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The Obama administration recently announced it would fund experimental programs to test possible approaches to reforming the medical malpractice system, and doctors and trial lawyers are undoubtedly paying close attention. Beginning in 2010, the Department of Health and Human Services will award a total of $25 million in grant money (with individual grants of up to $3 million) to states and health care systems to initiate the programs, dubbed “demonstration projects,” and the administration hopes these projects may reveal effective ways to improve virtually every aspect of the current system.

According to a government fact sheet, recipients of the grants will use the money to test models to reduce liability premiums and frivolous lawsuits, enhance the quality of doctor-patient communication, decrease injuries to patients, and ensure that patients who do suffer medical injuries receive fair compensation in a timely manner. That’s a tall order.

As potential grantees begin preparing proposals, an examination of 2 traditional criticisms of the current medical malpractice system may provide a useful guide in establishing the contours of a new approach. First, there is the popular conception that extravagant judgments for frivolous claims have driven up the price of malpractice insurance and the cost of health care more broadly. Second, there is the notion that, aside from the cost of malpractice judgments themselves, the fear of lawsuits creates unnecessary costs by spurring many doctors to engage in defensive medicine, the recommendation of treatments and diagnostic procedures unlikely to benefit patients, but that may shield doctors from malpractice liability.

Yet empirical evidence shows the first claim is simply false. Moreover, while there may be some truth to the second claim, its validity in a given instance depends on how we define defensive medicine and how we calculate the values of life and limb in deciding whether a procedure is worthwhile. A better understanding of the available evidence on the impact of malpractice suits and of the implicit values inherent in the designation of a doctor’s recommendations as constituting defensive medicine can help policy makers determine the most effective ways to improve the current regime.

**Frivolous Lawsuits and Health Costs**

The belief that plaintiffs’ attorneys pursuing frivolous claims in front of credulous juries is a major cause of skyrocketing malpractice insurance and other health-care costs is so deeply rooted that many doctors take its veracity as an article of faith. Yet numerous studies have demonstrated this is not the case. The claim that frivolous lawsuits in particular are driving up insurance premiums and other health costs is belied by the results of a 2006 Harvard School of Public Health study finding that most meritless malpractice claims result in no compensation to the plaintiffs who bring those claims and that, even in the cases when claims involving no medical negligence do result in compensation, that compensation tends to be considerably lower than for cases in which there was some medical error. If the total number of frivolous claims had increased drastically over time, then increased administrative costs could, hypothetically, drive up the price of insurance premiums, even if all frivolous claims were eventually resolved without compensation for the plaintiffs who brought them. However, the total number of malpractice claims does not seem to have risen significantly in recent years, and there is no evidence of any dramatic spike in frivolous claims either. Ultimately, claims not involving medical errors account for only 13% to 16% of the malpractice system’s total costs, including judgments, settlements, and administrative costs.

The data on hand also contradict the assertion that all malpractice claims, including both meritorious and frivolous claims, are responsible for severe increases in insurance premiums and health costs. As early as 1986, at the height of the tort reform movement, the National Association of Attorneys General released a report con-
cluding, contrary to the vigorous arguments of insurance company lobbyists, that rising insurance premiums were the result of the insurance industry’s own mismanagement, not an alleged liability crisis. Since then, repeated analysis has shown there is no strong correlation between total malpractice payments and the size of insurance premiums. For example, states with the highest increases in malpractice payments between the early 1990s and early 2000s were not the states with dramatic increases in insurance premiums. And although total malpractice payments have grown over the years, these increases have been generally proportional to overall increases in health spending, suggesting that rising medical costs, which are a major component of damages in malpractice judgments and settlements, explain much of the escalation in payments. In other words, health costs may be driving up malpractice payments, not the other way around.

Ultimately, most medical errors never lead to malpractice claims at all. A 1991 study suggested that when medical negligence results in harm, injured victims decide to pursue malpractice claims only 2% to 3% of the time. If that is the case, malpractice costs may represent dramatic undercompensation for harms caused by medical error. In any case, the direct costs of malpractice claims represent such a minuscule portion of overall medical spending that, even ignoring the forgoing data, the idea of malpractice payments as a major driver of health costs is implausible. The total cost of malpractice judgments, settlements, and administrative costs is less than $10 billion a year, less than one-half of a percent of total medical spending. Dogma aside, it is clear the direct costs of malpractice liability have not significantly contributed to escalating health care costs.

### Defensive Medicine

Even if the direct costs of malpractice claims are relatively low, fear of liability may lead many doctors to recommend treatments and diagnostic tests with little likelihood of benefitting patients. The economist Amitabh Chandra has estimated that the threat of malpractice claims may lead to as much as $60 billion a year in unnecessary medical spending. Thus, while malpractice payments and administrative costs are not significant immediate drivers of overall health costs, the practice of defensive medicine may represent serious wastefulness that adds substantial gratuitous costs to the system.

