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# Do Health Reform and Malpractice Reform Fit Together?

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## Introduction

A frequent claim among critics of the Patient Protection and Affordable Care Act (PPACA) is that they would have been more likely to support “real health care reform” if it included malpractice reform. Indeed, many Republicans argued that health care spending and defensive medicine could be controlled only if the PPACA included comprehensive malpractice reform. House minority leader John Boehner (R-Ohio) offered a health reform bill in the fall of 2009 that included a series of conventional restrictions on lawsuits, including a one-year statute of limitations on medical malpractice claims involving adult patients (with a longer and more complicated period for claims involving children), a \$250,000 cap on noneconomic damages recoverable from all sources for the same injury, and a sliding-scale limit on lawyers’ contingent fees, with a maximum of 15 percent of any amount recovered in excess of \$600,000.

The final version of the PPACA, however, included only two minor provisions related to medical malpractice. Section 6801 recites the “Sense of the Senate” that “health care reform presents an opportunity to address issues related to medical malpractice and medical liability insurance.” Section 6801 goes on to encourage states “to develop and test alternatives to the civil litigation system as a way of improving patient safety, reducing medical errors, encouraging the efficient resolution of disputes, increasing the availability of prompt and fair resolution of disputes, and improving access to liability insurance, while preserving an individual’s right to seek redress in court.”

The second provision is slightly more substantive. Section 10607 authorizes \$50 million over a five-year period to support demonstration grants to states for the “development, implementation, and evaluation of alternatives to current tort litigation for resolving disputes over injuries allegedly caused by health care providers or health care organizations.” To qualify for the new funding, a state must demonstrate that its proposal:

- Makes the medical liability system more reliable and efficient;
- Encourages the disclosure of health care errors and enhances patient safety;
- Improves access to liability insurance;
- Fully informs patients about the differences in the alternative and current tort litigation;
- Provides patients the ability to opt out of or voluntarily withdraw from participating in the alternative at any time;
- Does not conflict with state law and will not limit or curtail a patient’s existing legal rights.

The Department of Health and Human Services has not yet funded pilot programs under this section. However, the provision seems to contemplate grants similar to, although more comprehensive than, the awards the Agency for Healthcare Research and Quality made recently to state-based research groups.

Why did the PPACA not emphasize malpractice reform as a more important component of health care reform? Should the PPACA have done more to change the rules of malpractice liability? What kinds of changes might make sense? We provide a structured response to these questions, blending a discussion of politics and policy.

## Health Reform: Means and Ends

The PPACA attempts to achieve four distinct goals. First, assure that everyone can obtain health insurance at group rates. Second, subsidize coverage to make it affordable for people of limited means. Third, reduce health care spending by enhancing the quality and cost-effectiveness of health care services. Fourth, improve population and individual health.

An overwhelming majority of health policy analysts would agree with the desirability of the third and fourth goals. Indeed, the failure to achieve them is likely to lead to financial ruin, as private health insurance costs erode cash wages and spending on Medicare and Medicaid crowds out almost everything else in the federal budget.

What most clearly distinguishes supporters of PPACA from opponents is whether the first and second goals—which are undoubtedly insufficient to ensure long-term sustainability of the health care system—should be pursued before more substantial progress has been made on the third goal. Supporters believe addressing the first and second goals are necessary in the short run and should be prioritized. Opponents believe addressing the first and second goals before the third goal is achieved will likely amplify the cost pressures currently straining the system and accelerate its meltdown. This issue divides the authors of this study, one of whom strongly supports the PPACA for expressing a collective interest in health care access and efficiency, and one of whom is deeply skeptical about the PPACA’s limited ability to restrain health care spending.

Similar disputes divide those who argue for including malpractice reform in health reform. Few would argue that malpractice reform alone is sufficient to broaden access to health services, improve quality, and reduce costs. However, many people believe that the costs of defensive medicine are substantial and that malpractice reform should be deployed immediately to help curtail health care spending. Our analysis therefore examines the degree to which malpractice reform is *necessary* to achieve effective health care reform. We focus first on politics, then on policy.

## Politics

From a political perspective, it is not surprising that the PPACA ultimately offered little to erstwhile malpractice reformers. As one of us predicted before the 2008 election, although health reform “logically requires a planned system of accountability for error . . . the political maneuvering necessary to enact a universal coverage program will most likely sidestep tradeoffs between affordability and health care quality, avoid offending powerful corporate or trial lawyer lobbyists, and leave liability to the vagaries of courts and state legislatures.”<sup>1</sup>

In the run-up to the health reform debate, political insiders similarly suggested that malpractice reform would indeed be excluded. At a speech in August 2009, Howard Dean, a nonpracticing physician and the former chair of the Democratic National Committee, explained the reasoning: “Here is why tort reform is not in the bill. When you go to pass a really enormous bill like that the more stuff you put in, the more enemies you make, right? And the reason why tort reform is not in the bill is because the people who wrote it did not want to take on the trial lawyers in addition to everybody else they were taking on, and that is the plain and simple truth.”<sup>2</sup>

Dean’s observations only hint at the tenacity and ferocity of malpractice politics. The partisan gap over malpractice reform has been as large, the differences as longstanding, and the

rhetoric as strident as any issue other than abortion. As one commentator observed:

The debate over medical malpractice can often seem theological. On one side are those conservatives and doctors who have no doubt that frivolous lawsuits and Democratic politicians beholden to trial lawyers are the reasons American health care is so expensive. On the other side are those liberals who see malpractice reform as another Republican conspiracy to shift attention from the real problem.<sup>3</sup>

As a result of thirty-five years spent battling in state and federal legislatures, stakeholder positions have become deeply entrenched. Since 1975, roughly thirty states have adopted caps on noneconomic or total damages in medical malpractice cases.<sup>4</sup> These state laws vary in their design details, but the most popular version among tort reformers remains California's Medical Injury Compensation Reform Act of 1975 (MICRA), which imposed a flat cap of \$250,000 on noneconomic damages, not indexed to inflation. Several states adopted caps, only to have them invalidated on state constitutional grounds. For example, Illinois enacted caps on noneconomic damages three times – but each time, the law was overturned by the Illinois Supreme Court.

Increasing partisanship in Washington, D.C., during the 1990s and 2000s magnified and altered the politics of medical malpractice. The malpractice crises of the 1970s and 1980s were fierce but narrow fights involving doctors, liability insurers, and malpractice lawyers. An uneasy truce lasted through the 1990s because medical malpractice insurance premiums stabilized, but dramatic increases in the early 2000s produced a third crisis, and a return to open warfare over malpractice reform.

By then, however, medical malpractice had become the poster child for and against general tort reform. Democrat officeholders and candidates focused on the plight of those who are negligently injured (which positioned them to receive campaign contributions from many trial lawyers, including those who usually sue large corporations). Their Republican counterparts focused on how personal-injury lawsuits create risks and impose costs (which positioned them to receive campaign contributions from manufacturers, insurance companies, and those with general business interests).

At the federal level, the House of Representatives passed a cap on noneconomic damages in 2002, 2003, and 2004—only to see it die each time in the Senate. In his 2003 State of the Union address, President George W. Bush argued strongly in favor of a federal cap on malpractice damages, asserting that “to improve our health care system, we must address one of the prime causes of higher cost, the constant threat that physicians and hospitals will be unfairly sued. Because of excessive litigation, everybody pays more for health care, and many parts of America are losing fine doctors. . . . I urge the Congress to pass medical liability reform.”<sup>5</sup> The issue also figured in the 2004 presidential election but receded from view as the latest malpractice crisis eased, although President Bush mentioned it in his 2005, 2006, and 2007 State of the Union addresses.

At times during the 2009 congressional debates over health reform, efforts were made to attract bipartisan support. Malpractice reform was a logical “olive branch” with which to encourage Republicans to sign onto the PPACA. In his speech to both houses of Congress on September 9, 2009, President Barack Obama signaled his willingness to negotiate on this issue, stating, “I don’t believe malpractice reform is a silver bullet, but I have talked to enough doctors to know that defensive medicine may be contributing to unnecessary costs.”<sup>6</sup> In the same breath, he committed to funding a set of malpractice reform demonstration projects recommended by the

Institute of Medicine in 2002—unexpectedly reviving a report that had been roundly ignored since its release.

Beyond that, however, the olive branch was never actually extended. The Obama administration was unable to trade malpractice reform for other concessions, in part because Republican opposition to the PPACA’s other provisions hardened, and in part because the general business and trial lawyer constituencies most interested in the outcome of tort reform were less concerned about the PPACA-version of health reform. As one of us observed at a conference in October 2009 on whether malpractice reform might be part of a “Grand Bargain,” such proposals were more likely to fracture support for the bill than overcome opposition to it.

