

The Ethicality of Capping Non-Economic Damages against Physicians, Hospitals and Insurance Companies: Waging a Holy War against a Perceived Unfair Process

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Abstract

Since the mid-70's, the healthcare industry has been plagued with three primary issues: quality, costs and access. In an effort to address the issue of cost, Congress passed the Health Maintenance Organization Act in 1973. Although not intended to be a panacea, this act gave impetus to the establishment of a variety of Managed Care Organizations (MCOs). Consequently, in the decade of the 90's, healthcare insurance premiums and healthcare costs experienced a period of decline and stabilization. However, this period of economic euphoria did not last long. Toward the end of the 20th Century, healthcare expenditures and insurance premiums began to escalate. Therefore, in an effort to address the next round of increasing costs, the focus shifted to another battle front, rising malpractice insurance premiums. This article explores the rationale for capping non-economic damages as an attempt to address rising malpractice premiums. Specifically, it examines the ethicality of imposing caps and how this reform is inexplicably linked to three concepts: (a) distributive justice, (b) procedural justice, and (c) retributive justice.

INTRODUCTION

Since the mid-70's, the healthcare industry has been plagued with three primary issues: quality, costs and access. In an effort to address the issue of cost, Congress passed the Health Maintenance Organization Act in 1973. Although not intended to be a panacea, this act gave impetus to the establishment of a variety of Managed Care Organizations (MCOs). Consequently, the health care industry experienced a stabilization of healthcare expenditures, partially attributed to managed care. In the decade of the 90's, healthcare insurance premiums and healthcare costs experienced a period of decline and stabilization (Barton, 1999). However, this period of economic euphoria did not last long. Toward the end of the 20th Century, healthcare expenditures and insurance premiums began to escalate. Therefore, in an effort to address the next round of increasing costs, the focus has shifted to another battle front, rising malpractice insurance premiums. Today, for the first time since medical malpractice crisis that raged in our country in 1975 and 1985 respectively the United States finds itself enthralled in yet another medical malpractice dilemma (Mehlman, 2003). Physicians and hospitals in many states are experiencing a dramatic rise in malpractice insurance premiums. On average, premiums for all physicians nationwide rose by 15

percent between 2000 and 2002 (CBO Brief, 2004). This sharp rise is nearly twice as fast as total health care per individual. The impact is not limited to hospitals, even managed care organizations, which were structured to address the issues of cost, quality and access to healthcare, have not escaped the impact of the medical malpractice crisis. MCOs seek to contain and stabilize the costs associated with healthcare services by negotiating relationships with healthcare providers. These agreements allow members of the organization to access care provided by the network physicians and hospitals at costs that have been predetermined through the agreement. As these healthcare providers are faced with escalating premiums, they often look to their revenue sources to relieve the impact of increased costs. The increase in premiums is often passed on to the managed care organization to continue providing services to members of the organization. Without predictability of future costs, MCOs are often placed in a position of making decisions with respect to network providers which then affects the member access. In addition, the practice of defensive medicine, which is linked to malpractice claims, drive increases in costs experienced by MCOs. Consequently, healthcare leaders throughout the industry have sounded alarms that patients may have

difficulty accessing medical services, particularly in high-risk specialties such as obstetrics, physicians may be forced to retire or move to more favorable locations, and the rising costs of malpractice insurance will be passed on to the consumer and increase healthcare expenditures.

Evidence suggests that premiums have risen for two main reasons. First, insurance companies are faced with an increased cost to pay claims from a growth in malpractice awards. Second, malpractice insurers have experienced reduced income from their investments and short-term factors in the insurance market has exacerbated this problem. Some observers flatly assert that the U.S. medical liability system is broken. These observers also claim that U.S. citizens are facing a dangerous equation: lawsuit abuse = skyrocketing insurance for doctors = less care for patients (CBO Brief, 2004).

The current crisis has stimulated calls for changes to the legal rules that govern medical malpractice. Many of these proposals attempt primarily to reduce malpractice insurance premiums. Some, however, see an opportunity to improve the overall performance of malpractice law, including far-reaching changes such as replacing the tort system with a no-fault or administrative approach to compensation (Mehlman, 2003; Health Coalition on Liability and Access, 2004).

