Essential Administrative Ingredients of Risk Management as a Preventive Against Malpractice

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THE PROBLEMS attendant to the issue of malpractice have been described extensively by the press. The threat of legal action has been sufficient to alter the behavior and performance standards and practices of those individuals, agencies, and institutions involved in the delivery of care and services to the public. As stated by Phillips (*1*): ". . . rather than pay the high premiums, some specialists have stopped certain, so-called, high-risk procedures; some have stopped all surgery; and some of our smaller hospitals may be faced with a decision to close their surgery departments when the only anesthesiologist in the area loses his insurance coverage." The continued operation of emergency departments in smaller hospitals is also in jeopardy. "When certain specialists curtail their practices," he continued, "then some of the hospital emergency rooms will have to send many accident victims on to the next larger hospital, no matter how far the distance."

At this point in the history of health services delivery, the term malpractice has come to mean the label, method, and the process by which consumers (patients) of care may redress their grievances, mild or severe, against those who furnish and deliver the care. In effect, malpractice has entered the populist arena and, with wide media exposure, has become a household term. Special vulnerability exists for the agencies and institutions, the clinics, and the hospitals, which through their structured and complex social and behavior systems of professional, supporting, and administrative personnel, provide and deliver care and services to a variety of patients in the communities they serve. When an institution is conceived as delivering care and services, far too frequently the administrative personnel are judged not to have a role in that health services delivery. It is my opinion, however, that administrative mechanisms and patterns of institutions may offer fertile and unexplored territory for risk management against malpractice, particularly as the nation continues to change health services from the model of the private solo practitioner to the clinical group environment.

For 20 years, I have directed the largest ambulatory clinical complex in eye care in the United States, the University Optometric Center of the State University of New York (formerly the Optometric Center of New York). We have not experienced a single malpractice suit in that two-decade period. Without the hazard of ego, but with much pride by anybody's standard, the zero record is a remarkable achievement. I address here some of the administrative ingredients that are considered essential to secure a progressively more favorable climate in risk management in institutions.

Quality

Clearly, the process of administration and the administrative aspects of the control of the environment within which health care is delivered are not the sole parameters of a risk management program. But they do provide rational starting points and, perhaps, underused but potentially effective ones. Any intellectual exploration of this subject, particularly with regard to institutions, must begin with an understanding of the clinical situation where quality exists as a fact, not a fantasy. Indeed, it is the struggle and the drive to achieve quality health services delivery that motivates administrative leadership. Unless there is an absolute attitude of urgency on the part of administrative leadership about the concept of quality, then malpractice risks are in a precarious state.

Quality health care is professed by many but achieved by few. Is it a concept that eludes achievement because it is not understood? Is it a concept that is too costly and, therefore, difficult to secure? Or, is it a concept that is not sufficiently ingrained so that it is relatively easily obviated? The answers to the three questions are, in my opinion, "yes." In the climate of today's public opinion and attitudes, it would be tragic to define quality health care as that which is delivered in the absence of malpractice

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suits. The lack of legal action does not, perforce, mean quality health services, and the presence of a legal action (or the threat) does not automatically mean poor health care.

In a sense, quality care is like honesty. It must pervade the very fiber of the individual or the institution. It is particularly important that quality care be an ingrained philosophy in an institution where there is a complexity of behavior and performance patterns, secured by rules, and developed through some rational plan. To be effective and to reflect the character of the institution, quality and the striving for it must be intrinsic in the myriad of decision making processes that, in summary, characterize the totality of operations of the institution.

But how is quality measured? Do procedures exist that permit a rational method or means by which to "stamp" one institution as being of a higher quality than another? The answers to both questions are elusive and, given the rudimentary state of the art, undoubtedly controversial. In the words of McKillop (*2*):

> Primitive is perhaps the best word to describe the present state of the art of quality assessment. The analysis of one chart by an individual member of a medical audit committee parallels the work of an individual artisan before the industrial revolution. The failure of this method to attain quality control is obvious. Many articulate spokesmen for the health care field acknowledge that hospital medical staff activities to ensure consistent quality and to maintain quality control have not been successful.
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> Nonsystematic is another descriptive term for the present state of the art. When medical care is evaluated, it is done on an individual, random, episodic basis. The results contribute little to continuing medical education, quality of patient care, and quality control of medical practice.
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> Episodic is another word that may be used to describe the present process of evaluating medical care in most hospitals. The episodic nature of medical audit flows of necessity from the episodic nature of medical care. Physicians, sociologists, and representatives of many other disciplines have talked long and often about the nature of today's medical care, which is episodic, crisis-oriented, and disease-oriented. Those concerned with the nature of the evaluation of such care find themselves describing the review process in the same terms that those who describe the actual process of care use.