As a result, not only did Minority Leader Boehner’s proposals go nowhere in the House of Representatives, but Democratic leaders also moved back toward their base. Indeed, one leading health care bill authorized additional grants to states that adopted “effective” tort reform, but it expressly excluded damages caps from the list of qualifying initiatives. The *Wall Street Journal* pointedly described this as a “hidden Pelosi tort bomb.”<sup>7</sup>

Bipartisanship failed as a political strategy, but were there other political arguments for including malpractice reform in the PPACA? It is still possible that the omission of stronger malpractice provisions cost health reform efforts valuable political capital.

### *Public appeal*

The best political argument for including malpractice reform as part of health reform is that the public expects it to be there. Medical malpractice is the tabloid celebrity of health policy. Loud, loquacious, and larger than life, it is hard to take your eyes off it, even though you can see it coming from miles away and know that another train wreck is imminent. Liability reform is framed by outrageous anecdotes, skewed statistics, and hyperbolic talking points. Many of the most visible parties involved seem to be angry—doctors are angry about being sued; lawyers are angry that legislators are messing with the tort system; and injured patients are angry that no one treats them with respect or wants to learn from their experience.

Regardless of what experts may assert, public opinion persistently identifies malpractice reform as a necessary component of health reform. The public believes that fear of lawsuits increases the cost of treatment and reduces the supply of physicians. Medical errors have attracted more attention since the publication of *To Err Is Human*, the Institute of Medicine’s landmark 1999 report, but people tend to believe that their own physicians and hospitals are uniquely capable. As a result, the public concludes that patients are more likely to be harmed by defensive medicine (including inability to find a physician when they need one) than by bad medical care.

### *Federalism and Fiscal Politics*

Federal malpractice reform raises separation of powers and federalism concerns. Tort law is almost always state law, and it is typically made or modified by state judges. In an environment resistant to centralizing control over health care in the federal government, an activist approach to medical liability could be politically risky. Congress might well prefer to avoid opening that can of worms.

However, if malpractice reform is scored as generating significant budgetary savings, then it might make it easier to enact durable health reform. When the Congressional Budget

Office (CBO) analyzed the costs of the malpractice system during the Bush administration, it estimated that replicating California's MICRA law at the federal level would save only about \$5 billion in federal outlays over a ten-year period (CBO's usual time horizon). During the debate over the PPACA, however, it revised that estimate upward by a factor of ten, concluding in an October 9, 2009, letter to Senator Orrin Hatch (R-Utah) that federal tort reform would save \$54 billion over ten years, mostly by reducing Medicare payments for defensive medicine.<sup>8</sup>

### *Stakeholder Politics*

Every previous attempt at national health reform since Franklin D. Roosevelt's presidency has been stymied by opposition from organized medicine. Increased attention to malpractice reform might have been used during the latest health reform debate to court the profession and lock in physician support. Perhaps surprisingly, the American Medical Association (AMA), though not all of its state and local counterparts, remained an ally of the Obama administration from start to finish. This support mooted the question of additional concessions beyond those contained in President Obama's September 2009 speech.

The basis of the AMA's position has not been well described. It was probably a complex mix of moral conviction regarding the need for universal coverage, frustration with the hassles associated with continually rising health care costs, fear that legally mandated reductions in physician fees under Medicare's sustainable growth rate formula might actually be implemented, a promise from the administration to "fix" the physician payment system more favorably to physicians, and the desire to play a central role in reforming health care.

But the battle for physicians' hearts and minds was likely unwinnable if the menu of proposed malpractice reforms strayed from the familiar. Some health care providers engage in magical thinking about the power of MICRA-style reforms and tend to regard unfamiliar ideas as trial lawyer trickery. Consequently, more innovative and comprehensive malpractice reforms may provoke hostility from physician groups, leaving the political process little room for negotiation beyond a brass-knuckle exchange of conventional tort reforms for physician acceptance of payment restrictions or other delivery-system reforms.

Malpractice reform embedded in health reform has the potential to backfire in exactly this way. In 1993, the Clinton administration attempted to generate goodwill among physicians by proposing that malpractice liability in a restructured health care system be borne, not by the medical profession, but by the "accountable health plans" that would have competed to provide benefits to individuals covered through the Health Security Act's proposed "health alliances" (precursors to the "health insurance exchanges" in the PPACA). Because a shift in accountability seemed to imply a loss of control, the administration's "enterprise liability" proposal was loudly condemned by physicians, with one prominent doctor publicly decrying the violation of his "constitutional right to be sued."<sup>9</sup> This hostility was encouraged by physician malpractice insurers, many of which used their close ties to state and local medical societies to beat back what would have been a serious threat to their market power.

In the debate over the PPACA, there were clear risks that offers of federal relief from malpractice liability might again inadvertently prescribe cures that physicians regarded as worse than the disease. In the early 1990s, the proposed transfer of malpractice liability to health maintenance organizations (HMOs) seemed to confirm the profession's fears that medical decisions would be made by insurance companies, not physicians. (This was not an issue five years later, when the reality of managed care briefly persuaded the AMA to make common cause

with the trial bar to *expand* patients’ rights to sue health insurers.) Recent reform proposals to shield physicians from liability if they comply with clinical practice guidelines, or to deem physicians federal employees in order to cover their malpractice costs under the Federal Tort Claim Act, might receive a tepid reception or worse if physicians see such measures as further eroding their clinical discretion or, more dramatically, as a harbinger of socialized medicine.

## Policy

The remainder of this paper considers whether malpractice reform is necessary to the success of health care reform as a matter of public policy, rather than as a political strategy. This question can be further distilled and reframed as follows. First, might malpractice reform accomplish important malpractice policy objectives when combined with major changes to health care financing and delivery that it could not accomplish without those changes? Second, might the goals of health reform be easier to achieve by including stronger malpractice reforms than by omitting them?

We believe that the prospect of stand-alone malpractice reform is potentially very different from its strategic incorporation into a broader health reform bill. Implicit in this statement is our sense that many of the claims both supporters and opponents of malpractice reform make are not supported by the evidence. There has long been a striking mismatch between stakeholder opinion regarding malpractice reform and what is actually known about the tort system’s performance. Indeed, as one of us has noted previously:

[Although] the malpractice reform debate is highly polarized, the . . . principal conflict is between the major political stakeholders on one side, and the academic community on the other. The former group understands the central question to be the desirability of enacting MICRA-style measures to discourage lawsuits and limit recoveries, with a \$250,000 cap on noneconomic damages as its centerpiece. The latter group is essentially unanimous in its opinion that traditional “tort reform” offers incomplete solutions to only a subset of critical problems.<sup>10</sup>

Stated differently, if you diagnose the disease incorrectly, you are unlikely to arrive at the correct treatment.

It is important to recognize that tort reformers and health reformers tend to speak different languages. A grid that crosswalks terminology between health policy and malpractice policy can shed light on both the potential synergies and tensions between the two analytic traditions. Some policy changes map easily to specific intersections of malpractice and health policy, while other intersections less readily translate from one policy sphere to the other. Table 1 illustrates some of those connections.

Health policy is typically described using three dimensions: access to care, cost of care, and quality of care. Access and cost are functions of both supply and demand, with population health (age, chronic disease, etc.) increasingly recognized as the major driver of demand. Quality of care is often divided further into technical quality and interpersonal quality. Quality also has both static and dynamic aspects, with the latter frequently labeled “innovation.”

Malpractice policy uses different but related terminology. The ability to make victims whole by obligating injurers to pay damages is referred to as “compensation.” The prospect of paying damages induces potential defendants to behave non-negligently—which is called

“deterrence.” Distinguishing blameless from blameworthy acts and making its conclusions known to the parties and to society is described as “corrective justice.” Efficiency is also important, whether one is focusing on the direct adjudication and insurance costs of the liability system, or the wasteful spending it might induce by defendants and plaintiffs. In performing these general functions of tort law, medical malpractice policy relies on three specific sets of actors and institutions: professionals and institutions that deliver health care services, legal processes that resolve disputes, and liability insurers (and, indirectly, health insurers) that reduce and spread the risk of financial loss.