A recent snapshot of medical malpractice reform proposals taken by the Health Insurance Association of America shows that 41 state legislatures debated medical malpractice reform in their 2003 sessions, but only 11 passed legislation (and Missouri's legislation was vetoed). Seven states have adopted caps on non-economic damages. These states include Colorado, Florida, Idaho, Ohio, Oklahoma, Texas, and West Virginia. According to the National Governor's Association, in addition to caps, states also considered shortening their statute of limitations to file suit, reducing frivolous suits by reporting, and more stringent doctor discipline. (Spigal, 2003).

On the federal level, the Administration and Members of Congress have proposed several types of restrictions on malpractice awards. Bills introduced in the House and Senate in 2003 would impose caps on awards for non-economic and economic damages, reduce the statute of limitation on claims, restrict attorneys' fees, and allow evidence of any benefits that plaintiffs collect from other sources (i.e., insurance) to be admitted at trial. Currently, President Bush's proposal for a \$ 250,000 national cap on

non-economic damages has stalled in Congress.

Additionally, the National Conference of State Legislatures resolved at its 2003 annual meeting to oppose a national cap on the grounds that it would usurp state authority (CBO Brief, 2004; Spigal, 2003).

Evidence from states that have actually enacted some form of legislative malpractice tort reform indicates that premiums for malpractice insurance are lower when tort liability is restricted than they would be otherwise. However, even large savings in premiums can have only a small direct impact on health care spending, private or governmental. This is true because malpractice costs account for less than 2 percent of that spending. Advocates cite other possible effects of limiting tort liability, such as reducing the extent to which physicians practice "defensive medicine" by conducting excessive procedures; preventing widespread problems of access to health care; or conversely, increasing medical injuries. However, evidence for those other effects is weak or inconclusive (CBO Brief, 2004).

Notwithstanding the fact that current evidence indicates that tort liability restrictions, specifically, caps on non-economic damages are insignificant, inconclusive and weak at best as a methods of lowering insurance premiums, many still advocate such policy. This leads one to ask the question, "Why are doctors, hospitals, HMOs and medical associations going after malpractice litigants and their lawyers with such a vengeance through the use of non-economic damage capping proposals?"

This article will attempt to answer the question posed above, while discussing critical fairness and ethical considerations that may be at the heart of the real issue driving the repeated calls for restrictions on several types of medical malpractice awards. Specifically, it will examine the ethicality of capping non-economic damages and how this reform is inexplicably linked to three concepts: (a) distributive justice, (b) procedural justice, and (c) retributive justice. Moreover, it will show how the capping of non-economic damages is in fact unethical and no more than a retributive justice response on behalf of physicians, hospitals, insurance companies and conservative legislators. Finally, it will demonstrate that the retributive justice response by physicians, hospitals, insurance companies and conservative legislators is in essence part of a larger "Holy War" being waged by the same against medical malpractice litigants, personal injury lawyers and liberal judges.

OPERATIONAL DEFINITIONS

The following is a list of definitions of terms and concepts frequently used in this article:

1. Distributive justice: Social scientists define this type of justice as “outcome fairness”. This psychology of outcome fairness or distributive justice is described as follows: When people receive the compensation, resources, or reward that they believe they deserve, they feel satisfied with the outcome. Moreover, when people are satisfied with the outcome they will reciprocate by fulfilling to their obligation to the legal system to the letter of the law (Kim and Mauborgne, 1997).
2. Economic damages: Funds to compensate a plaintiff for the monetary costs of an injury. For example, costs incurred for medical care received as a result of an injury. (CBO Brief, 2004).
3. Ethics: The norms that a community defines and institutionalizes to prevent individuals from pursuing self-interest at the expense of others (Costa, 1998).
4. Malpractice: Failure of one rendering professional services to exercise that degree of skill and learning commonly applied under all the circumstances in the community by the average prudent reputable member of the profession with the result of injury, loss or damage to the recipient of those services or to those entitled to rely upon them CBO Brief, 2004).
5. Non-economic damages: Damages payable for items other than monetary losses, such as pain and suffering. The term technically includes punitive damages, but those are typically discussed separately (CBO Brief, 2004).
6. Procedural justice: Social scientists define this type of justice as the “fair process”. The psychology of fair process or procedural justice builds trust and commitment. In turn trust and commitment produce voluntary cooperation and voluntary cooperation drives performance, leading people to trust in a legal system without being coerced into doing so. The fair process is based on three mutually reinforcing principles: expectation clarity, engagement, and explanation (Kim and