In the absence of some kind of grading system, reputation is the means by which some hospitals and clinics achieve a greatness and are thought of as quality institutions. Rarely are the achievements of quality or of greatness in institutions obtained by accident. More often the achievement is by design, deliberative planning, and persistent hard work. Quality is the exponent of the caliber of professional and support staffs and the administrative matrix. But the caliber of personnel does not automatically mean quality care. The additional essential element is quality administration.

Leadership for quality. Adherence to principles of quality and the constant efforts needed to strive for them in a health care institution begin (and, indeed, may falter and end abruptly) with the element of leadership. Leadership is that aspect of administration that sets the tone of an institution. And, clearly, as in any form of complex organization, the major function of the head of the institution, its chief administrative officer, is to exercise leadership to accomplish the stated and accepted goals and objectives. He enunciates them. He interprets them to the staffs and to the community. He provides the inspiration for others to follow. It is that very leadership function that ingrains those desirable behavioral patterns that result in quality outcomes. As stated by Wilcox (*3*):

> Their reasoning is that the hospital corporation is ultimately responsible for the quality of patient care provided in the hospital and may be named as a defendant and be held liable for any injury directly caused by a staff member's act that is performed within the hospital.

Leadership that is goal- and achievement-oriented, with quality as a behavioral objective, is constant and never ending. It recognizes and rewards quality in all of its aspects, and it analyzes in order to repair and upgrade those areas and functions that are identified for their lack of quality.

Planning for quality. If everything is done correctly, does that mean quality? The answer is "no," emphatically. Quality can be planned. Such planning is a deliberate and carefully thought out effort to identify omissions, delays, and inefficiencies in order to reduce time, conserve energies and resources, and allow for the achievement of objectives more directly, more successfully, and with a crispness of style. This is what patients feel and understand—an air of efficiency that comes about because a plan has been rationalized for the operation. The more effective the planning effort as an administrative function, the clearer the element and process of accountability—particularly to the institution's clientele, the patients.

No plan achieves its goals—quality care and services—unless the plan is understood.. And there can be no commitment to the carrying out of the plan in the absence of that understanding. Commitment is total, not partial, and it is translated for all personnel of an institution, not just a few.

Molding attitudes about quality. Of course, everyone believes in quality care. In fact, who among the staff is against it? But the reality frequently differs from the attitude, and it is the collective attitude of

the institution's personnel that postures the relative degree of quality exhibited by the institution. An actively favorable attitude about all aspects of quality in the delivery of health care must be aggressively pursued. Failing such an action, particularly on the part of administration, may result in a sense of passivity that is akin to a "high verbal but low performance" environment. It becomes the ongoing role of the administrative leadership to analyze and to mold, in very lifelike situations, attitudes of staff members at all levels from the patients' viewpoints. A training program to foster positive attitudes toward patients should be continuous and unrelenting, and it should be thoroughgoing to all levels of the staff and to their performances. The key to molding of attitudes of the staff is the fundamental understanding of their roles in the myriad of positive reinforcements in patient care that, in totality, compose quality care.

Achievement of quality resources for implementing an administrative program. No program comes about by itself. It requires manpower, time, space, and money. Clearly, in any kind of administrative budget for which there are identifiable goals spelled out in terms of programs, one of the goals must be the achievement of excellence and quality. It requires funds, a trained staff, suitable space, and committed time during which these resources may be interwoven with professional and supporting staffs for the emergence of administrative procedures and personal attitudes regarding the achievement of quality in the delivery of health services. It is a continuing staff orientation and dedication effort as well as a persistent patient orientation and education effort. If staff orientation and dedication proceed without an understanding of the patient orientation and education effort, a deficient program is promoted. It is just as much the responsibility of professional and supporting staffs to understand and to strive for the achievement of quality in the delivery of health care services as it is the responsibility of patients to understand the nature of the quality services that are being attempted. The understanding of services requires a continuous program of patient education. An informed patient population is another mechanism to stimulate staff, both professional and supporting, to strive for and to achieve excellence in all phases of delivery of health care services.

The lack of budgetary support for achieving excellence, identifiable by specific program objectives, would constitute a serious deficiency in any administrative program that attempts to plan, mold, and evaluate a program effort to achieve quality. This is much more than an ombudsman effort. What is conceived is much more than consciousness raising in an institution. Such a program, total and pervasive, carried by the administration's dedication to quality and enunciated by the spirit of its leadership, undoubtedly is costly to an institution—but so are the settlement of grievances, malpractice claims, and lawsuits. Although no data base readily exists by which to make financial comparisons, an institution's risk management program, carefully planned and deliberately budgeted, will prove to be less costly. Surely, in terms of the sheer expenditure of time, aggravation, and the travail and upset in the attendance to and pursuit of grievances, malpractice claims, and legal suits, an institution's leadership-sponsored and administration-managed program of risk prevention and avoidance is less expensive. It must lead to a more productive morale environment. This is a field that begs for research endeavors and demonstration programs.

