



Robert Wood Johnson Foundation

Spotlight on Malpractice Reform

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What's At Stake

The debate about medical malpractice liability is one of the most emotional in health care. Beleaguered doctors blame a broken liability system for out-of-control costs, saying they order billions in unnecessary tests and procedures and sometimes shun high-risk cases to protect themselves from lawsuits.

Opponents of tort reform, primarily trial lawyers and some consumer groups, counter that patients injured by medical errors deserve to be compensated, and that the threat of legal action deters unsafe practices. The real problem, they say, is not frivolous claims, but an unacceptably high rate of medical errors which leads to thousands of injuries and deaths every year.

In recent years, a growing body of research has challenged assumptions on both sides. Studies have documented that while defensive medicine breeds waste, it's not nearly as much as many doctors believe. The Congressional Budget Office pegs the direct costs of litigation at \$10 billion a year— less than one half of a percentage point of medical spending. The larger, indirect costs ascribed to defensive medicine are notoriously difficult to assess, but [Harvard economist Amitabh Chandra has estimated \\$60 billion per year, or about three percent of overall medical spending](#), as a reasonable, upper-end estimate. His research is cited by both doctors' and trial lawyers' associations.

While they may not be a game-changer, those sums are significant. President Obama said as much in his State of the Union address, when he promised to fund pilots to promote alternatives to the liability system. "I've talked to enough doctors," he said, "to know that defensive medicine may be contributing to unnecessary costs."

But there are other compelling reasons to reform the malpractice system: First and foremost, [research suggests it does not serve injured patients well](#). Only a tiny minority of wrongfully injured patients ever file a claim, studies show. Of those who do, one in six receive no compensation. Patients who get damages, meanwhile, wait an average of five years before their cases are resolved, with one third of claims requiring six years or more to resolve. For those who get compensation, 54 cents of every dollar goes to cover administrative and legal costs.

"A tiny number of injured patients win huge jackpots while the majority gets nothing, in a gaming process rife with outrageous overhead costs," [wrote Darshak Sanghavi](#), chief of pediatric cardiology and assistant professor of pediatrics at the University of Massachusetts Medical School.

Perhaps more important, patient safety advocates contend the current system is an obstacle to safer medical

practice because it discourages transparency about mistakes. Ever since the landmark 1999 [Institute of Medicine report](#) that found that as many as 98,000 patients die each year from preventable medical errors, reformers have argued that the best way to reduce errors is to acknowledge them, analyze them, and see what can be done to prevent them from happening. That is hard to do if you're covering them up to avoid being sued.

"There is a deep-seated tension between the malpractice system and the goals and initiatives of the patient-safety movement," [Harvard researchers David Studdert, Michelle Mello and Troyen Brennan wrote in the New England Journal of Medicine](#). "At its root, the problem is one of conflicting cultures: trial attorneys believe that the threat of litigation makes doctors practice more safely, but the punitive, individualistic, adversarial approach of tort law is antithetical to the non-punitive, systems-oriented cooperative strategies promoted by leaders of the patient safety movement."

The Background

Nearly all states require physicians to have liability insurance to protect against the cost of being sued. Even in those states that don't mandate it, doctors need it to get privileges at hospitals. But unlike the way drivers are rated for auto insurance, there is no direct relationship between a provider's skill and experience and the cost of his or her malpractice insurance. The rates are largely a function of specialty and location.

Some say the disconnect between performance and premiums lessens the deterrence value of lawsuits. But there is some evidence that liability has spurred practice improvements. [Motivated in part by a large number of lawsuits, anesthesiologists searched for safer ways to administer anesthesia](#) that dramatically dropped the risk of death in surgery from one in 4,000 to one in 250,000 over a 25-year-period. In that same time, their insurance premiums dropped among the highest among doctors to some of the lowest.

Other specialties have had a very different experience, though. Over the last 25 years, escalating malpractice premiums have led to episodic crises where doctors in some regions have been hard-pressed to afford insurance. Specialties like obstetrics and general surgery have been particularly hard hit.

One such crisis in the 1980s led a team of Harvard researchers to embark on a landmark study of medical records from over 30,000 hospital discharges in New York. They projected that negligent care caused approximately 20,000 disabling injuries and 7,000 deaths in New York hospitals in 1984. Yet only a tiny percentage of those injured - 3,500 - filed malpractice claims.

Another [Harvard study in 2006](#) concluded that two thirds of malpractice cases were the result of medical errors. That team reviewed nearly 1,500 claims from five different malpractice insurers, determining whether a patient was injured and, if so, whether it was due to physician error. It also found that the legal system acted appropriately most of the time. Seventy-three percent of injuries in which a doctor committed an error resulted in payments. Seventy-two percent of cases in which there was an injury which was not due to physician error did not result in payment.