**TABLE 1**  
**CROSSWALKING HEALTH POLICY AND MALPRACTICE POLICY TERMINOLOGY**

	<i>Malpractice Policy Terminology</i>			
<i>Health Policy Terminology</i>	Deterrence of poor-quality care	Compensation for injury suffered	Corrective justice	Administrative efficiency
Access to care	Reduced “avoidance behavior” (negative defensive medicine)	Expanded health insurance coverage	Reduced health disparities	Keeping liability premiums affordable for new types of providers
Cost of care	Reduced “assurance behavior” (positive defensive medicine); outcome-based payment	Reduced financial burden of illness; de-fragmented clinical care (including bundled payment)		Decreased insurance costs; decreased dispute resolution costs
Interpersonal quality			Error disclosure to patients; less adversarial dispute resolution	Less adversarial dispute resolution

**TABLE 1 (CONT.)**

	<i>Malpractice Policy Terminology</i>			
<i>Health Policy Terminology</i>	Deterrence of poor-quality care	Compensation for injury suffered	Corrective justice	Administrative efficiency
Technical quality	Patient safety; health information technology; outcome-based payment; nonpayment for avoidable error	Nonpayment for avoidable error		
Innovation	Health system coordination (e.g., ACOs); development of new tools and treatments		Patient-centered care (e.g., medical homes)	Improved liability insurance markets
Demand for care/population health	Preventive care and healthier behaviors	Less need for care and potential exposure to medical error	Reduced health disparities	

Characteristics of *both* the health care and malpractice systems determine the signal-to-noise ratio (i.e., the strength and clarity) of the informational signal from an alleged act of medical negligence. As table 2 shows, any system for resolving malpractice disputes will generate four kinds of results: proper payments (true positives), improper payments (false positives), improper payment denials (false negatives), and proper payment denials (true negatives). Proper payments and proper payment denials are the outcomes consistent with corrective justice. They also send the most effective deterrent signals and reduce the incentives for inefficient defensive medical practice. However, compensation will suffer if efforts to ensure proper payment denials result in an increase in improper payment denials.

**TABLE 2**  
**A TYPOLOGY OF MALPRACTICE SIGNALS REGARDING CLAIMS AND PAYMENTS**

Was the claimant injured negligently?	Was the claimant compensated?	
	Yes	No
Yes	Proper payment	Improper payment denial
No	Improper payment	Proper payment denial

Importantly, the “positive predictive value” of filing a malpractice claim depends not only on the reliability of a determination of liability as an indicator of substandard care, but also on the base rate of substandard care in the health care system. Positive predictive value is the likelihood that a successful claim is actually a valid one, which is the attribute of the malpractice system most salient to physicians. If medical errors are frequent, positive predictive value will tend to be high because true positives (properly compensated harms) are more likely to surface than false positives (nonmeritorious claims that receive payment). On the other hand, if medical errors are less frequent, false positives are more likely to surface than true positives.

Thus, as the safety of medical care improves, the case for demanding greater precision from the malpractice system becomes stronger. Conversely, if other vehicles exist to finance the medical costs of negligent injury, the malpractice system can tolerate lower sensitivity to possible negligence in its liability determinations. More broadly, improvements in patient safety will amplify problems with deterrence and justice unless the sensitivity of the claiming system improves in parallel. After all, malpractice litigation is supposed to compensate those who are negligently injured – not those who suffer a non-negligent medical injury or are not injured at all.

*Patient Safety and Deterrence of Error*

Degree of Mismatch among Claims, Payments, and Negligence. For the malpractice system to create the appropriate incentives, patients injured negligently must sue—and if patients injured non-negligently sue, they should not receive compensation. The conventional wisdom is that malpractice claims are frequent, and follow medical injury regardless of fault. Obstetricians joke about being sued eighteen years later when Harvard rejects babies they had delivered. However,

the evidence is clear that relatively few injured patients demand compensation. At the highest level, one can compare the estimated number of medical injuries (not all of which are the result of negligence) to the number of malpractice lawsuits filed nationwide. By one estimate, there more than 1 million medical injuries, but only eighty-five thousand malpractice claims annually.<sup>11</sup>

The findings of three major studies<sup>12</sup> using data from four different states support this conclusion. Focusing on patients hospitalized in California during 1974, Don Harper Mills found that negligent injuries exceeded malpractice claims by a factor of ten. The Harvard Medical Practice Study (HMPS) examined hospitalizations in New York in 1984 and found that the number of negligent (i.e., avoidable) injuries was 6.7 times larger than the number of statewide malpractice claims. The third study, conducted by researchers associated with the HMPS, looked at hospitalizations in Colorado and Utah in 1992. It found comparable ratios of negligent (i.e. avoidable) injuries to statewide claim filings of 5:1 (Colorado) and 6.7:1 (Utah). These studies are now somewhat dated, and subsequent research has focused on specific treatments, conditions and settings, rather than on state-wide analysis. But, the consistency of these findings across three decades and four states is still striking, and we have no evidence that there has been a change for the better since the Colorado and Utah studies were published in 2000. These findings indicate that there is significant under-claiming -- which means that many negligently injured patients are inadequately compensated and that negligence is under-deterred.

Do the right people get paid? Once an inquiry or complaint giving rise to a formal claim has received initial evaluation and response, how effectively does the legal system sort the wheat of meritorious claims from the chaff of nonmeritorious claims? Critics of the tort system argue that it is essentially random, using language like “jackpot justice” and “lawsuit lottery” to describe the manner in which the system allocates payments. The argument is frequently bolstered with anecdotes describing out-of-control juries and complaints about the irrationality of noneconomic damages.

Judged by the basic framework set forth in table 2, the medical malpractice system gets to the “right” result most (but certainly not all) of the time. Studies using experts to review medical records for evidence of error find that claimants who received substandard care usually obtained compensation, that claimants who received proper care generally did not, and that claimants whose care quality was uncertain wound up in between. A recent study of claims by HMPS-related researchers found that the malpractice system reached the “right” result about 75 percent of the time, with false negatives (improper payment denials) a more frequent problem than false positives (improper payments).<sup>13</sup>

To be sure, some patients sue even though their injuries were not caused by provider negligence. Such over-claiming is common, but it is important to note that saying a claim is non-meritorious does not necessarily make it “frivolous.” Information is often difficult to obtain following a medical injury, leaving malpractice lawyers to serve a necessary (albeit inefficient) investigatory function. To the extent that patient safety procedures within provider organizations improve and the results of post-injury investigations are shared promptly with patients and their families, there is less need for the legal system to assume this role.

Once one moves beyond the investigatory phase, the malpractice system again sorts cases imperfectly. Almost all of those who receive medical treatment are sick to begin with, and some are at death’s door. In many cases, it can be difficult to differentiate malpractice from the natural course of disease. Every contested case involves opposing experts with conflicting opinions of

the quality of care that was delivered. When experts disagree, we should not expect omniscience from judges and juries.

Focusing on claims that are filed but later dropped or dismissed obscures the larger reality that most injured patients do not file claims even when negligence caused them harm. Moreover, the overwhelming majority of improper payments (false positives) result from settlement, not an erroneous adjudication of liability. When a malpractice insurer voluntarily pays a claim that an expert reviewer in a retrospective research study adjudges to lack merit, legitimate questions remain as to whether the payment was wholly unwarranted or due to other factors. Insurers refuse to pay most medical malpractice claims, suggesting that some of the “false positive” payments identified in several studies may be the result of variation in expert medical opinion.

Clinical Responses to Deterrent Signals. As the legal system handles a malpractice claim, a liability/nonliability signal is created by lawyers, judges, and juries based on prevailing legal norms. The signal then is processed through the two other parts of the malpractice system: liability insurance and clinical care. In principle, given the basic match between poor care and claims payment (under-claiming aside), a liability insurer that charges high malpractice premiums might create a visible and salient incentive for providers to improve the quality of the services they are offering. Under this theory, allowing malpractice premiums to rise, instead of taking steps to artificially cap them, harnesses the self-interest of providers and increases the probability that patients will receive error-free care.

Unfortunately, major imperfections in the markets for liability insurance and medical care make effective deterrence from malpractice litigation less likely, even if premiums are allowed to rise. The correlation between malpractice premiums and quality of care is far from perfect. There is little risk-rating of individual physicians; instead, premiums vary by a physician’s specialty and type of practice and the county in which he or she works. For most complex illnesses, physicians depend as a practical matter on the judgment and performance of many other professionals and institutions. However, physicians’ nominal clinical authority has remained largely unchallenged, so that a much larger percentage of health care spending (approximately 70 percent) is traceable in litigation to their individual decisions than is earned by them as fees (approximately 20 percent).

Moreover, the American health care system remains highly fragmented, with many physicians working in solo or small-group practice settings and being paid independently of the hospitals that provide the most expensive subset of services used by their patients. Future medical expenses are a major component of malpractice damages. As the cost of medical care rises, physicians in a few specialties are obligated to bear far more liability than their proportionate share of health system revenues and their actual degree of control would seem to justify. Financing the liability potentially associated with this health care spending is a major challenge for individual practitioners.

