The Dallas/Fort Worth Healthcare Daily ran a fascinating excerpt from the Steve Jacob’s book *So Long, Marcus Welby, M.D.* The excerpt contained some very interesting assertions and statistics. For example:

- Consultant PwC, relying on that Congressional Budget Office (CBO) report, estimated that malpractice insurance and defensive medicine accounted for 10 percent of total health-care costs. A 2010 *Health Affairs* article more conservatively pegged those costs at 2.4 percent of healthcare spending.
- In a 2010 survey, U.S. orthopedic surgeons bluntly admitted that about 30 percent of tests and referrals were medically unnecessary and done to reduce physician vulnerability to lawsuits.
- A 2011 analysis by the American Medical Association found that the average amount to defend a lawsuit in 2010 was $47,158, compared with $28,981 in 2001. The average cost to pay a medical liability claim—whether it was a settlement, jury award or some other disposition—was $331,947, compared with $297,682 in 2001.
- Doctors spend significant time fighting lawsuits, regardless of outcome. The average litigated claim lingered for 25 months. Doctors spent 20 months defending cases that were ultimately dismissed, while claims going to trial
took 39 months. Doctors who were victorious in court spent an average of 44 months in litigation.

- A study in *The New England Journal of Medicine* estimated that by age 65 about 75 percent of physicians in low-risk specialties have been the target of at least one lawsuit, compared with about 99 percent of those in high-risk specialties.
- According to Brian Atchinson, president of the Physician Insurers Association of America (PIAA), 70 percent of legal claims do not result in payments to patients, and physician defendants prevail 80 percent of time in claims resolved by verdict.

**Fending Off Liability**
The issue of physician liability gets the blood boiling quickly. Doctors throughout the country feel as though one mistake could destroy their careers. Indeed, California Proposition 46, which was defeated on the November 2014 ballot, would have raised the state’s cap on non-economic damages that can be assessed in medical negligence lawsuits from $250,000 to more than $1 million. Thus, as noted above, many physicians over-treat as a defense mechanism. Who can blame them given the litigious nature of our society?
The problem, of course, is that over-treatment is immensely wasteful and expensive (for more, see “Overtreated” by Shannon Brownlee). Tort reform is often mentioned as a possible solution to this problem but that misses the forest for the trees in a way. Yes, tort reform may be part of the solution but at a much deeper level the issue isn’t legalistic: It’s about making health care much safer so that many fewer patients are injured.
Like so much in health care, there is greater clarity when we look at issues from a patient-centered perspective.

**Focus on Patient Safety**
The reality is that there is a huge gap between how safe health care is today and *how safe it could be.*
[Virginia Mason Medical Center](https://www.vmmc.org) in Seattle is an example of an organization that has through its lean management approach worked relentlessly to reduce errors and improve safety. It has often been cited as a model of safety improvement.
When a scandal engulfed the Mid Staffordshire hospital trust in England—negligent care caused deaths and widespread suffering among patients—English
leaders turned to Virginia Mason for guidance. Jeremy Hunt, secretary of state for health in the United Kingdom, traveled to Seattle to learn firsthand about Virginia Mason’s safety efforts. Mr. Hunt pronounced Virginia Mason as, “one of the safest hospitals in the world and perhaps the safest in the world.” Virginia Mason consistently receives top scores on the Leapfrog Group’s safety scores. (The Hospital Safety Score was developed by the Leapfrog Group, an independent national nonprofit run by employers and other large purchasers of health benefits.)

Another source of safety best practices is the Lucian Leape Institute at The National Patient Safety Foundation. According to the Leape Institute, “the free, uninhibited sharing of information ... is probably the most important single attribute of a culture of safety. In complex, tightly coupled systems like healthcare, transparency is a precondition to safety. Its absence inhibits learning from mistakes, distorts collegiality and erodes patient trust.”

What are the building blocks for a culture of safety? What safety best practices have you implemented? Are there barriers to implementing these? How have these been overcome? 

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