Nonetheless, it is worth analyzing the bases for the value judgments that inform decisions on whether to characterize recommended treatments and diagnostic tests as constituting defensive medicine in the first instance. In tort law, a classic mathematical model for determining whether a recommended precaution is worthwhile, and, thus, whether failure to take the precaution constitutes actionable negligence, is to compare the cost of the precaution to the likely loss if the precaution is not taken. Judge Learned Hand, who developed the analytical model, suggested that failure to take a precaution should be considered negligent when the cost of the precaution is less than the figure derived by multiplying the probability of loss in the absence of the precaution by the magnitude of the likely harm. Such a model could be useful in determining whether a medical procedure is worthwhile in any given instance, or, alternatively, whether use of the procedure deserves to be classified as defensive medicine. The problem, however, is that the accuracy of the formula depends on being able to come up with precise values for the figures in the equation. While the cost of the precaution (the medical procedure in question) may be easy to determine, and while it may often be possible to come up with a reasonable statistical estimate for the likelihood of a loss in the absence of the precaution, determining the magnitude of loss when the loss in question is human life is inherently impossible to do with precision.

In a July 2009 article arguing for rationing of health care, the bioethicist Peter Singer cited Rabbi Daniel Zemel’s relation of a Jewish maxim that if you put a single human life on one side of a scale and the entire world on the other side, the scale is balanced equally, and Singer went on to suggest that people opposed to rationing health care may think along the same lines. Of course, as Singer noted, we already assign values to human life when, for example, the Department of Transportation makes decisions about how much it will spend on safety precautions statistically likely to save some finite number of human lives; in making decisions about how much to spend on any given safety measure, in 2008, the Department of Transportation valued 1 human life at $5.8 million. This kind of calculus may seem crass, but, of course, anytime one is faced with the necessity of allocating scarce public resources with life-and-death implications, it is necessary to place some fixed value on the lives in question.

Looking at the problem from the perspective of the people whose lives are at stake, as opposed to estimations of a public bureaucracy, some economists examine how much consumers are willing to spend on safety products. If buying X product will reduce the risk of death by N%, then dividing the price a consumer is willing to pay for X by the likelihood of X saving the consumer’s life can produce a crude estimate of how much that consumer values his own life. Similarly, some economists examine the differences in wages for high- and low-risk jobs, dividing the wage premium for a high-risk job by the increased risk of death to come up with a value. However, the validity of these estimates depends on consumers and workers having a full understanding of the extent of the risks they face and making rational decisions about how to deal with those risks. If consumers are not aware of the extent to which a product might reduce the risk of death, and if other factors, such as
marketing, may influence purchasing decisions, then the values that result from these calculations are meaningless. Likewise, if workers in high-risk jobs do not fully appreciate the increased risk of those jobs, and if those workers have no viable alternatives to such jobs, we cannot derive useful estimates from the mere fact of dangerous working conditions. In addition to these valuation issues, there is the problem that, ex ante, no amount of money would be great enough to induce most people to give up their lives.

Given the necessity of valuing life when allocating scarce resources, including health care, and given the inescapable imprecision of the process, we might use Hand’s formula as a guide in determining whether a medical procedure is worthwhile, recognizing that it is, at best, a rough guide. Under such circumstances, those interested in improving the malpractice system might focus on the Obama administration’s goal of using its demonstration projects to foster improved communication between doctors and patients, and to advance that imperative, it is worth promoting an increase in the number of jurisdictions that evaluate the adequacy of medical disclosure with reference to the question of what a reasonable patient would want to know, unlike the bulk of medical decision making, which courts in most jurisdictions analyze purely in relation to the standards the medical profession sets for itself.

If we can routinely expect doctors to tell patients about possible treatments and diagnostic procedures, even when those procedures have a relatively low likelihood of paying off, there will be 2 benefits. First, some patients will have the means and the will to pursue those procedures, even if the doctor may think the treatment or diagnostic test is probably not worth the cost. By allowing patients to make these determinations themselves when they have the means to do so, we recognize that, given the difficulty of determining the value of human life, we should leave decisions about its valuation to those whose lives are at stake, at least when collective resources are not at issue. Second, by informing patients of the costs and expected benefits of procedures even when the expected benefits are low and even when the patient in question does not have the means to pay for the procedure herself, we increase public consciousness and may stimulate discourse that could lead to collective reassessment of what we characterize as defensive medicine in the first instance. And, as we consider a dramatic overhaul of the entire health system, including large commitments of public funding, we may reconsider what we are willing to pay for collectively.

Ultimately, while the threat of malpractice liability may cause serious apprehension in the medical community, that threat also provides incentives to avoid negligent behavior that causes harm to patients. Each of us, doctors and non-doctors alike, faces the possibility of liability for the harms we cause through our negligence when we interact with the world. While it may be true that defensive medicine causes serious waste in the health system, our determinations about what constitutes defensive medicine, and, consequently, what behaviors we deem reasonable or negligent, turn on decisions we cannot make without reference to individual preferences and broad public discourse.

REFERENCES