# *In the Literature*

## WILL PHYSICIAN-LEVEL MEASURES OF CLINICAL PERFORMANCE BE USED IN MEDICAL MALPRACTICE LITIGATION?

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Physicians have been slow to embrace the dissemination of quality measures known as physician clinical performance assessment (PCPA). For many clinicians, this wariness may be due in part to fears that PCPA could increase the risk of lawsuits if data are used as evidence in malpractice claims. But according to new research supported by The Commonwealth Fund, such fears are likely unfounded: only a remote chance exists that performance data could be admissible as evidence.

In medical malpractice claims, information must be deemed relevant to the case to be admissible as evidence. Even relevant information, however, can be disallowed if the judge decides that its potential to mislead or confuse a jury outweighs its usefulness. "Generally, information about a person's prior behaviors, or 'other acts,' fails this balancing test," says Aaron S. Kesselheim, M.D., J.D., a researcher at the Harvard School of Public Health and the lead author of "Will Physician-Level Measures of Clinical Performance Be Used in Medical Malpractice Litigation?" (*Journal of the American Medical Association*, Apr. 19, 2006). Current examples of PCPA fall within this category of information.

Two kinds of PCPA data—process measures (e.g., the proportion of eligible women who have annual mammograms) and patient satisfaction surveys—make only tenuous connections to claims of medical negligence, say the authors. The third, outcomes of care, has the greatest potential to be used as admissible evidence. If a patient experienced a serious adverse event—for example, a heart attack during coronary artery bypass graft surgery—and PCPA data showed the cardiac surgeon had abnormally high mortality rates related to this procedure, a judge could determine the data suggest an underlying problem.

Format, too, can influence admissibility. Positioning physicians in tiered categories creates opportunities to flag those consistently in the lower tiers. More specific formats, including a rank order allowing identification of the clinicians deemed "worst in class," are more likely to be considered admissible.

The authors identified only two cases where "other act" information was used in malpractice claims. In both cases, injuries to the patients were unexpected and remarkably similar in nature, and both stemmed from identical procedures. This pattern is somewhat unusual, note Kesselheim and colleagues. Most malpractice claims involve distinctive clinical circumstances that resist being grouped with other episodes of care.

In general, the bar for admission of "other act" evidence in malpractice litigation is high, the researchers say, and the possibility that PCPA data will reach this bar seems remote. Currently, PCPA data present aggregate information on physicians' practices; they do not describe particular episodes of care. The Institute of Medicine supports this approach and suggests moving further away from specificity to measuring care over time and emphasizing shared accountability across a patient's entire care team. "As long as PCPA measures aggregate episodes of care, aggregation will severely limit the prospects of their use as evidence in malpractice litigation," the authors conclude.