice action against them, regardless of the ultimate legal and financial outcome of that claim (McQuade, 1991). Living through the legal process itself is more intimidating than the specific financial result (which, even at the worst, ordinarily is taken care of by sufficient liability insurance).

This attitude about the very act of being named a defendant in a malpractice case makes most physicians highly risk-averse in terms of their own perceived legal exposure. This acute risk-aversion, in turn, potentially confers a substantial degree of power on those—such as risk managers (see Chapter 3)—who physicians believe can affect their susceptibility to being sued for professional wrongdoing.

Virtually every practicing physician wants to behave toward patients in good faith—that is, competently and ethically. A clinician's good faith behavior may be called into question by: external entities, most significantly one's own patients and the legal system; one's professional peers; and, ultimately, the physician himself or herself (Bosk, 1979, pp. 170–171).

In this chapter, I endeavor to lay the analytical groundwork for the ethical evaluation of specific manifestations of defensive medicine that follows in subsequent chapters. I first speculate about physician conceptions of what the public wants and expects from modern American medicine, with special emphasis on what physicians surmise they need to do in order to please their individual patients and—sometimes even more importantly in terms of risk management—their families. This leads naturally to an exploration of physician attitudes and understandings regarding the legal system as the other (along with individual patients) most important external entity functioning in the role of constant overseer and potential critic. Next, I offer informed hypotheses about the etiology of physicians' law-related anxieties. I ask specifically where physicians manage to come up with their ideas—so often factually erroneous—regarding the particular medical conduct required, permitted, or forbidden by that mysterious and engulfing black hole, "the law." Finally, I prepare the way for ensuing sections by examining the major expectations and standards that physicians impose upon themselves and their colleagues, including a brief notice of how the concepts of medical error and uncertainty fundamentally affect medical professionals' careers and lives.

WHAT DO THEY WANT OF ME?

Patients and Their Families

Overwhelmingly, physicians believe that their patients want their professional caregivers to "do things" to them and, moreover, that the public has been conditioned to believe that more—and more expensive—medical intervention is virtually always preferable to less-intrusive and cheaper strategies (Wright, 1995). Modern patients, according to this portrait of the medical environment, almost insatiably demand and expect a constant barrage of tests, procedures, and prescriptions. The medical profession, as well as its social critics (Annas, 1996, p. 105), decry the fact that today's physicians too often have been reduced in moral stature from the role of professional exercising appropriate judgment and discretion to that of "provider" responding to "consumer demands" personified by patients "showing up for appointments with articles in their fists." Most physicians complain about feeling pressured, both by the competitive marketplace with its premium on hustling for patients and by the fear of potential malpractice suits brought by disgruntled individuals, to accede too often to scientifically unreasonable patient (or family) requests to render particular purported diagnostic or therapeutic treatments of questionable, if any, likely benefit to the patient.

Assuming that physicians are correct on this matter (which is by no means a foregone conclusion [Britten, 1995]), these complaints still must be evaluated carefully in light of how closely and compatibly patient expectations and desires for maximum medical intervention comport with the technological, data-glorification imperative into which medical practitioners become thoroughly socialized and the economic incentives that, until the recent ascension of managed care (see Chapter 6), influenced physicians to overtreat patients as a way to maximize payments to providers. Skepticism should be heightened by a realization that modern public images of medicine and its unlimited capabilities emanate not only from fantasies projected by the entertainment industry and unsophisticated, ill-informed snippets in the popular press and other media. These images emanate as well from the successful "selling job" that the medical profession itself has accomplished on the public.