Liability insurance markets compound the problem. As small businesses, most physicians purchase commercially underwritten coverage that is rated according to their specialty and geography, not their safety record. Hospitals, by contrast, self-fund large retentions until excess liability coverage kicks in. The principal deterrent associated with physician coverage therefore is a blunt one. Premiums can rise sharply or a physician can be dropped from coverage after a costly claim, particularly during one of the periodic “hard markets” for malpractice insurance. At the same time, there are few opportunities for physicians to work

together and with hospitals to improve their practices and derive a financial reward in the form of reduced liability insurance costs from doing so. This may change if a substantial percentage of American physicians become employed by hospitals (or by hybrid entities such as Accountable Care Organizations) and the enterprise rather than the individual physician becomes the focus of liability and/or malpractice insurance.

Anesthesia provides a useful case study of how tort signals can serve as effective deterrents in some environments and less effective deterrents in other environments. Today, anesthesia is the safest part of many surgical procedures, but it once exposed patients to serious risks. Credit for improvement belongs to the leaders of the American Society of Anesthesiologists (ASA), who initiated an ambitious patient-safety initiative. Although studies found that most anesthesia mishaps were preventable, anesthesiologists did little to reduce the frequency or severity of mistakes until 1983–85, when the ASA organized a conference on patient safety, created the Anesthesia Patient Safety Foundation (APSF), and inaugurated a closed claim study. The study identified major areas of malpractice losses and proposed strategies for injury prevention. For example, after the ASA concluded that preventable respiratory-related events were “the single most important source of liability,” APSF researchers promulgated practice guidelines and helped manufacturers redesign the machines used to deliver anesthesia.

A 2005 article in the *Wall Street Journal* summarized the striking impact of these efforts:

Today, anesthesia-related adverse events and emergencies are rare, and anesthesiologists’ malpractice insurance premiums are low. Anesthesiologists pay less for malpractice insurance today, in constant dollars, than they did 20 years ago. That’s mainly because some anesthesiologists chose a path many doctors in other specialties did not. Rather than pushing for laws that would protect them against patient lawsuits, these anesthesiologists focused on improving patient safety. Their theory: Less harm to patients would mean fewer lawsuits.<sup>14</sup>

The ASA started taking patient safety seriously because rising insurance premiums and an unflattering 1982 television documentary forced its hand. In the words of the former head of the ASA, “[a]nesthesiology [malpractice] premiums were . . . among the very highest—in many areas, two to three times the average cost for all physicians. By the early 1980s, anesthesiologists recognized that something drastic had to be done if they were going to be able to continue to be insured.”<sup>15</sup> Another participant in the initiative wrote that it might never have gotten off the ground had there not been “a malpractice crisis that was markedly reducing the incomes of anesthesiologists.”<sup>16</sup>

Anesthesiology had certain advantages over other medical fields when making this transition. Its work was performed in a hospital environment, with support staff and capital improvements available more than in physicians’ offices. Serious anesthesia errors were immediately apparent and difficult to conceal. Causation was usually straightforward. Technology was improving rapidly and could be shared among practitioners. Anesthesiology also was emerging as a distinct specialty, which hastened the adoption of innovative techniques and new procedures.

Not all of the decrease in anesthesiologists’ malpractice exposure—particularly that associated with labor and delivery—was the result of improved safety. Monitoring technologies that produce objective readings of vital signs indeed alert anesthesiologists to impending,

preventable disaster. But they also create irrefutable documentation that some bad outcomes are not the anesthesiologist's fault, transferring the liability risk to other physicians. In other words, the specialty's response to liability was both protective and deflective, with only the (large) former one representing true safety improvement.

Lessons for Health Reform. If the PPACA succeeds in reducing provider fragmentation, improving coordination of care, and basing payment for services on error-free value received from systems of health care such as Accountable Care Organizations and bundled payment programs, the relationship between liability premiums and deterrence may begin to approach what theory and common sense would predict. A recent RAND study of hospital safety and malpractice claims at the county level in California, not focused on anesthesia, found a strong correlation between reduced adverse events and lower malpractice claim rates.<sup>17</sup> Put simply, malpractice premiums primarily reflect the cost of compensating injured patients and the administrative costs of doing so – and not the costs of frivolous litigation. In one study, fully 80 percent of the incurred costs were attributable to claims in which negligent treatment occurred, even though 40 percent of claims did not, in the opinion of expert reviewers, contain evidence of errors in care.<sup>18</sup>

Reformers should stop focusing so narrowly on the risk that small physician practices will find liability coverage inaccessible during occasional periods of insurance market volatility, while hoping that damage caps and similar MICRA-style tort reforms will, as a by-product, significantly reduce the inefficiencies and financial excesses associated with the fee-for-service medicine usually practiced in these settings. Instead, malpractice reformers should seek changes to legal processes and liability insurance structures that help move the health care system toward more coordinated, cost-conscious approaches to clinical care. This has two parts, which are not incompatible with some limitations on claims or recoveries: first, placing accountability for injury on the organizations best able to avoid errors; and second, protecting cost-conscious provider organizations from degrees of liability risk so large (that is, punitive damages) that innovative forms of care may fail to develop. We discuss both of these ideas at greater length below.

### *Compensation and Sources of Payment*

Patients Who Sue. The malpractice system routinely undercompensates most claimants, although victims with small claims are sometimes modestly overpaid. Undercompensation also correlates positively with injury severity, so that victims suffering the worst injuries recover the smallest portions of their losses. As one commentator notes, “[t]his pattern of overcompensation at the lower end of the range and under-compensation at the higher end is so well replicated that it qualifies as one of the major empirical phenomena of tort litigation.”<sup>19</sup>

Injury severity is nonetheless an important predictor of the magnitude of payouts. More severe injuries consistently receive higher payouts. The award of noneconomic damages and the chance of a multi-million-dollar verdict also correlate strongly with injury severity, although payouts to estates of deceased claimants are lower than payouts to the most severely injured (but still living) claimants.

Even a large verdict provides no guarantee of complete compensation for a serious injury, however. Comparing verdicts to actual payments in Texas cases where patients won at trial, plaintiffs rarely collected large verdicts in full, especially if verdicts exceeded providers'

insurance policy limits.<sup>20</sup> Both the likelihood and magnitude of discounted recoveries increased with verdict amount, meaning that the patients entitled to the most compensation (judging by the jury verdict) gave up the most, both in absolute dollars and as a percentage of their verdicts, in post-trial settlement negotiations.

In the current system, little direct compensation is available to claimants beyond what is provided by physicians' liability insurance. In the Texas data, insurers frequently tendered policy limits to plaintiffs with strong cases and occasionally paid beyond those limits to avoid a subsequent claim for failing in bad faith to properly defend the physician policyholder. Whether because of asset protection schemes, jury discomfort with "blood money," or high transaction costs of collection, injured patients rarely received compensation from physicians' personal funds.<sup>21</sup>

This means that the availability of liability insurance is crucial to ensuring compensation if defendants are individual professionals (as opposed to institutions). Further, the amount of available insurance strongly predicts the maximum compensation that can be paid—with attendant risks of undercompensating severely injured claimants and overcompensating claimants injured by providers who happen to have more coverage.

Patients Who Do Not Sue. As noted previously, the malpractice system is beset with both under-claiming and over-claiming, with the former the more frequent problem. Patients who fail to initiate a claim or lawsuit obviously receive nothing from the medical malpractice system. The economic costs associated with their injuries are assumed by the patients themselves, their relatives and friends, first-party insurers (especially health insurers, but also life and disability insurers), and public social welfare systems.

Incentives for attorneys are a critical consideration. To obtain compensation, patients must convince lawyers to represent them. Because plaintiffs' attorneys work on contingency and malpractice claims are protracted and expensive to litigate, a case yielding less than \$150,000 in recoverable damages is often a bad business proposition for a potential plaintiff's counsel. Empirical studies report that plaintiffs' attorneys screen malpractice cases carefully and reject the overwhelming majority of those who request representation.<sup>22</sup>

Tort reforms make lawyers even more selective. Some states have limited contingent fees directly, which may be warranted in certain cases but still tends to exacerbate the problems of under-claiming because plaintiffs' lawyers may well conclude that the risk and expense of litigation outweigh the potential reward. Damage caps indirectly limit contingent fees. In Texas, lawsuits have dropped dramatically since strict noneconomic damage caps were enacted in 2003. The effect of similar MICRA-style reforms that have been adopted by a majority of states is to make malpractice and malpractice insurance cheaper for potential defendants (by reducing the frequency of lawsuits and the amounts that must be paid to resolve them). Mandatory offsets for collateral sources of compensation for economic loss (such as health insurance) also can have these effects if noneconomic damages alone are not large enough to make representing a plaintiff profitable for the lawyer. Further, patients may be unwilling to become plaintiffs if most of the proceeds must be repaid to their health insurers.