Mauborgne, 1997).

7. Retributive justice: Social scientists define this type of justice as “revenge justice”. The psychology works like this: When individuals have been so angered by the violation of fair process that they been driven to organize protest. Their demands often stretch well beyond their desire to not only restore fair process, but they also seek to deliver punishment and vengeance upon those who have violated it in compensation for the disrespect the unfair process signals (Kim and Mauborgne, 1997).
8. Tort: A civil wrong not arising from a breach of contract. A breach of a legal duty that proximately causes harm or injury to another (Miller and Jentz, 2000).

THE PROS AND CONS OF CAPPING NON ECONOMIC DAMAGES

Before attempting to directly address the questions put forth earlier, it is essential to understand the primary arguments supporting and opposing the capping of non-economic damages as a method of malpractice reform. In order to clearly recognize and eventually understand the heart of the problem in this ongoing medical malpractice war, it is important for one to take in and feel the emotion, fear and anger embedded in both sides of the issue.

Proponents who support the capping of unlimited non-economic damages argue vehemently that unlimited non-economic damages turn the justice system into a “lottery.” Supporters contend that jurors are often sympathetic to plaintiffs, and award them much more than is necessary because that is what the juror would want for themselves. Furthermore, supporters argue that economic damages, which compensate for actual medical costs and lost earnings would not be capped, thus a limit on non-economic damages would ensure that plaintiffs received the compensation they deserved. Additionally, they believe that unlimited non-economic damages undermine the states' health-care system. Ultimately the system absorbs the cost of run away verdicts. Supporters of capping contend that lawyers pursue medical malpractice cases in hopes of reaping large sums of money in emotional cases with jurors who may not understand the impact of multimillion-dollar awards on the entire health-care system. They believe that non- economic damages such

as pain and suffering and disfigurement can be difficult to quantify precisely, unlike economic damages such as medical costs and lost earnings. They also believe that when premiums rise too high, doctors stop practicing, thereby threatening access to medical care for all U.S. citizens. Proponents further contend that capping non-economic damages at reasonable limits would encourage insurers to do business in all states by ensuring that they would not incur massive losses because of large damage awards. They believe that as more insurers joined the market, competition would reduce premiums (House Research Organization, 2003).

Supporters of caps say that the bottom-line is that more than 10,000 medical malpractice lawsuits are filed each year. Finally, the supporters of caps on non-economic damages sum up their argument as follows (Health Coalition on Liability and Access, 2004):

1. Patient care is at risk due to excessive liability costs.
2. Law suites hinder access to health care.
3. Doctors are abandoning high-risk procedures.
4. Doctors are leaving or moving their practices to avoid rising liability costs.
5. Women are suffering the most.
6. Insures are fleeing the market.

Opponents of caps on non-economic damages argue as vehemently for almost just the opposite. They specifically argue that caps would limit unfairly a patient's right to redress. For example, in Texas the Constitution expressly protected a plaintiff's right to have access to the courts to resolve civil disputes. Thus it was necessary to amend the state Constitution via a resolution making a cap on non-economic damages legal. Opponents also contend that economic damages account only for medical bills and wages, not intangible losses, such as becoming homebound, being unable to care for one's children, suffering caused by major disfigurement, and other horrible results of medical malpractice. Cap opponents believe that economic damages alone do not make a patient whole. Further, the believe that any cap on damages places an arbitrary value on human life, one that would diminish the value of the lives of homemakers, children, the elderly, and the disabled, who