Most physicians acknowledge, albeit often begrudgingly, their own individual and collective roles in creating the success—that is, in convincing the public of medicine's magic—of which they are now partially victims. A few are still in deep denial, however. After attending a professional conference on the medical malpractice problem in another city not long ago, I rode in a van to the airport with

several physicians I had just met. I called to their attention the irony of a billboard we passed that advertised the "laser perfect" results patients could expect if they indulged in cosmetic services from a particular local plastic surgeon. One of my medical vanmates failed to grasp the irony, proclaiming that "since everyone knows that health care advertising is filled with lies anyway, no reasonable person would believe that billboard." The upshot of his argument was that health providers ought to be permitted to advertise the quality of their services (i.e., to tell lies to people who know they are being lied to) but should not be held accountable for the substance of those lies. Although not exactly the most ringing endorsement of the present health care industry in the United States by one of its participants, this physician's cynical special pleading was, unfortunately, hardly an example of an isolated mind-set.

With this larger historical and social context before us, then, we cannot avoid asking to what extent physician lamentations about unreasonable patient expectations function primarily as a pretext (conscious or not) used by physicians to rationalize conduct (i.e., excessive medical intervention) that really has other, less publicly acceptable, motives at its core (Sox & Nease, 1993). This "legal anxiety as pretext" theme is one that I will refer to repeatedly throughout this volume.

However we resolve that part of the puzzle, every physician certainly endures a certain proportion of unpleasant patients and families. Most physicians, of course, want to maintain positive fiduciary or trust relationships with their patients and patients' family members as a central element of the general satisfaction inspiring a medical career in the first place. As noted previously, though, there also are two externally induced reasons that physicians now feel more of a need to attend to the quality of these relationships: namely, (a) the need to compete for insured "customers" in the brave new world of managed care, and (b) the fear that unhappy partners (including in many situations family members) in the physician-patient relationship may play out their frustrations in the context of malpractice litigation. These forces for short-term appeasement of patients and families who make unreasonable demands for medical interventions, even when the more honest and beneficent physician reaction would be to devote the time and effort needed to educate and convince them otherwise, frequently are reinforced by administrative officials when the scenario unfolds (as it usually does) within an institutional or organizational setting.

Though a small percentage of both patients and physicians probably permit thoughts—conscious or unconscious—about possible litigation to infuse every aspect of each medical encounter, for the majority such

a constant state of extreme vigilance would be exhausting to the point of rendering them dysfunctional. Although some physicians "see a lawsuit every time a patient walks through the door," for most the threat of litigation is omnipresent but only at the level of "background noise." One neurosurgeon advises his colleagues to treat this threat "as they would a chronic skin disease, seldom fatal but always nettlesome, never sure where the next eruption will appear, and for which one forgoes the hope of cure and seeks, at most, a means to cope" (Davey, 1990, p. 210).

But background noise in many instances can be quite loud and even deafening when the physician (as every physician periodically does) "smells" a souring relationship with a patient or family. Physicians are uniformly convinced that any of their patients would, under the "right" circumstances, adopt an "entitlement mentality" and turn on them legally. Most physicians are under the impression that to the extent that patients ever think about these matters proactively, their patients subscribe to an unseen but lingering notion that the threat of litigation serves the inevitably positive purpose of assuring quality care by "keeping physicians on their toes."

More specifically, patients on the whole are seen as far less worried about the potential excesses and risks of defensive medicine than about the possibility of being cheated out of adequate attention because of the physician's financial incentives to skimp under managed care. One hears few stories of patients and families telling the physician, "Please be conservative in your diagnostic and treatment plan, and we won't sue you if you miss an opportunity that turns out later to be significant." The opposite scenario—"Miss something and we'll sue you"—is much easier to envision. This patient attitude is natural, given the extent to which organized medicine and individual physicians have both publicly and privately savaged the idea and the implementation of marketplace-driven health care and lobbied for legislative protections from it (see Chapter 6), at a level just as vicious as the medical community had previously risen to in bashing the possibility of government-driven health care and its excessive legislative entanglements.

Lawyers and "Their" System

In light of the previous discussion, physicians' concerns about unreasonable and unsatisfied (and often inherently unsatisfiable) expectations among patients and their families spills directly into concerns about lawyers and the legal system. There is a bit of variation among different medical specialties and practice settings in terms of the intensity of legal apprehension; oncologists, for instance, ordinarily are