Lessons for Health Reform. It is hard for the malpractice system alone to compensate negligently injured claimants adequately – and it is harder still when past tort reforms have increased the number of uncompensated injuries (by making some cases no longer worth bringing), and widened the gap between losses and payments in cases where compensation is paid.<sup>23</sup> General

problems with the health care system—such as lack of health coverage, incomplete benefits, seemingly arbitrary pricing, and relentless cost growth—pose parallel challenges to the compensatory goals of medical malpractice law. Individuals who lack health insurance may incur crippling costs for additional medical care necessitated by injury if they do not file a lawsuit. Even patients with good-quality private health insurance may lack adequate coverage for long-term supportive care if they suffer serious, permanent disability.

Because the financial risk of catastrophic medical error is so great, one of us has argued that universal coverage is the most powerful tort reform. To the extent that the PPACA succeeds in expanding coverage while also rationalizing and reducing health care spending (because effective care will cost less and be more readily accessible), it has the potential to significantly dampen the demand for malpractice litigation. However, if the PPACA's coverage expansion primarily accelerates health care spending and does not materially improve quality of care, it may be more likely to increase the number of malpractice claims.

Severe birth injury cases may require special attention because of the profound nature of the plaintiff's injury, the sympathy it naturally generates, the financial burden of care, and the attenuated connection between many such outcomes and provider negligence. These cases are readily litigated, often against deep-pocketed hospitals as well as physicians, because estimates of the lifetime costs of medical and supportive care can reach eight figures or more. This harm is pecuniary, which means that jury awards are not subject to noneconomic damage caps. The associated financial risk is sufficient to jeopardize the availability of a hospital's excess coverage in tight reinsurance markets, or at least to render it unaffordable. At the same time, the estimates that yield these large payments are contestable, typically produced by partisan experts based on inflated medical charges that are hard to counter by defendants without seeming to concede liability.

Two states, Florida and Virginia, have dedicated birth injury compensation programs that attempt to deal with these cases on a no-fault basis.<sup>24</sup> However, the programs were adopted during earlier malpractice crises, were designed primarily to stabilize liability insurance premiums for obstetricians, and have lacked secure, adequate funding. A productive direction for the PPACA might be to develop a federal program for neonatal injury compensation, analogous to the national vaccine injury compensation fund, that emphasizes community-based prenatal care, safe birthing practices, and new models for managing long-term disability.

### *Justice, Honesty, and Fairness*

Inefficiency and Immorality. Righteous indignation is never in short supply where malpractice policy is concerned. Legal and public policy scholars tend to analyze tort liability in dispassionate terms of economic efficiency—witness the largely sterile discussions of deterrence and compensation in previous sections of this paper. The feelings of participants in actual cases are often far less temperate, invoking basic moral concepts of justice, honesty, and fairness. As a result, some scholars have revived a view that tort law is about vindicating the right of victims to seek redress in court for conduct that is “just wrong,” rather than allocating the cost of negligence to the “cheapest cost avoider.”<sup>25</sup>

Medical malpractice policy is caught between these two perspectives on tort law. On one hand, medical injuries impose real costs on patients and society that demand efficient prevention and compensation. On the other hand, a patient mistreated by a physician feels that he or she has suffered a private wrong that needs correction, while an unsupported allegation of medical

negligence against a physician is a personal affront that demands refutation.<sup>26</sup> Partly for this reason, physicians' views on malpractice policy typically come from the gut and are entwined with feelings about their professional reputation and self-worth.

Disclosing Medical Errors. Over the last ten years, a new movement has urged physicians and other health care providers to be honest with patients and families when unexpected bad outcomes of medical care happen. Interest in error disclosure blossomed in the wake of the IOM's 1999 report on medical error. Conventional tort reformers initially regarded error disclosure with suspicion, believing it at best to be a distraction from aggressive lobbying for damage caps and at worst a litigator's trick to get potential defendants to go on record regarding their malfeasance. The discordance between improving patient safety information and the established politics of tort reform was neatly captured by the glacial debate in Congress over patient safety legislation, which took nearly a decade to produce a modest statute allowing the creation of Patient Safety Organizations to collect and analyze provider reports of errors and near-misses.

The skeptics were wrong. In practice, disclosing medical errors struck a resonant chord with both patients and physicians. If a malpractice suit is seen as an accusation of moral failure, it is not hard to embrace honesty as proof of moral worth. Moreover, younger generations of physicians have been socialized to be more likely to respect patient autonomy, seek informed consent, share decision making, and discuss end-of-life options. Disclosing and discussing medical errors is consistent with this worldview.

It even turned out that transparency increased institutional incentives for self-critical analysis, contrary to the expectations of the first generation of patient safety pioneers. As current CMS administrator Donald Berwick has said in support of quality reporting generally, "I have completely lost faith in the concept of confidentiality as an important asset in improvement."<sup>27</sup>

Finally, voluntary disclosure of error constituted a self-help measure that is seldom available to modern physicians. Physicians are well paid, but they have sensed a loss of control over their professional circumstances during recent decades. Conventional tort reforms had a poor track record in this regard: years of lobbying and associated political contributions often produced legislation that was subsequently invalidated by courts on state constitutional grounds. Evidence also accumulated that disclosing errors and even apologizing to patients were not merely helping trial lawyers prove their cases. Notably, prominent academic centers such as the University of Michigan reported markedly lower costs associated with malpractice litigation after adopting disclosure policies.

Distributional Issues. Justice and fairness intersect with malpractice policy in other ways. Poorer, older, sicker individuals typically receive less benefit from malpractice litigation, while paying the steepest price in terms of access to services during liability insurance crises. One consideration is who files suit, which is a function both of individuals' proclivity to use legal process and of lawyers' incentives to take their cases. Although there are exceptions in certain communities, on balance the poor and elderly sue less frequently.

Another distributional issue is the common mischaracterization of reductions in malpractice insurance premiums as evidence of societal "cost savings." This claim is simply wrong; if one caps damages, the resulting reduction in insurance payouts and malpractice premiums is largely a redistributive transfer, not an efficiency gain (apart from reductions in transaction costs). Tort damages transfer wealth from health care providers to injured patients.

Reducing those awards will transfer wealth in the opposite direction, but does not by itself constitute net “savings.”<sup>28</sup> If reducing awards also reduces injuries, social savings will result, but there is no reason to believe that will happen.

Finally, the interaction of malpractice liability and access to care raises fairness issues. During malpractice crises, it is commonly claimed that restrictions on lawsuits are needed to maintain access to specialized medical care, such as neurosurgery and high-risk obstetrics, in rural and underserved communities. Based on available research, the boost to overall physician supply from damage caps is small (approximately 3 percent) though nontrivial.<sup>29</sup> However, it seems plausible that supply effects at the margin would benefit poor and minority populations who, for reasons of geography or economics, have tenuous access to medical care. Still, tort reform is unlikely to be the most efficient way to accomplish that goal, especially if adopted on a statewide or national basis.

Lessons for Health Reform. In malpractice policy, justice is more about individual experience than about social welfare. The most damning criticisms of the current malpractice system relate to process, not outcome. Suffering from a serious medical error, or committing one, is terrible. But malpractice litigation itself also is inhumane for both plaintiffs and defendants, as is watching others endure that experience. Moreover, any mental image a patient might conjure of vindication in open court is illusory—the more likely outcome is years of stonewalling and uncertainty followed by an impersonal payment conditioned on signing a confidentiality agreement (at best) or an outright loss (at worst). Neither will a physician, once accused, ever feel truly exonerated. Efforts to find more humane alternatives to litigation are desperately needed.

But replacing one bureaucracy with another is unlikely to bring the justice that patients and physicians seek. For this reason, proposals for “health courts” need rethinking. Health courts have been promoted on the belief that lay judges or juries unfairly blame physicians for bad medical outcomes. To the contrary, evidence suggests they are quite forgiving, even when they should not be. A different process modeled on what patients and physicians jointly value—honesty, compassion, and nonabandonment—is likely to perform better for all concerned. Furthermore, these goals should be pursued at the patient’s bedside or shortly thereafter, not years later on the courthouse steps.