Other researchers have found only equivocal evidence that malpractice has driven doctors to significantly restrict their practices. [A 2004 report by the CBO](#) did cite instances of reduced access to emergency surgery and newborn delivery "in scattered, often rural, areas, where providers identified other longstanding factors that affect the availability of services." But it also said that many reported shortages could not be substantiated or did not widely affect access to care.

The Debate

Traditionally, doctors groups have sought caps on the size of malpractice awards as the answer to escalating insurance premiums. Over the objections of consumer groups, more than half the states have enacted these, mostly in the form of limiting non-economic, or "pain and suffering" damages with ceilings ranging from \$250,000 to \$700,000.

The results are mixed at best. Some advocates of caps point to [the experience of Texas where the number of malpractice suits reportedly dropped by half](#) after damage caps were instituted in 2003 while the supply of doctors increased. Other states have seen no falloff in lawsuits.

“The best evidence shows that although caps modestly constrain the growth of insurance premiums, they don’t reduce the number of claims or address any of the fundamental pathologies of the system,” [Harvard’s Michelle Mello and Amitabh Chandra wrote for The New York Times](#).

A growing number of critics of the malpractice system urge more thoroughgoing changes that would enable victims of negligence to get timely, reasonable compensation, while encouraging doctors to learn from their mistakes. The ideas most often discussed include:

- [Special health courts](#): This proposal, developed by the Harvard School of Public Health and Common Good with funding from the Robert Wood Johnson Foundation, calls for a specialized court presided over by judges with medical expertise, or an administrative panel that would award damages on the basis of judgments by neutral experts. Supporters say they would provide consistent rulings and expedited proceedings, encouraging early offers and settlements on legitimate claims. All information would be fed back into the system so that doctors and hospitals learn from mistakes. Supporters, including many doctors’ groups, say it would dramatically decrease defensive medicine. Consumer advocates are mixed: While the AARP endorses the idea, groups like the [Center for Justice and Democracy are strongly opposed](#). “If you take away the threat of litigation, you’re actually going to make it more difficult for patients” to secure a settlement from defendants,” said Joanne Doroshow, the center’s executive director.
- [Safe harbors](#): The idea is to immunize doctors if they adhered to evidence-based medical practices. For example, legislation introduced by Sen. Ron Wyden, D-Oregon, in February would create a presumption that care was not negligent if the physician followed accepted clinical practice guidelines. Similarly, physicians could be insulated from liability, or given a favorable presumption if they practiced in accordance with findings of credible comparative-effectiveness research. This would give physicians a legal incentive to practice evidence-based medicine. Some fear, however, that safe harbor might discourage doctors from delivering the best care for a particular patient in favor of a one-size-fits-all approach.
- [Disclosure-and offer programs](#): These encourages health providers to disclose unanticipated outcomes of care to patients and make prompt offers of compensation in appropriate cases. Patients do not waive their right to sue by accepting the offer, but reportedly few go on to file lawsuits. While he was a senator, President Obama co-sponsored legislation to promote this approach. Many see this as promising, though the programs have not yet been formally evaluated.

Where Things Stand in Washington

While the president is on record that liability reform must be part of health reform, the issue has gotten scant attention from Congress – in large measure, because Republicans, the traditional champions of tort reform, have been on the sidelines of the health reform debate. [Harvard’s Mello and Brennan wrote in the New England Journal of Medicine this summer that incorporating liability reform could be “an enticing sweetener”](#) for doctors and perhaps even a few Republicans. But to date, only small steps have been taken.

Following the president’s promise to fund pilots, the U.S. Department of Health and Human Services has allocated \$25 million to states and health systems to test demonstration models that would improve patient safety, reduce preventable errors and improve the liability system. It was unclear at the time of publication what programs might be funded. Some critics say that sum is too small to produce real change.

The House health reform bill calls for providing unspecified financial incentives to states that provide alternatives to medical liability law, but only if they do not limit “attorneys’ fees or impose caps on damages”—a clause that has antagonized tort reformers.

The Senate bill authorizes \$50 million over five years for state demonstration programs for alternative medical

liability reforms - without restricting what projects could be funded. The Senate also calls for a Government Accountability Office study about whether any policies enacted as part of health reform create potential new legal liabilities for physicians.

It was unclear at the time of publication how the bills would be reconciled.

