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Medical Malpractice (book review)

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MEDICAL MALPRACTICE


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INTRODUCTION

Medical malpractice reform is back on the nation’s agenda. In its latest iteration, for example, the American Medical Association, together with several dozen allied health provider organizations, petitioned the congressional “supercommittee” addressing the long-term federal deficit to consider a cap on noneconomic damages to diminish incentives for defensive medicine as a way of reducing health care costs, a major contributor to that deficit.1 The plaintiffs’ bar once again is crying foul. The tenor of the debate and the identity of its partisans are reminiscent of the battles over legislative reforms of malpractice law at the state level coinciding with each of the three “medical malpractice crises” triggered by spikes in liability insurance premiums in the mid-1970s, mid-1980s, and at the turn of this century. Proposed damage limits modeled on California’s $250,000 nonmonetary damage cap from the first “crisis” in the mid-1970s figured prominently in those battles, as they do today.

The malpractice reform debate in this decade, however, is not (to borrow from Yogi Berra) “déjà vu all over again.”2 An impressive body of scholarship spanning the last 20 years has given us a clearer understanding of the causes of the three “malpractice crises” and the consequences

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of the various legislative responses. This outpouring of scholarship has illuminated the effects of various reforms on particular age and income cohorts; the costs and savings linked to the various reforms; and the workings of the liability insurance markets that are key to the operation of compensation systems. Equally important, this scholarship has offered us a broad range of proposals for ameliorating the medical tort system’s well-recognized inefficiencies and anomalies. Many recent proposals link legal reforms to better patient safety practices, connecting with the nation’s reawakening to the problem of widespread medical error documented in the studies spotlighted in the Institute of Medicine’s pathbreaking 1999 report, *To Err Is Human.*

Some of these recent proposals are the subject of state-level demonstration projects funded under the Patient Protection and Affordable Care Act of 2010, and of voluntary policy experiments initiated by hospital groups, state agencies, and liability insurers. Influenced by this scholarship, spurred by the range of available proposals, and drawing on upcoming evaluations of the state-level demonstration projects, the malpractice reform debate this next time around is likely to be conducted at a more informed and articulate level—pennised more on fact and analysis and perhaps less on rhetoric and anecdote.

**COMPREHENSIVE, CLARIFYING, AND CLEAR-EYED**

Frank Sloan’s and Lindsey Chepke’s superb book *Medical Malpractice* is required reading for serious participants in this upcoming debate. Sloan, a distinguished health care economist, and Chepke, an attorney, have diligently gathered complex evidence from a wide range of disciplines—law, medicine, insurance, politics—and presented it in a fashion easily understandable by nonspecialists in any of those fields. The book provides a balanced, comprehensive, factual overview of the structure of our legal system relating to malpractice, the system’s flaws and merits, the causes of cyclical insurance pricing and availability difficulties, ameliorative initiatives both implemented and proposed, and the political considerations affecting the achievability of leading reform proposals.

I characterize the authors’ approach as “balanced” in that they review available evidence thoroughly and impartially. But when the evidence leads to clear conclusions about what works and what does not, what proposals have a chance politically and what proposals do not, the authors do not hesitate to state where they stand. Their stances will discommodate many participants.

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2 Institute of Medicine, *To Err Is Human: Building a Safer Health System* (Linda T. Kohn et al. eds., 1999).

in the debate, physicians and trial lawyers alike; but their evidence-based conclusions cannot be ignored.

The book’s organization is a model of explanatory power. Nonspecialists, as well as readers whose familiarity with malpractice issues is compartmentalized by their particular training, might lack a grasp of malpractice reform efforts’ historical evolution, the range of alternative solutions, the critical role of the liability insurance industry, and the scholarly evidence about the effects of “tort reform” legislation. This book lays it all out in logical fashion.

The book begins with a politically and intellectually provocative chapter setting out four conceptually distinct markets in which medical malpractice operates—legal, insurance, medical care, and governmental activity markets—and five oft-repeated factual assertions that heretofore have framed the national debate. The debunking of these “five myths of medical malpractice” is central to the book’s mission, and its value. The (evidence-shattered) myths are:

1. There are too many medical malpractice claims. (The vast majority of patients injured by medical negligence never file claims and go uncompensated.)
2. Only “good” doctors are sued. (There is no statistical association between the sophistication of physicians’ practices and the frequency of lawsuits against them.)
3. Dispute resolution in medical malpractice is a lottery. (“There is a definite relationship, albeit an imperfect one, between independent assessments of liability and of injury cost and outcomes of legal disputes alleging medical malpractice.” [17])
4. Medical malpractice claimants are overcompensated for their losses. (On average, they are undercompensated.)
5. Medical care is costly because of medical malpractice. (Malpractice-related costs form only an inconsequential proportion of overall health care inflation.)