The projects recently funded by AHRQ, and the more ambitious demonstration projects to be funded through the PPACA, have some promise to move in this direction by emphasizing error disclosure, alternative dispute resolution processes, and/or liability “safe harbors” for evidence-based practice. Because the PPACA was passed on a purely partisan basis, it is important to build trust among participating stakeholders that the new initiatives are serious efforts to improve the malpractice and health care systems, and not merely window dressing to hide the absence of traditional tort reforms.

Another important step is to use public programs as a test bed for developing less adversarial processes linked to safety improvement and increased transparency. Claims against physicians practicing in Federally Qualified Health Centers must be brought under the Federal Tort Claims Act (which limits attorneys fees, utilizes bench trials, and makes the United States liable for malpractice instead of the individual physician). The Department of Health & Human Services also operates an “early offer” program to encourage speedy resolution of such claims. It would be worthwhile to develop an alternative dispute resolution process for those cases. More sweepingly, similar dispute resolution processes connected to patient safety could be constructed

within the Medicare and Medicaid programs.<sup>30</sup>

These efforts should be approached with two priorities in mind. First, everyone involved should have reasonable expectations about what medical care can accomplish, whether particular care is cost-effective, and what might go wrong regardless of fault. Second, there is a need for speed. Delay benefits nobody when a serious problem has occurred. Patients need assistance, physicians need support, the health care system needs to learn from its mistakes, and the insurance mechanisms that finance it all need predictability.

### *Cost and Defensive Medicine*

Clinical and Administrative Costs. We have saved the cost-effectiveness of the malpractice system for last. Although cost-effectiveness is not a goal of tort law in itself, lack of cost-effectiveness undercuts all the other goals. This is particularly true for the contentious costs of defensive medicine, which are included in this section even though they most directly affect the malpractice and health policy dyads of deterrence/quality and compensation/access to care. Tort law aspires to induce behavior that prevents harm and is cost-justified. Defensive medicine falls outside this boundary. Physicians engage in both assurance behaviors (performing additional services, such as diagnostic imaging, primarily to counter a subsequent allegation of malpractice) and avoidance behaviors (ceasing to offer categories of services associated with increased malpractice risk or expense). These wasteful clinical practices constitute “over-deterrence” that can increase costs, curtail access, and reduce quality.

Defensive medicine also rhetorically bridges the gap from the ex post perspective (that is, focusing on the interests of those who have already been negligently injured) to the ex ante perspective (that is, considering the interests of everyone before it is known who needs medical care and who will be negligently injured). Everyone wants to avoid unnecessary medical expenses, which explains why defensive medicine typically becomes the primary justification for tort reform whenever liability insurance premiums decline from crisis levels.

To be sure, defensive medicine is not the only cost issue in the malpractice system. Psychic costs for both plaintiffs and defendants, while hard to quantify, are real as well. Administrative costs are high and appear to have increased considerably in recent years.<sup>31</sup> Between hefty payments for lawyers and experts defending malpractice cases, and the plaintiff’s legal fees and expenses, it costs about sixty cents to move a dollar from a defendant or liability insurer to a plaintiff. Overall, nearly 80 percent of administrative costs are associated with litigation involving actual errors in care.<sup>32</sup> Awards that pay mainly for attorney fees are not available as compensation to patients. If malpractice litigation is too expensive, some negligently injured patients will not pursue claims and some nonnegligent physicians will settle for a payout, weakening deterrence and justice. The cost of administering the liability insurance system is also significant, as is the time physicians spend purchasing insurance and defending claims.

Avoidable Costs. Measuring the costs of the malpractice system is challenging. The most recent such estimate (\$56 billion annually) provides a starting point for thinking about the costs and benefits of the liability system, compared to its alternatives.<sup>33</sup> As the authors recognize, that estimate is only as good as its assumptions. One difficulty is that the estimate reflects only monetized costs—meaning that it disregards any welfare loss that does not result in paid damages. So if an individual suffers a negligent medical injury but does not receive

compensation, all losses, even the cost of additional medical care, are not included. More importantly, the \$56 billion estimate focuses only on the costs of the malpractice system, not on the benefits (including costs avoided because of deterrence of medical error). Finally, the authors do not attempt to compare the current costs of the malpractice system to a plausible alternative. Before settling on a policy response, one must understand the costs and benefits of the other approaches, rather than simply recite the costs of the status quo. The connection between asserting the high cost of the malpractice system and promoting a particular malpractice reform remains more of a political choice than an empirical conclusion.

Lessons for Health Reform. There are significant opportunities for synergy between malpractice reform and health reform in reducing wasteful spending and promoting cost-effective care. On the other hand, we are persuaded that meaningful cost savings from malpractice reform without major alterations of the health care delivery system are unlikely.

The debate over defensive medicine encapsulates this limitation. Research shows that many physicians practice defensively and that virtually all physicians *believe* that they practice defensively.<sup>34</sup> These habits and beliefs seem unaffected by evidence regarding the actual likelihood of a lawsuit or the level of potential damages. In one recent study, physicians in states with strong tort reforms and in states lacking those reforms articulated identical views regarding malpractice risk.<sup>35</sup> Even physicians practicing in low-liability-risk environments display high levels of anxiety about the malpractice system.

In conjunction with major national reform of the delivery system, however, malpractice reform can reassure physicians that they will not face increased liability by changing their organization and behavior, and can prevent the imposition of additional, undesired costs on the health care system once changed. If malpractice reform can allay these fears and reduce these risks, substantial gains in efficiency and cost-effectiveness may be achievable. By the same token, efforts to make health care more efficient and cost-effective through financial and structural incentives may be less fruitful if physicians remain fearful of malpractice risk.

## **New Directions for Malpractice Policy**

We close with several malpractice reform proposals that build on and complement the policy themes of health reform.

### *Smart Caps*

Tort reform should be used strategically. All states with damages caps apply them equally to all providers, regardless of the effort providers have expended to improve the quality of their services. A better strategy would be to use damage caps to encourage providers to improve their quality of care. One could reward providers who report errors by capping damages against them, while punishing those who hide mistakes by increasing damage awards against them. Similarly, one could adjust allowable damages to reward providers who achieve defined quality benchmarks in their overall clinical practices.

## *Payment Reform*

At the federal level, health policy is payment policy. Medicare primarily pays physicians on a fee-for-service basis, unconnected to the quality, effectiveness, and cost-effectiveness of a test or treatment. Strikingly, the cost of malpractice insurance is explicitly incorporated into the physician-payment methodology, which means that the malpractice system effectively reinforces continued reliance on fee-for-service physician payment, and fee-for-service physician payment reinforces continued reliance on conventional physician malpractice insurance.

Building on initiatives from the Bush and Clinton administrations, the PPACA includes several pilot programs and demonstration projects seeking to move physician payment toward bundled payment and payment for value. The PPACA also creates a Center for Medicare and Medicaid Innovation to test new ways of structuring health care payment and delivery systems. There is evidence that providers improve when payers tie compensation to results or quality targets, although design details matter. If payment reform results in improved quality of care, the drop in medical injury rates will reduce the amount of money flowing through the malpractice system. Thus, payment reform can act synergistically with malpractice reform, while also changing the political dynamics that have locked in the status quo.

## *Transparency*

Transparency initiatives can help improve quality and reduce errors while also improving (or avoiding) the process of resolving disputes. Public reporting of process- and outcome-based quality measures encourages health care providers to do a better job, either because consumers choose to patronize higher-performing providers (a demand-side effect), or because providers do not want to appear to be below average (a supply-side effect). For example, Medicare's endorsement of basic quality measures and use of mild payment penalties for nonreporting entities caused hospitals' compliance with evidence-based treatment guidelines to skyrocket. At the individual level, both physicians and patients value honesty about errors, which the law can encourage with incentives or require outright. Because disclosure laws influence private transactions without substituting direct government regulation, transparency has bipartisan appeal. Conservatives tend to applaud "market facilitation" and "self help," while liberals celebrate "empowerment" and the "right to know."<sup>36</sup>

## *Improving the Dispute Resolution Process*

Criminal defense lawyers tell their clients "even if you can beat the rap, you can't beat the ride." That insight also applies to malpractice; physicians who are sued spend several years in limbo until their case is tried, settled, or dropped. Plaintiffs also experience those long delays. Process improvements have the potential to change the interpersonal dynamics and speed resolution of claims. Examples include mediated conversations between providers and patients after unexpected outcomes of care, legal protection to ensure apologies are not used against those offering them, and experiments with administrative adjudication mechanisms such as hearings before specialized officials, schedules of appropriate damages, and dedicated compensation funds for selected injuries.