Malpractice Reform Reading List

1. [The Role of Medical Liability Reform in Federal Health Care Reform](#)
Michelle Mello and Troyen Brennan of Harvard's School of Public Health discuss rationales to make tort reform part of health reform, from cost-savings to political enticements for doctors and Republicans. *New England Journal of Medicine*, July 2, 2009.
2. [Claims, Errors, and Compensation Payments in Medical Malpractice Litigation](#)
David M. Studdert, Michelle Mello, et al. Review of almost 1,500 closed malpractice claims finds reports that the malpractice system is stricken with frivolous litigation are overblown. *New England Journal of Medicine*, May 11, 2006.
3. [Medical Malpractice](#)
David Studdert, Michelle Mello and Troyen Brennan. A survey of the field yields a picture of a system that has internal logic, but falls far short of its social goals of promoting safer medicine and compensating wrongfully injured patients. *New England Journal of Medicine*, Jan. 15, 2004.
4. [Medical Malpractice: Impact of the Crisis and Effect of State Tort Reforms](#)
Claudia Williams and Michelle Mello examine the effects of the most popular malpractice reforms such as caps on non-economic damages, Robert Wood Johnson Foundation, May 2006.
5. [Understanding Medical Malpractice Insurance: A Primer](#)
Michelle Mello parses claims about the origins of the malpractice crisis and suggested policy solutions. Synthesis Project, Robert Wood Johnson Foundation, January, 2006.
6. [To Err is Human: Building a Safer Health System](#)
This landmark report documents the extent of preventable medical errors and lays out a strategy for government, health care providers, industry, and consumers to reduce them. Institute of Medicine, November, 1999.
7. [White House Fact Sheet: Patient Safety and Medical Liability Reform Demonstration](#)
The parameters of President Obama's initiative to address patient safety and medical liability. Sept. 9, 2009.
8. [Medical Malpractice Reform and Employer-Sponsored Health Insurance](#)
MA Morrissey, ML Kilgore and LJ Nelson write that although tort reform has been championed as a way to reduce health costs, their analysis of health insurance premiums several years after states enacted tort reform reveals that families and individuals have not realized any savings, Robert Wood Johnson Foundation, December 2008.
9. [The Cap Doesn't Fit](#)
Harvard economists Michelle Mello and Amitabh Chandra argue that capping damages on malpractice awards won't address 'the fundamental pathologies' of the malpractice system. *New York Times*, July 11, 2009.
10. [CBO Scoring of Tort Reform](#)
Congressional Budget Office offers an updated analysis of the effects of proposals to limit costs related to malpractice. Oct. 9, 2009.
11. [Limiting Tort Liability for Medical Malpractice](#)
Congressional Budget Office finds the evidence "does not make a strong case" that restricting malpractice liability would have a significant effect, either positive or negative, on economic efficiency. Jan. 8, 2004.
12. [Medical Malpractice System Breeds More Waste](#)
New York Times columnist David Leonhardt parses the reasons to reform the malpractice system. *New York Times*, Sept. 23, 2009.

13. [Do We Have a Winner? How to Reform the Broken Medical Malpractice System](#)
Dr. Darshak Sanghavi talks reforming liability so that injured patients get timely compensation, but in a manner that protects doctors and encourages them to learn from their mistakes. *Slate*, Nov. 9, 2009.
14. [Any Malpractice Reforms Should Put Patients First](#)
Kevin Pho, M.D., a primary care physician in Nashua, N.H, writes about the problems of reforming malpractice. *USA Today*, Oct. 26, 2009.
15. [I'm a Doctor. So Sue Me. No, Really](#)
Rahul K. Parikh, M.D. explains why he takes issue with doctors' groups that argue that capping malpractice suits will make health care cheaper, *Salon*, Oct. 27, 2009.
16. [Tax Reform's Lesson for Health Care Reform](#)
Former Sen. Bill Bradley says the two parties must strike a grand bargain on universal coverage and malpractice tort reform. *New York Times*, Aug. 30, 2009.
17. [Just Medicine](#)
Common Good Chairman Philip K. Howard argues that creating a system of health courts to handle medical liability would save millions and restore a foundation of trust. *New York Times*, April 1, 2009.
18. [Could Health Courts be An Answer to Malpractice Reform?](#)
A compilation of resources about health courts. Robert Wood Johnson Foundation, Oct. 23, 2009.
19. [The Menu of Malpractice Reforms](#)
Atlantic correspondent and Common Good Chairman Philip K. Howard compares the various proposals to reform medical malpractice, *The Atlantic*, Sept. 13, 2009.
20. [Health Courts: Bad for Patients and Unconstitutional](#)
The Center for Justice and Democracy, a consumer advocacy group, enumerates the reasons it opposes health courts. 2006.

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