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POLICY FORUM

Maine's Medical Liability Demonstration Project—Linking Practice Guidelines to Liability Protection

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In 1990, Maine enacted legislation to test whether the practice of defensive medicine could be reduced by providing protection to physicians who complied with guidelines established by their peers and national specialty organizations. The law provided that physicians who participated in the project could use adherence to the guidelines and protocols as an affirmative defense in a medical malpractice lawsuit. More than four hundred physicians elected to participate. Between 1990 and 1992, 19 practice parameters for the medical specialties of obstetrics and gynecology, radiology, anesthesiology, and emergency medicine were developed by medical specialty advisory committees comprising physicians, insurers, allied health professionals, and patients. The law was a joint project of the Maine Medical Association (MMA), the Maine Board of Licensure in Medicine, the Maine Bureau of Insurance, and the Maine legislature, and it had the support of the relevant medical specialty societies.

The project was eventually extended to 8 years, but was allowed to expire by the year 2000 when supporters of the law concluded that the affirmative defense intended to assist physicians had not been used in a single case in court. The purpose of this article is to explain the project and to explore the reasons for its enactment and its eventual demise.

The reasons physicians and legislators were interested in the idea of linking practice guidelines to liability protection will sound familiar. The 1980s had seen dramatic increases in both liability claims and premiums nationwide, and Maine was no exception. And the cost of health insurance was increasing as well, partly because physicians were practicing more defensively, ordering more tests and procedures than were medically necessary in an effort to protect themselves against potential liability claims. The Maine legislature also had considerable experience with the medical malpractice issue, having enacted three previous rounds of tort reform legislation, including, in 1987, the law establishing pretrial medical malpractice screening panels, which have proven very helpful in the state over the past 25 years. Much of the legislation has been supported by all the interested parties, including the Maine Trial Lawyers Association. Maine is a small state, and we all try to get along the best we can.

The four specialties were chosen because their state specialty organizations expressed interest and they had well-established national guidelines. The radiologists

were interested in field-testing new standards developed by the American College of Radiology, which the project would allow them to do. Emergency medicine was chosen because it was believed to be one in which more testing was going on than was arguably in the best interest of either patients or the public. The American Congress of Obstetricians and Gynecologists and the American Society of Anesthesiologists had well-established national guidelines that made those specialties natural fits for the project.

The proposed legislation included a provision that the project would not begin in a specialty without the active support of at least one-half of its members in the state. Despite the opposition of some (including, unfortunately, a number of prominent defense attorneys), we surpassed the 50 percent threshold in each of the specialties. Specialists determined which existing guidelines would be put into the project. This was a critical phase, as the legislation provided that the specialists would develop the guidelines but that the Board of Licensure in Medicine would then propose the guidelines as state regulations, thus ensuring that they would have the force of law if compliance with them were asserted as an affirmative defense. Nineteen guidelines were eventually selected by the physicians, and, in each case, the licensing board proposed and adopted the guidelines as board regulations. The adopted guidelines borrowed liberally from the standards enacted by national organizations such as the American Society of Anesthesiologists and the American College of Obstetrics and Gynecology and the underwriting guidelines utilized by the state's largest medical liability carrier, Medical Mutual Insurance Company of Maine.

It should be noted that the establishment of the guidelines as rules did not mandate that a specialist adhere to the guideline, as the legislation provided that adherence to the guideline could be asserted by a participating specialist as an affirmative defense, but that failure to abide by the guideline *could not be used against the physician* unless the physician introduced the guideline as an affirmative defense. It was probably this provision, more than any other, that led trial attorneys to oppose the bill.