### *Improving Liability Insurance*

Physicians control roughly 70 percent of health care costs through their referral and prescriptive authority, and they are held legally responsible for injuries caused by those decisions. This structure saddles the physician sector with an aggregate “warranty cost” that it is poorly equipped to support. When something goes wrong with very expensive medical care, mitigating the harm is also very expensive, but only a small portion of the original revenue stream was captured by physicians and is therefore available to insure them. Worse still, liability insurance premiums are volatile, with the cost unevenly distributed among physicians. This gives rise to considerable discontent, although it is tempered to some extent by the fact that lucrative procedural specialties (e.g., orthopedics and neurosurgery) tend to have higher premiums than less remunerative cognitive ones (e.g., psychiatry and pediatrics) because harms from the former are usually easier to prove. Nonetheless, the allocation of malpractice premiums on this basis intensifies periodic insurance crises, fosters specialty-specific defensive practices, and threatens bottlenecks in certain services and locations. Policymakers might explore alternatives to the current system’s allocation of liability. One obvious possibility is to bundle liability coverage with the funding of the care that gives rise to the risk of claims. Public and private health insurers might be able to finance liability risks less expensively than the status quo, with its mix of first-party and third-party coverage. Private contract provides an obvious tool with which to test this approach.

### *Corporate Liability*

There are reasons to be concerned about the excessive attribution of liability to both existing and new institutions that provide or manage medical care. Public suspicion of commercial influences in health care increases the incentive to pursue claims against institutions, particularly when previously scattered injuries can be collected under a corporate umbrella and attributed to financial self-interest. Despite the erosion of the locality rule, independent physicians are rarely held responsible (either legally or in the subjective estimation of the average juror) for lacking access to a cutting-edge diagnostic or therapeutic technology. Not so for hospitals, whose capital-investment decisions are considered deliberate choices, not determined by external circumstances. Hospitals also reasonably fear that attempts to influence physicians’ clinical decisions to contain costs will result in liability.

Even greater potential liability may attach to the care-coordination and cost-containment efforts of health insurers. In the 1990s, courts and medical professional organizations rejected the idea that managed care should be held to a different malpractice standard than fee-for-service medicine. Because the public feared that HMOs would ration care in pursuit of profit, juries applying conventional malpractice standards to the behavior of large, wealthy insurers were more likely to impute malicious intent, assign liability, and award punitive damages. Employer-sponsored health plans have been substantially protected from this risk by federal preemption of state tort remedies under the Employee Retirement Income Security Act, but systematic efforts by health plans to oversee or provide strong incentives for cost-conscious physician practice may still result in vicarious liability. If liability risk and its attendant bad publicity become too great, health plans will withdraw from more intensive levels of care management (as they did in the

1990s).

These same considerations apply to new entities formed in direct response to the PPACA, such as physicians and hospitals working together to accept bundled payment and Accountable Care Organizations that attempt to systematically coordinate medical services within communities. They also apply to recent innovations in affordable health care delivery, such as retail medical clinics. Such considerations may influence the development and implementation of health information technology, which is frequently portrayed as a panacea for inefficient care delivery. The exchange of price and quality data may give rise to novel theories of liability associated with the accuracy, impartiality, and security of that information.

It is sensible to place accountability for injury on the organizations best able to avoid errors and to protect provider organizations from being attacked simply for being cost-conscious. Possible strategies include heightened scrutiny of punitive damages awards, statutory safe-harbors for good-faith efforts to restructure care delivery, and enforceable indemnification agreements for the allocation of liability risk.

### *Guidelines*

Recently there has been renewed interest in conferring immunity from malpractice claims on physicians based on their compliance with clinical practice guidelines. Experiments with guidelines as stand-alone malpractice interventions—such as a decade-long demonstration project conducted in Maine during the 1990s—have had unimpressive results.<sup>37</sup> Mistrust and inertia seem largely responsible for that failure, likely because guidelines were framed as a compromise between opposing sides in the tort reform debate and not as an important component of health system change.

Guidelines can play a broader, potentially more constructive role today. The science of guideline development has improved dramatically since 1990. The guideline projects that are underway bridge many areas of health system operation, including benefit design, payment, fraud control, and liability. To be sure, the process by which guidelines are developed and updated demands attention, as does the potential legal accountability of the organizations who promulgate guidelines. There also is little consensus on whether guidelines should constitute a sword (to be used by plaintiffs when treatment does not satisfy the guideline), a shield (to be used by defendants when treatment meets or exceeds the guideline), or both.

### *De-Fragmented Physician Practice*

Physicians in larger-practice organizations tend to have less intense fears about malpractice risk than those in solo or small-group practices. Some large clinical organizations have developed innovative systems for addressing patient injury using captive or self-funded insurance vehicles and more efficient systems of dispute resolution – although it is not clear whether such strategies translate into lower rates of negligent injury, better handling of disputes about negligent treatment when they occur, or both. Malpractice reform that helps disseminate such bottom-up strategies to the broader physician community has the potential to make everyone better off.

### *Nonphysician and Interdisciplinary Practice*

As tens of millions of newly insured individuals seek services, the need for high-quality, cost-

effective primary care will become even more acute. A large percentage of these critical services seems likely to be provided in interdisciplinary, community-based settings such as a “medical home,” which is specifically endorsed by the PPACA, or by advanced-practice nurses, physician assistants, and other nonphysician professionals in independent community practice. However, professional liability coverage remains dominated by models based on physicians’ practice patterns and income streams, and it is often sold by physician-owned mutual companies that are inaccessible to other health professionals. Reform proposals should take account of this important market need, without which it will be harder to develop affordable forms of primary care.

## **Conclusion**

The PPACA’s omission of malpractice reform was a missed opportunity to secure the support of physicians for payment reform and delivery-system transformation. The latter reforms will not succeed without the willing participation of physicians. Recall how many psychiatrists it takes to change a light bulb. Answer: the light bulb has to want to change. Reform that addresses the legitimate malpractice fears of physicians can only help.

To be sure, the politics of malpractice warrant caution. In malpractice circles, special interests frequently pose as general ones. Beyond the health care sector, business or trial-lawyer constituencies may exploit medical malpractice policy for strategic advantage in an overall civil justice agenda. Within the health care industry, focused commercial interests such as existing liability carriers may seek to protect favored positions. The real issue is what we want our health care system and our malpractice system to do when working together. Modifications to both should be undertaken with that question in mind.

## Additional References

William M. Sage and Rogan Kersh, eds., *Malpractice and the U.S. Health Care System* (Cambridge, UK: Cambridge University Press, 2006).

Tom Baker, *The Medical Malpractice Myth* (Chicago: University of Chicago Press, 2005).

Frank A. Sloan and Lindsey M. Chepke, *Medical Malpractice* (Cambridge, MA: MIT Press, 2008).

Randall R. Bovbjerg, “Malpractice Reform in Policy Perspective,” *Milbank Quarterly* 85 (2007): 297.

David A. Hyman and Charles Silver, “Medical Malpractice Litigation and Tort Reform: It’s the Incentives, Stupid,” *Vanderbilt Law Review* 59 (2006): 1085–1136.

## Notes

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<sup>1</sup> William Sage, “Both Symptom and Disease: Relating Medical Malpractice to Health Care Costs,” in *Antidote: Strategies for Containing America’s Runaway Health Care Costs*, ed. M. Gregg Bloche and Leslie A. Meltzer (Washington, DC: Brookings Institution Press, forthcoming 2011).

<sup>2</sup> Mark Tapscott, “Dean Says Obamacare Authors Don’t Want to Challenge Trial Lawyers,” *Washington Examiner*, August 26, 2009, available at [www.washingtonexaminer.com/opinion/blogs/beltway-confidential/Dean-says-Obamacare-authors-dont-want-to-challenge-trial-lawyers-55140567.html](http://www.washingtonexaminer.com/opinion/blogs/beltway-confidential/Dean-says-Obamacare-authors-dont-want-to-challenge-trial-lawyers-55140567.html) (accessed November 19, 2010).

<sup>3</sup> David Leonhardt, “Medical Malpractice System Breeds More Waste,” *New York Times*, September 22, 2009.

<sup>4</sup> David A. Hyman et al., “Estimating the Effect of Damage Caps in Medical Malpractice Cases: Evidence from Texas,” *Journal of Legal Analysis* 1, no. 1 (2009): 355.

<sup>5</sup> George W. Bush, “Text of President Bush’s 2003 State of the Union Address” (speech, Washington, DC, January 28, 2003), available at [www.washingtonpost.com/wp-srv/onpolitics/transcripts/bushtext\\_012803.html](http://www.washingtonpost.com/wp-srv/onpolitics/transcripts/bushtext_012803.html) (accessed November 19, 2010).