Administrative Purposes and Objectives

In this era of mass understanding (and misunderstanding) of malpractice and with all the attendant publicity that it has received, it becomes ever more essential for administrative leadership of institutions concerned with the delivery of health care and services to carefully, and with studied reason, define the purposes of the program and the objectives devised to achieve excellence and quality in all of their aspects. The idealized aim must be carefully enunciated by administrative leadership and carefully understood by all levels of professional and supporting staffs. It should be understood by the patient population as well. The translations of the idealized aim into a subject-by-subject program are those crucial steps that must be taken in order to begin the program to achieve quality.

Risk Prevention and Avoidance

The program of risk prevention and avoidance is a daily one. It begins with personnel retention and staff orientation at all levels and for all types of personnel. Its purposes must be so well defined that they are seamlessly connected to behavioral objectives for personnel translated to more effective and better quality patient care. Such a program, involving attitudes, procedures, and operations, requires monitoring by a constant infusion of audits and other evaluative mechanisms. To evaluate means to improve—thereby better to enable institutions to achieve their defined purposes.

It has been stated that the specter of malpractice has forced the staffs of clinics and hospitals to deliver health care and services defensively. The patient looms as the potential adversary, and tensions surely must result in a slow but progressive deterioration both in the nature of the care and services and in the behavioral environment. There is an antidote to such deprivation, and the institution that does not find it is in serious trouble.

The atmosphere created by a program of risk prevention and avoidance, involving both staff personnel and patients, is one of mutual respect. It is an atmosphere in which there is a sensible understanding of limitations on all sides. And that leads to more realistic limitations of expectations of outcomes—except in one. That critical one is the understanding that the striving for quality is never ending, and courtesy and understanding (by all) can never be compromised.

In this era of consumerism, the concept of a patient bill of rights and the mechanism of the pursuit of patient (consumer) complaints have come into being. But are they active concepts and utilized mechanisms? The pursuit of a consumer complaint as an active and well-conceived process may form a method by which to abort the escalated and more serious time and financial resource-consuming process of malpractice threat or suit. Although the issues of consumerism, the patient bill of rights, patient advocacy, and ombudsmanship have come into existence in varying degrees and with mixed and diverse results, they are frequently misunderstood, particularly by the professional staff. That misunderstanding frequently can lead to hostility, and when that stage of resentment occurs, whatever advantages were perceived by leadership and administration are quickly dissipated, if not lost.

Some of the proposals and suggestions that have been made to limit the liability of institutions and individuals in malpractice risks are to:

- provide for legislative revisions of the legal tort system,
- set into place a compensation system by which, through arbitration and other procedures, malpractice suits will be adjudicated.
- provide means to dampen the somewhat perceived enthusiasm of some members of the legal profession to promote (if not to provide) malpractice claims,
- remove adjudication of malpractice claims and suits from the consideration of juries,
- require insurance carriers to maintain a field of endeavor when their risk exposures have escalated to the point of panic,
- implement a no-fault concept insurance, and
- require that agencies, institutions, and individuals be self-insured.

Conclusions

All of the suggestions and proposals mentioned have been debated extensively and each has some merit and some flaws. Most will be pursued in various ways and to varying degrees, but what has emerged from the "boiling" of the malpractice crisis and the resultant rash of studies and commissions in a host of States is no clearcut answer or solution.

No one system is clearly and consistently better than another. Surely, no panacea has yet been devised to resolve the malpractice crisis on a long-term basis. It may well be that the intensity of the crisis will continue to escalate with the resultant pressures on all concerned mounting increasingly. The rapidly and perilously rising malpractice insurance costs for agencies, institutions, and individuals cannot continue much longer without employment of sheer Draconian methods to control the situation totally. Partial answers may prove to be mere palliatives. The Draconian initiatives may be, for the moment, socially and politically unacceptable. But, the ever-mounting pressures of the malpractice crisis have already forced substantial movements in the health care delivery system, and they will continue to do so.

Notwithstanding these aforementioned events, professional and administrative leaders hold unique and critical positions in clinics and hospitals to initiate and to innovate methods of risk management through imaginative, carefully planned, and adequately budgeted programs of risk prevention and avoidance. If they do not exist in some institutions, they should be initiated. If they are weak, they should be strengthened. Insurance carriers, the patient population, the agencies and institutions and their personnel staffs, and the personnel of the entire legal process have converging interests in this development and so do those in public social policy. The administrative methods and ingredients described are, indeed, nothing less than essential.

References

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