Four standards were selected for anesthesia, two for emergency medicine, four for radiology, and nine for ob-gyn. The major goal of the project (reducing defensive medicine) may be best demonstrated by the protocol adopted by the emergency physicians regarding the use of cervical spine x-rays. Assume a victim of a motor vehicle accident who is brought to the ER by ambulance arrives completely immobilized on a back board. In the vast majority of instances, the treating physician, fearing the legal consequences, will obtain complete cervical spine films before moving the cervical collar, regardless of the clinical findings. Adequate studies have shown, however, that, in the absence of neck pain or neurologic signs in the conscious patient, the likelihood of a cervical fracture is virtually nil and therefore x-rays are not necessary. The practice guideline for emergency physicians defines the indications for cervical spine films based upon these scientific observations and provides the physician with the protection he or she needs to make the appropriate clinical decision without fear of litigation [1].

As noted above, the practice guidelines, once made into rules by the Board of Licensure in Medicine, had the full force and effect of state law. The rules became effective on January 1, 1992 and established the legal standard of care for malpractice claims based on actions occurring after that date. For better or for worse, for the next 8 years, not a single case was filed in Maine courts in which a physician used the affirmative defense.

Perhaps the proverbial handwriting was on the wall during the discussions leading up to the project. For an article in *The Quality Letter* in October of 1995, I was asked whether there was anything I knew then that I wish I had known in 1990 when the law went into effect. Here are the first two paragraphs of my answer at that time:

> I'm much more skeptical about our ability to use this methodology in actual litigation. It's going to take several court cases and judges looking at the law—not to mention lawyers willing to use the law—before we can really say that we've protected physicians from malpractice charges.
>
> To date, we haven't had a case in which this defense has been used, which is why the legislature recently extended the law for three years. But we've known from the outset that lawyers here had misgivings about the project. Their suspicions are beginning to look like self-fulfilling prophecy. This bothers me because it's the defense lawyer and the insurance company—not the doctor—who will decide whether the affirmative defense is ever used [2].

Defense lawyers had been up front during the initial discussions with the concern that it would not be possible to draft protocols that were broad enough to be accepted by the profession but narrow enough to capture a fact pattern in a specific medical liability case. In addition, there was genuine fear on the part of the defense bar that a defendant-physician's image before the jury might be tarnished by a cookbook or checklist image of medical care, in contrast to the traditional approach of portraying the defendant as a caring and thoughtful practitioner applying his or her wealth of clinical knowledge as well as he or she could under difficult circumstances. (And it is no secret that defense attorneys are conservative by nature. They are not inclined to try new approaches in defending cases, particularly when the statute had never been tested at the trial or appellate court level.) And it is possible that, if a guideline were adhered to and a case filed, that a defense attorney may have chosen to defend the case in a traditional way rather than asserting the affirmative defense and ending up in the State Supreme Court testing this unique approach. Finally, the defense attorneys were concerned that, despite the clear language in the statute, the guidelines would be somehow used against the physicians in instances in which they did not adhere to them.

But, as influential as the defense attorneys may have been in the termination of the project, there were several other factors that contributed to the statute's not being used. Perhaps the most significant was the relative amount of practice affected by the project. While at the time, 19 guidelines in four specialties seemed reasonable, in retrospect, the protocols did not cover enough practice to concern even a few malpractice cases over the 8 years. For instance, the only two guidelines in emergency medicine involved the cervical spine x-rays discussed above and interhospital transfers. Although it is not an observation based upon much evidence, I estimate that all of the protocols put together did not touch more than 1 to 2 percent of medical practice cases in the state. That being so, it is not particularly surprising that no cases emerged.

In summary, for the most part the physicians who elected to participate and MMA itself do not consider the project a failure. Among the positive outcomes were the distribution of the guidelines to all the physicians in the specialties involved, which many of the specialty leaders believe improved quality by encouraging a more uniform approach to the procedures and treatments included in the project, and the education the project provided to observers around the country on the relationship between practice guidelines and liability protection. Given the proliferation of guidelines since the expiration of the project, I believe that a similar approach should be tried in another state and with more specialties. Virtually all observers of our very expensive medical malpractice system believe that physicians who adhere to established guidelines should be protected from claims of medical malpractice. The Maine Liability Demonstration Project did not prove otherwise. It simply did not confirm that this treatment fit the diagnosis.

References

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