<sup>6</sup> Barack Obama, “Remarks by the President to a Joint Session of Congress on Health Care” (speech, Washington, DC, September 9, 2009), available at [www.whitehouse.gov/the\\_press\\_office/remarks-by-the-president-to-a-joint-session-of-congress-on-health-care/](http://www.whitehouse.gov/the_press_office/remarks-by-the-president-to-a-joint-session-of-congress-on-health-care/) (accessed November 19, 2010).

<sup>7</sup> “. . . And a Buried Tort Bomb,” *Wall Street Journal*, November 12, 2009.

<sup>8</sup> Congressional Budget Office (CBO), letter to Senator Orrin Hatch, October 9, 2009, available at [www.cbo.gov/ftpdocs/106xx/doc10641/10-09-Tort\\_Reform.pdf](http://www.cbo.gov/ftpdocs/106xx/doc10641/10-09-Tort_Reform.pdf) (accessed November 19, 2010).

<sup>9</sup> William M. Sage, “Enterprise Liability and the Emerging Managed Health Care System,” *Law and Contemporary Problems* 60, no. 159 (1997): footnote 46, available at <https://www.law.duke.edu/journals/lcp/downloads/LCP60DSRING1997P159.pdf> (accessed November 19, 2010).

<sup>10</sup> William M. Sage, “Understanding the First Malpractice Crisis of the 21st Century,” in *Health Law Handbook*, ed. Alice G. Gosfield (Eagan, MN: West Group, 2003).

<sup>11</sup> David A. Hyman and Charles Silver, “Medical Malpractice Litigation and Tort Reform: It’s the Incentives, Stupid,” *Vanderbilt Law Review* 59, no. 1089 (May 2006): 1085–1124.

<sup>12</sup> Don H. Mills, J. S. Boyden, and David S. Rubsamen, *Report on the Medical Insurance Study* (San Francisco: Sutter Publications, 1977); Troyen A. Brennan, Lucian L. Leape, Nan M. Laird et al., “Incidence of Adverse Events and Negligence in Hospitalized Patients—Results of the Harvard Medical Practice Study I,” *New England Journal of Medicine* 324 (1991): 370–76, available at [www.nejm.org/doi/full/10.1056/NEJM199102073240604](http://www.nejm.org/doi/full/10.1056/NEJM199102073240604) (accessed November 19, 2010); Eric J. Thomas, David M. Studdert, Helen R. Burstin et al., “Incidence and Types of Adverse Events and Negligent Care in Utah and Colorado,” *Medical Care* 38, no. 3 (2000): 261–71, available with subscription at [www.jstor.org/pss/3767190](http://www.jstor.org/pss/3767190) (accessed November 19, 2010).

- 
- <sup>13</sup> David M. Studdert, Michelle M. Mello, and Atul A. Gawande, "Claims, Errors, and Compensation Payments in Medical Malpractice Litigation," *New England Journal of Medicine* 354 (2006): 2024–33, available at [www.nejm.org/doi/full/10.1056/NEJMsa054479](http://www.nejm.org/doi/full/10.1056/NEJMsa054479) (accessed November 19, 2010).
- <sup>14</sup> Joseph T. Hallinan, "Once Seen as Risky, One Group of Doctors Changes Its Ways," *Wall Street Journal*, June 21, 2005.
- <sup>15</sup> Ellison C. Pierce Jr., "The 34th Rovenstine Lecture: 40 Years Behind the Mask: Patient Safety Revisited," *Anesthesiology* 84, no. 4 (1995).
- <sup>16</sup> Jeffrey B. Cooper, "Getting into Patient Safety: A Personal Story," Agency for Healthcare Research and Quality, available at [www.webmm.ahrq.gov/perspective.aspx?perspectiveID=29](http://www.webmm.ahrq.gov/perspective.aspx?perspectiveID=29) (accessed November 18, 2010).
- <sup>17</sup> Michael D. Greenberg, Amelia M. Haviland, J. Scott Ashwood, and Regan Main, "Is Better Safety Associated with Less Malpractice Activity? Evidence from California," RAND Institute for Civil Justice 2010 (TR-824-ICJ).
- <sup>18</sup> Studdert et al, *supra* note 13.
- <sup>19</sup> Michael J. Saks, "Do We Really Know Anything about the Behavior of the Tort Litigation System—and Why Not?" *University of Pennsylvania Law Review* 140, no. 4 (1992): 1147–1292.
- <sup>20</sup> David A. Hyman et al., "Do Defendants Pay What Juries Award? Post-Verdict Haircuts in Texas Medical Malpractice Cases, 1988–2003," *Journal of Empirical Legal Studies* 4, no. 1 (2007): 3–68.
- <sup>21</sup> Kathryn Zeiler et al., "Physicians' Insurance Limits and Malpractice Payments: Evidence from Texas Closed Claims, 1990–2003," *Journal of Legal Studies* 36, no. 2 (2007): S9–S45.
- <sup>22</sup> Hyman & Silver, *supra* note 11.
- <sup>23</sup> Myungho Paik, Bernard S. Black, David A. Hyman, William M. Sage, and Charles M. Silver, "How Do the Elderly Fare in Medical Malpractice Litigation, Before and After Tort Reform? Evidence from Texas, 1988–2007" (working paper, September 28, 2010), available at <http://ssrn.com/abstract=1605331>.
- <sup>24</sup> Randall R. Bovbjerg and Frank A. Sloan, "No-Fault for Medical Injury: Theory and Evidence," *University of Cincinnati Law Review* 67 (1998): 53.
- <sup>25</sup> John C. P. Goldberg and Benjamin C. Zipursky, "Torts as Wrongs," *Texas Law Review* 88 (2010): 917.
- <sup>26</sup> See William M. Sage, "Reputation, Malpractice Liability, and Medical Error," in *Accountability: Patient Safety and Policy Reform*, ed. Virginia A. Sharpe (Washington, DC: Georgetown University Press, 2004), 159–83.
- <sup>27</sup> Robert Galvin, "'A Deficiency of Will and Ambition': A Conversation with Donald Berwick," *Health Affairs* web exclusive, January 12, 2005, available at <http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w5.1v3> (accessed December 6, 2010).
- <sup>28</sup> Office of Management and Budget Document on "Best Practices" for Preparing Economic Analysis of Significant Regulatory Action Called for under Executive Order 12866 (1996) (available at [http://www.whitehouse.gov/omb/inforeg\\_riaguide](http://www.whitehouse.gov/omb/inforeg_riaguide)).
- <sup>29</sup> Daniel P. Kessler, William Sage, and David J. Becker, "The Impact of Malpractice Reforms on the Supply of Physician Services," *The Journal of the American Medical Association* 293, no. 21 (2005): 2618–25.
- <sup>30</sup> Eleanor D. Kinney and William Sage, "Resolving Medical Malpractice Claims in the Medicare Program: Can It Be Done?" *Connecticut Insurance Law Journal* 12, no. 1 (2005–2006): 77–136.
- <sup>31</sup> Bernard Black, David A. Hyman, William M. Sage & Charles Silver, "Defense Costs in Medical Malpractice and Other Personal Injury Litigation: Evidence from Texas, 1988–2004," *American Law and Economics Review* 10, no. 245 (2008): 185–245.
- <sup>32</sup> Studdert et al, *supra* note 13.
- <sup>33</sup> Michelle M. Mello, Amitabh Chandra, Atul A. Gawande, and David M. Studdert, "National Costs of the Medical Liability System," *Health Affairs* 29, no. 9 (September 2010): 1569–77.
- <sup>34</sup> David M. Studdert et al., "Defensive Medicine among High-Risk Specialist Physicians during a Malpractice Crisis," *Journal of the American Medical Association* 293, no. 21 (2005): 2609–17.
- <sup>35</sup> Emily R. Carrier, James D. Reschovsky, Michelle M. Mello, Ralph C. Mayrell, and David Katz, "Physicians' Fears of Malpractice Lawsuits Are Not Assuaged by Tort Reforms," *Health Affairs* 29, no. 9 (September 2010): 1585–92.
- <sup>36</sup> William M. Sage, "Regulating through Information: Disclosure Laws and American Health Care," *Columbia Law Review* 99, no.7 (1999): 1701–1829.
- <sup>37</sup> Michelle Mello, "Of Swords and Shields: The Use of Clinical Practice Guidelines in Medical Malpractice Litigation," *University of Pennsylvania Law Review* 149, no.2 (2001): 645–710