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SYMPOSIUM

COMPARING MEDICAL PROVIDERS: WHAT DO STATISTICS TELL US AND HOW SHOULD THEY BE USED?

FOREWORD

For many years information has been available concerning the possible adverse effects of various medical procedures on a particular patient's diagnosis. This information has obvious uses in medical decision making and, when not offered to patients, has often provided the basis for informed consent litigation. Until recently, however, quantified information as to the possibility of adverse effects for a given procedure provided by a particular physician or hospital was not available. In 1990 the New York State Department of Health began to release to the public detailed information about the comparative risk of open heart surgery at different hospitals. The Department of Health study not only compiled raw mortality data for the various hospitals on open heart surgery, but also, using a complex statistical model, provided a risk-adjusted mortality rate for each hospital that controlled for over twenty variables which could affect patient mortality. Use of the model has already been expanded to measure the risk factors of individual doctors and the model soon will be applied to other procedures.

The availability for the first time of such provider-specific statistical data is certain to have a profound impact on law and

medicine. This issue of the *Brooklyn Law Review* includes articles that emerged from Brooklyn Law School's 1992 *Symposium on Comparing Medical Providers: What Do Statistics Tell Us and How Should They Be Used?*

On the legal side, Professors Aaron D. Twerski, J.D., and Neil B. Cohen, J.D., of Brooklyn Law School note in their article, *Comparing Medical Providers: A First Look At The New Era of Medical Statistics*, that since the number and sophistication of such comparative statistical studies will only increase over time, the issue to be addressed is whether, and to what extent, these statistical studies pose problems when they are used in negligence and informed consent claims. The authors are prepared to recognize a new cause of action in negligence. Under certain circumstances, they argue that a provider's decision to perform a procedure at which she is substantially less skillful than the relevant market itself constitutes negligence. This new cause of action is distinct from whether the procedure was performed negligently. In so doing, the authors explore ways the legal system can compare the actual injury resulting from the negligent act of performing the procedure with the injury that might, or might not, have occurred if an alternative provider had performed the procedure. Twerski and Cohen ultimately argue that patients are entitled to partial recovery based on the decreased chance of a successful procedure brought about by the provider's deficient skill, despite some statistical pitfalls.

In addition, the authors foresee a new cause of action in informed consent for a provider's failure to disclose to a patient these available, although currently imperfect, data. At the same time, the authors acknowledge the potential problems spawned by this new cause of action. In particular, the disclosure of these data to patients by providers may drive providers with "bad"—albeit flawed—statistical profiles out of the market.

The authors recognize that whether a provider is "bad" enough to warrant sanctions on either a negligence or an informed consent theory will require a finding that the deviation from whatever norm is chosen is statistically significant and of sufficient magnitude to demand legal recognition. This will require courts to evaluate carefully the statistics to determine whether both statistical significance and overall performance are so important that the law ought to take them into account. These new informed consent claims have the potential to change

the health care delivery system dramatically.

Paul D. Rheingold, J.D., a leading plaintiff's attorney in products liability, medical malpractice and drug-related litigation, examines in his article, *The Admissibility of Evidence in Malpractice Cases: The Performance Records of Practitioners*, how the availability of mortality and morbidity statistics of specific hospitals and practitioners may be used in medical malpractice litigation. He concludes that the goal of improving the quality of health care will not necessarily be furthered, and may be frustrated, if performance data are allowed into court as some evidence in malpractice actions of the doctor's good or bad performance. Nonetheless, he argues that these performance statistics should be revealed because a doctor has a duty to disclose what is known about treatment risks and failure to do so constitutes a breach of that duty.

On the health care side, Jesse Green, Ph.D., contends in his article, *Problems in the Use of Outcome Statistics to Compare Health Care Providers*, that while research into effectiveness of care should continue, premature use of the early fruit of such research raises the specter of misinforming health care consumers. Green examines the scientific basis on which such outcome studies rest and explores some of the pressing concerns about their validity. In particular, he finds that mortality statistics may be biased against some providers that offer excellent care to very high-risk patients. In addition, some of the databases used for analyzing provider outcomes fail to meet scientific standards of accuracy and completeness. He concludes that provider-specific outcome statistics must be carefully evaluated for reliability and validity whenever they are used as evidence in court.

Mark V. Pauly, Ph.D., Benheim Professor at the Wharton School of Business, University of Pennsylvania, approaches the rise and use of outcome studies somewhat differently, looking at the era of outcomes measurement within the context of the movement to contain costs in health care delivery. In his article, *The Public Policy Implications of Using Outcome Statistics*, Pauly argues that although statistical measurements are intrinsically imperfect in measuring health outcomes, public policy will continue to demand their use. How these measures will be used depends on the rest of the health care delivery and financing system. In the end, he suggests that outcome statistics will have a significant impact on the economics of health care delivery.

Patients, as consumers and voters, increasingly will be making choices based on these statistics.

This series of articles is a preview of the potential effect of outcome statistics on medical care, legal practice and public policy. We hope these pieces will spur further scholarship in this new and potentially transforming area of the law.

The Editors