might not have earnings that can be compensated by economic damages but still suffer severe loss. Additionally, opponents of non-economic caps argue that current capping proposals equate a person's life to the amount of money earned, which clearly would discriminate against people whose value exceeds their income. They say that even in the case of a wealthy person with high earnings potential, a cap on non-economic damages would place an arbitrary value on that person's life. They believe that only jurors, rather than federal or state legislators are legitimate and credible bodies to make those types of value distinctions on a case-by-case basis. Opponents staunchly believe that federal and state legislatures should focus on other tools it has to lower medical malpractice insurance rates, such as improvements in the regulation of physicians and insurance reforms rather than grant the broad authority to limit damage awards in all cases, no matter how justifiable and legitimate those awards may be (House Research Organization, 2003).

Opponents say the bottom-line is that special interests are promoting self-serving legislation and caps on non-economic damages for irresponsible hospitals and medical providers at the expense of patient safety and access to quality healthcare (Texas Watch, 2004). They believe that increasing malpractice premiums are not the result of "run away" jury verdicts. They point to the fact that 70 percent of all medical malpractice claims made against doctors do not result in payment to the plaintiff. Only 1.3 percent of all claims result in a jury award to the plaintiff. Moreover, a RAND study found that only 43 cents of every medical malpractice lawsuit dollar actually goes to the injured party (Health Coalition on Liability and Access, 2004).

In summary, the opponents of imposing caps on non-economic damages believe that (Texas Watch, 2004):

1. Caps will not lower doctors' insurance premiums.
2. Caps lower the quality of health care.
3. A one-size fits all-cap discriminates against women, children, and the elderly, and low-income communities.
4. Caps make all U.S. citizen taxpayers foot the bill for malpractice
5. Caps only benefit insurance companies.
6. Most malpractice verdicts favor the defense.

After absorbing the rhetoric of the pros and cons on both sides of this issue, it is fairly easy to see and understand that both supporters and opponents view the issue of capping non-economic damages as a major change to the legal rules that govern the malpractice system. Additionally, it is quite apparent that the capping argument poses much more than mere intellectual disagreement between parties; it is an extremely visceral argument that strikes deep at the “heart” of every one affected by the rules of the system.

So, in light of what has been presented, the question remains, “Why are doctors, hospitals, HMOs and medical associations going after malpractice litigants and their lawyers with such a vengeance through the use of non-economic damage capping proposals?” This article supports the premise that the answer to this question is rooted in understanding the concepts of fairness and justice. Why have they waged a “holy war” against a perceived unfair process?

ETHICS AND VALUES THE CORNERSTONES OF FAIRNESS/PROCEDURAL JUSTICE

According to Costa (1998), ethics are the norms that a community defines and institutionalizes to prevent individuals from pursuing self-interest at the expense of others. Acosta posits that the basic assumption of ethics is that people will not usually self-regulate. He argues that without the opprobrium of society, and threatened punishment for non-conformance, individuals will slide into behavior that maximizes personal advantage. He also believes that individuals will yield to temptation, particularly when rewards are substantial. Therefore, Costa makes it clear that ethical norms create the basis for fair process (Costa, 1998).

Additionally, Burns (1998) posits that there are three distinct types of leadership values: ethical values, modal values, and end values. Burns believes that modal values are essential to establishing a sense of fairness and end values are critical to creating a context of justice. Moreover, Burns argues that end values are the heart of transforming leadership, which seeks fundamental changes in society, such as the enhancement of individual liberty and the explanation of justice and of equality of opportunity.

THE REAL ISSUE: WHY FAIR PROCESS COUNTS

Through out history writers and philosophers have been fascinated with the study of justice. However, serious research on fair process was not conducted until mid-1970s,

when two social scientists, John W. Thibaut and Laurens Walker, combined their interest in the psychology of justice to study the subject process in earnest. Concentrating their research focus on legal settings, they sought to understand what makes people trust a legal system so that they will comply with laws without being coerced into doing so. Their research found that people care as much about the fairness of the process through which an outcome is produced as they do about the outcome itself. It seems that the central idea that continues to emerge from fair process research is that individuals are most likely to trust and cooperate more freely with legal systems when a fair process is observed. This holds true whether the individuals who are involved with the system win or lose as a result of the rules of the system. Follow on research by Tom R. Tyler and E. Allan Lind further demonstrated the power of a fair process across diverse cultures and social settings (Kim and Mauborgne, 1997).