Because these five assertions are central to much of the controversy over medical malpractice, the authors’ characterization of them as “myths” and the evidentiary basis for the authors’ conclusions will be influential in debates over future reforms.

In Chapter 2 the authors proceed to the heart of what moves malpractice politics: liability insurance cycles. Clearly explaining a dynamic with which even most sophisticated readers are generally unfamiliar, the authors show that each “crisis” in liability insurance pricing and availability has been a by-product of insurance cycles. The crises are not the result of increases in the volume or award levels of malpractice claims, as organized medicine frequently asserts; nor are they caused by insurance companies’ attempts to recoup losses on poorly performing investments, as trial lawyers often argue.
Rather, combinations of the internal dynamics of the insurance industry and external events such as massive shocks affecting reinsurance (for example, 9/11 and natural disasters at the turn of the century) contributed to the periodically recurring spikes in physicians' liability insurance costs. The authors' conclusion: "[I]nsurance cycles, like business cycles and cycles in weather, clearly are here to stay." [49] We should therefore focus our attention, they argue in Chapters 2, 9, and 10, on measures to reduce the cycles' amplitude and destructive effects, such as public reinsurance for malpractice losses.

In Chapter 3, Sloan and Chepke take up the effects on physicians of the threat of lawsuits and of higher premiums: defensive medicine. Noting that public discussion of this issue "has been particularly confused" [53], the authors clarify matters by classifying defensive medicine into two categories: positive (diagnostic and therapeutic procedures in excess of what is called for solely by professional judgment) and negative (withdrawal of care due to threat of lawsuits or high premiums, either in the case of individual patients or by ceasing practice). Some defensive medicine is beneficial, deterring poor practice, as when a physician lacking sufficient competence to perform an indicated procedure declines to provide it for fear of a lawsuit. Other defensive medicine pushes up medical costs without justification, or restricts needed access to care.

What is the empirical evidence regarding how much medical malpractice litigation contributes to health care inflation and to access barriers? Surveying the studies, the authors conclude that in the long term, taking liability premium spikes together with periods of stability, actual trends in premiums "have been more moderate than much of the rhetoric asserts," rising from 0.91% of United States health care spending in 1975 to 1.58% in 2002 [58–59]. This represents a substantial percentage increase, to be sure, but it is only a small part of the overall health care cost picture, and on average, physician fee increases have covered the increased premium costs.

Premium increases alone, however, do not account for the full impact of defensive medicine on health care costs, because positive defensive medicine (excessive tests and procedures) must also be considered. The authors highlight solid work by Kessler and McClellan finding that liability-restrictive tort reform statutes in several states reduced Medicare payments for hospital care by 5 to 9%, compared to states without such laws, with no difference in mortality rates between the two groups of states—results indicating that liability-restrictive reform can reduce defensive medicine without harm to patients. Sloan and Chepke place this research in context, observing that even if such reforms do reduce the cost of care by 5 to 9%, "real spending on

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5 Daniel Kessler & Mark McClellan, Do Doctors Practice Defensive Medicine?, 111 Q. J. ECON. 353 (1996); Daniel P. Kessler & Mark McClellan, The Effects of Malpractice Pressure and Liability Reforms on Physicians' Perceptions of Medical Care, 60 LAW & CONTEMP. PROBS. 81 (1997).
personal health services increases by about this much in a two-to-three-year period. These reforms are not a panacea for reducing the growth in [health care] expenditures.” [77]

Reviewing evidence about the extent to which malpractice litigation is a cause of physician withdrawal from medical practice or from specific specialties (like obstetrics), Sloan and Chepke conclude such reports are “overstated” [70]. Far more important as barriers to access to care than the medical malpractice system, they conclude, are geographical inaccessibility and the widespread lack of health insurance.

As for the crucial question of whether medical malpractice litigation is an effective deterrent to poor care, Sloan and Chepke are unequivocal: “There is no convincing empirical evidence to indicate that the threat of a medical malpractice claim makes health care providers more careful. This lack of empirical support represents a serious indictment of medical malpractice as it currently exists.” [80–81]

In Chapters 4, 5, and 6, the authors set out a catalogue of legislative responses to the medical malpractice crises and evidence about the actual consequences of each type of legislation. Employing helpful tables, Chapter 4 summarizes these legislative initiatives and their results. “First-generation” initiatives include those aimed at limiting the size of awards and the number of suits, increasing plaintiffs’ difficulty or costs of winning, improving the judicial process, and reforming insurance. Among the “second-generation” initiatives are scheduling damages, using medical practice guidelines to set standards of care, mandating alternative dispute resolution in lieu of tort, various no-fault approaches, enterprise liability of hospitals, and private contracting to implement reforms. The authors discuss political factors that have marked first-generation reforms with widespread legislative success in the states, while second-generation proposals, with a few exceptions, have languished.