The concept of fairness has long been at the center of controversy when people gather to debate the value of legal systems. Without a doubt fairness is a critical attribute of a properly functioning system of medical liability. Fairness is both a legitimate outcome in itself and a process of achieving important social goals, such as preserving patient-provider relationships and maintaining confidence in courts and legislatures. If the status quo of the existing medical malpractice system is viewed as fair, then the status quo will most likely be retained. Likewise if changes to the medical malpractice system are viewed as fair, then the changes will most likely be enacted and retained. This seems to hold true for the proposed changes that would impose caps on non-economic damages pertaining to the current malpractice system (Mehlman, 2003).

In summation, a fair process counts because a fair process responds to basic human needs. People, regardless of their role or plight in the medical liability system want to be valued as human beings and not as faceless plaintiffs and defendants or pawns in a chess match. People want to be treated with dignity and respect. They want their ideas and input to be taken seriously. Moreover, people want to understand the rationale behind specific decisions and rulings. They are sensitive to the signals transmitted by a medical liability system's decision-making process. Finally, such processes can reveal a medical liability system's willingness to trust people and to seek their input and engage with them, or such processes can signal the opposite (Kim

and Mauborgne, 1997).

WHAT FAIR PROCESS MEANS

The term fairness is an elusive concept. In malpractice, what seems to count most is fairness to patients and potential patients. However, the relational aspect of health care implies that the system must also be fair to physicians. Fairness has two core components; outcome fairness or what social scientists call distributive justice and the psychology of the fair process or what social scientists refer to as procedural justice (Kim and Mauborgne, 1997; Mehlman, 2003).

Distributive justice operates in the realm of outcome fairness. In the case of a malpractice system, distributive justice is concerned with setting the appropriate goals (outcomes) for the system. The goals of the malpractice system may be in tension with each other. Additionally, how the malpractice system is financed is an indication of its goals. The psychology of distributive justice works as follows: When people get the compensation, resources or rewards that they believe they deserve, they will reciprocate by fulfilling to their obligation to the legal system to the letter of the law. Distributive justice has little to do with encouraging the active cooperation of the people it serves (Kim and Mauborgne, 1997; Mehlman, 2003). Examples of appropriate goals of a malpractice system are (Mehlman, 2003):

- Compensation of injured patients
- Deterrence of poor quality medical care
- Corrective justice (punishing providers who commit malpractice), but this may be in tension with other goals
- Affordability of malpractice insurance
- Availability of medical services

Procedural justice is the psychology of the fair process. It is quite different from distributive justice. In the case of a malpractice system, procedural justice is concerned with creating and sustaining a process that operates the system fairly. It gives credence that the goals (outcomes) of the system can be achieved by following the process. Procedural justice builds trust and commitment. In turn trust and commitment produce voluntary cooperation and voluntary cooperation drives performance, leading people to trust in a

legal system without being coerced into doing so. Procedural justice or fair process is based on three mutually reinforcing principles: engagement, expectation clarity, and accountability (Kim and Mauborgne, 1997; Mehlman, 2003). Examples of appropriate key process indicators of a fair malpractice system and how they line up in accordance with the three mutually reinforcing principles of procedural justice are identified below (Kim and Mauborgne, 1997; Mehlman, 2003):

- Engagement - Parties have a meaningful opportunity to be heard.
- Engagement - Parties are adequately represented.
- Engagement - Decisions are reasoned, based on evidence that is openly gathered and recorded.
- Engagement - The parties are treated with dignity and respect.
- Expectation clarity – It employs rules that are understandable and acceptable to all parties.
- Expectation clarity – Parties clearly understand what is expected of them.
- Expectation clarity – Providers understand in advance the consequences of particular conduct.
- Expectation clarity – Decision-makers are neutral and impartial.
- Accountability - Decision-makers are accountable.
- Accountability – The system is valid because it properly identifies the conduct it purports to target.
- Accountability –The system is consistent because it treats similar cases alike.
- Accountability – The system is proportional because it distinguishes among cases rationally.

FAIRNESS OF THE CURRENT SYSTEM WITHOUT CAPS

According to Mehlman, 2003 the current medical malpractice system performs poorly on a number of traditional benchmarks of distributive and procedural justice. Mehlman posits that if we were to grade the current malpractice system on how it performs against many of the traditional benchmarks of distributive justice (outcome

fairness) and procedural justice (fair process) listed above, it would score as follows (Mehlman, 2003):

In terms of achieving distributive justice (outcome fairness)-

- The “negligence” standard for malpractice is too narrow. A fairer system would compensate all those who suffered harm as the result of avoidable medical error.
- The system does not articulate and address conflicts among compensation, deterrence, and corrective justice. The main emphasis in a fairer system would be on preventing future errors rather than punishing individual malfeasance.
- The financing of the system is unsteady, and there is anecdotal evidence that it threatens access to care for some patients.

In terms of achieving procedural justice (creating a fair process)-

- Produces outcomes that are not substantively fair
- Uses rules that are not acceptable to all parties
- Produces most results without written decisions on the merits
- Does not always treat the parties with dignity and respect
- Lacks validity, consistency and proportionality

So, if we believe Mehlman's assertions that the existing medical malpractice system performs poorly when it comes to both distributive and procedural justice, we must ask ourselves which side is most seriously hurt by this lack of justice? More specifically, are patients/potential patients or physicians harmed more by a system that seemingly produces unfair outcomes from an unfair process? And maybe more importantly, what is the cost of this unfairness?

Regardless, whom we choose to believe, physicians unequivocally contend that they represent the side that has been harmed the most, as well as, the side that is right. Furthermore, physicians together with their brothers' in-arms, hospitals, insurance companies, and conservative legislators have bonded in joint protest to convince all who will listen that they are the victims of the current unfair

medical malpractice process. Moreover, they adamantly believe that they have been violated over and over again by malpractice litigants and their profiting lawyers who have taken advantage of this unfair process to achieve unfair outcomes, without regard to ethical norms or conduct. Maybe more, importantly this confederation of physicians, hospitals, insurance companies and conservative legislators are beginning to convince many U.S. voters that they are not only right and but all U.S. citizens are also victims of the broken medical malpractice system. Together this ever-growing contingent is calling for a reclaiming of fair process and the levying of punishment or what this article categorizes as a “holy war” against unscrupulous malpractice patients, their unethical personal injury lawyers and so called liberal judges. Whether this group led by physicians, hospitals and insurance companies is right or not, they are bringing to bear what may be the true cost of this perceived unfair process: a drastic change to the distributive outcomes and procedural process (House Research Organization, 2003; Texas Watch, 2004; Kim and Mauborgne, 1997).

THE COST OF AN UNFAIR PROCESS

Unfortunately, history tells us that legislative reform like tort liability restrictions, and more specifically caps on non-economic damages, which are designed to establish or re-establish fair process arise mainly in reaction to people's complaints and uprisings. However, by then it is usually too late. When individuals, such as physicians, hospital administrators, insurance representatives and a growing number of U.S. citizens have been so angered by a perceived violation of fair process that they have been driven to organized protest, their demands often stretch well beyond the reasonable to a desire for what theorists call retributive justice: not only do they want fair process restored, they also seek to impose punishment and vengeance upon those who have violated it in compensation for the disrespect the unfair process signals (Kim and Mauborgne, 1997). From the perspective of malpractice patients/potential patients and personal injury lawyers, this punishment and vengeance comes in the form of flat caps on non-economic damages, which they believe arbitrarily deny compensation to the most seriously injured patients. Furthermore, malpractice patients/potential patients and personal injury lawyers argue vehemently that flat caps in turn destroy the tenants of fair process and violate the cardinal rule of distributive justice. According to Mehlman (2003), flat caps are an unfair reform to the current medical malpractice system. Others say that it

is not only unfair, but downright unethical and thus the holy war is fueled (Blumenthal, 2004).