Sloan and Chepke review six studies assessing impacts of the reforms, to the extent those impacts can be disaggregated and linked to specific reforms. With regard to the first-generation reforms’ goals of reducing insurance premiums by diminishing the frequency and severity of malpractice claims, the evidence is mixed or negative as to all but one of the reforms. That one “effective” reform is now at the top of organized medicine’s political agenda: caps on damages.6

Balanced against damage caps’ effectiveness in lowering premiums is their social cost: the caps hurt those gravely injured by malpractice far more than they hurt those with minor injuries. That disparity increases over time when caps are not indexed for inflation. (California’s cap, the model for

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6To similar effect, see Kachalia & Mello, supra note 4, at 1566.
national reform proposals, is not indexed.) Chapter 5 addresses the most controversial aspect of high damage awards, the aspect most often a target of legislated damage caps: noneconomic damage for intangible injury, usually denominated “pain and suffering.” Acknowledging the problem of high payment variability, particularly at the upper end of the award scale, but insisting on the legitimacy of some compensation for intangible injury, the authors suggest more equitable ways of reforming damage awards: scheduling damages by use of award matrices, flexible ranges, injury scenarios provided to juries, or advance private contracting; and payments in the form of commitments to provide future service benefits as needed.

The authors address other later-generation reform proposals as well, some of which are being tested and evaluated in state-level demonstration projects funded under PPACA. One such proposal, arising largely from physicians’ dissatisfaction with having their work judged by lay jurors, is specialized health courts in which facts are determined and liability assessed by judges with scientific training, assisted by court-appointed experts in the relevant fields (Chapter 7). Health court proposals often incorporate damage schedules as one component, and aim at quick resolution and payment in cases of clear deviation from medical standards. The authors insightfully point out a chief advantage of health courts: “the potential for the court to monitor payment and care of injury victims over time and to facilitate coordination” among agencies providing care, an advantage making health courts “well worth considering” [186–87].

The most important reform recommendation Sloan and Chepke offer (Chapters 8 and 12) is to shift the focus of medical liability away from individual physicians to the hospitals in whose facilities, and under whose oversight, those physicians practice. This idea is by no means new; Paul Weiler and colleagues offered a similar proposal almost 20 years ago. Its chief merit is that it would align financial (liability-avoidance) and patient safety incentives on the part of the hospital—the entity with the most control over the safety system flaws identified by the Institute of Medicine as the major contributor to medical accidents. The lack of financial incentives for implementing potentially expensive patient-safety-oriented system improvements is frequently cited as the major reason for the nation’s slow progress in implementing evidence-based measures to diminish avoidable medical injury [199–200]. Centralizing injury compensation responsibility at the hospital or hospital-system level for injuries occurring within hospital walls would remedy this incentive mismatch.

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8 To Err Is Human, supra note 3.
CONCLUSION

Organized medicine, curiously, tends to be skeptical of such reforms aimed at shifting liability away from its physician constituency toward hospitals. This skepticism may be an artifact of physicians' timeworn plea that their professional autonomy to control all aspects of their patients' care must not be compromised. In this writer's view, the argument based on the value of professional autonomy has been seriously undercut by the disturbing statistics about wide variances in medical approaches to common conditions, and the persistence of medical error and non-evidence-based practice. The unreasonably high operative infection rate consequent upon failure to observe simple sanitary practices [215] is but one example of this point. As Sloan and Chepke put it, "some loss of physician autonomy is inevitable if meaningful changes in patient safety are to be realized" [319]. On this point, they are right on target. 9

The book does have a few limitations. On the safety-promoting effects of tort law, the authors could have given greater weight to the remarkable safety improvements achieved by anesthesiology specialists, partly in response to liability insurance premium hikes following adverse litigation results.10 The authors also could have enhanced the book's usefulness as a research tool by giving specific page citations to their references. Unfortunately, the manuscript appears to have been completed before most of the valuable studies on Texas malpractice claims appeared;11 those studies would have further enriched the analysis.

These quibbles aside, Sloan and Chepke have brought together in a readable, well-organized fashion the pertinent evidence on how our medical liability system works, what its flaws are, and what reforms might be politically achievable—skewering purveyors of misinformation right, left and center along the way. Medical Malpractice is outstanding.

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9 Efforts toward institutional liability may be bolstered further by the fact that today, a majority of physicians work in medical practices owned by hospitals and health systems. Gardiner Harris, More Doctors Giving Up Private Practice, N.Y. Times, Mar. 25, 2010, at B1.

10 The authors do mention this point (208–09), but apparently dismiss it when concluding that "no convincing empirical evidence" indicates that lawsuit threats make medical providers more careful [80].