THE BARRIERS LEADERS MUST OVERCOME TO ESTABLISH OR RESTORE FAIR PROCESS: CREATING A TRUCE IN THE HOLY WAR

So what must leaders in a complex medical malpractice system or for that matter any system overcome to establish or restore fair process. Most people probably think of themselves as fair, and systems leaders are no exception. However, if these leaders were asked the question, “what does it mean to be a fair leader?” most would likely respond by describing how the people affected by the system get the compensation, resources or rewards that they believe they deserve. In other words, they will confuse fair process with fair outcomes or distributive justice. The few leaders who actually focus on process might identify only one of the three fair process or procedural justice principles. And for that matter, most leaders would probably respond with the most widely understood principle of engagement and stop there (Mehlman, 2003; Kim and Mauborgne, 1997).

However, there are two more fundamental reasons, beyond simple lack of understanding that explain why fair process is so rare. The first involves power. Some leaders in the system, such as physicians, hospital administrators, insurance representatives, and legislators and for that matter personal injury lawyers and trial judges continue to believe that knowledge is power and that they retain power only by keeping what they know to themselves to enhance personal gain. So once more, we come back to the issues of ethics and what Burns calls modal and end values. The implicit strategy of those who wish to retain power is to preserve their leadership discretion by deliberately leaving the rules for success or failure vague. Other leaders, who may be some of the same medical malpractice system leaders previously mentioned maintain control by keeping other key players in the system or key system stakeholders at arm's length, substituting memos and forms for direct, two-way communication, thus avoiding challenges to their ideas or authority. Such styles can reflect deep seeded patterns of attitude and behavior, and rarely are leaders in a system conscious of how they exercise or abuse power. Fair process is a direct threat to these types of leaders (Mehlman, 2003; Kim and Mauborgne, 1997).

The second reason is also largely unconscious reason, because it resides in the economic assumption that most of

us have grown up believing at face value. This reason is the belief that people are only concerned with what is in their own best interest. However, there is much evidence to show that when the process is perceived as fair, most people will accept outcomes that are not solely in their favor. Evidence supports that people realize that compromises and sacrifices are necessary to create and sustain a fair process. Additionally, people also accept the need for short-term personal sacrifices in order to advance the long-term interests of the system (Mehlman, 2003; Kim and Mauborgne, 1997).

CONCLUSION

First, it is important to realize that the lack of a fair process in the current medical malpractice system has created a great divide among many U.S. citizens. Moreover, it is more important that leaders, who view fair process as a bother, inconvenience or as a limit on their freedom to operate any form of system, immediately understand that it is the violation of fair process that will wreak the most serious damage on the system's performance. As described earlier, retribution can be very expensive.

Fair process or procedural justice is critical to the process of changing the current malpractice system as well as sustaining the system far into the future. As Burns states end values lie at the heart of transforming leadership, which seeks in part to create important fundamental changes in society, such as the enhancement and expansion of justice. The fairness of the political process cannot be assumed because some key players or critical stakeholders have greater influence than others (Ciulla, 1998; Mehlman, 2003).

Finally, leaders in the medical malpractice system must understand that there are inherent tensions between fair compensation and fewer medical errors, on one hand; and patient access to health care, an economically viable health care sector, and a sustainable malpractice insurance financing system on the other. At some point, even severely injured patients would lose more by being denied access to health care than by not being fairly compensated. Legislators, judges and the public must engage and work together to assign values to fairness trade-offs noted above and to further weigh them against each other in order to make the best policy decision (Mehlman, 2003).

In conclusion, the question of fair process or procedural justice extends into an emotional dimension of the human psychology under explored in conventional leadership

studies. However, every system can establish, enhance or even restore its effectiveness by building trust through fair process. If we do not succeed, the holy war may destroy all vestiges of fairness (Kim and Mauborgne, 1997).

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