Proceedings of GREAT Day

Volume 2012 Article 10

2013

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Recommended Citation

Muller, James Gerard (2013) "Medical Liability Reform in the United States: A Comprehensive Approach to Medical Error," *Proceedings of GREAT Day*: Vol. 2012, Article 10.
Available at: https://knightscholar.geneseo.edu/proceedings-of-great-day/vol2012/iss1/10

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Medical Liability Reform in the United States: A Comprehensive Approach to Medical Error

James Gerard Muller

Medical liability, also referred to as "medical malpractice," is a form of professional negligence in which the treatment a health care provider administers falls below the accepted standard of practice in the medical community, thereby causing injury or death to a patient. In the United States, malpractice is resolved through the process of litigation. If a patient has reason to believe he or she is a victim of malpractice, the patient has the legal ability to file a lawsuit. The legal remedy patient-plaintiffs seek is monetary compensation, measured by "economic loss" or financial loss and damage suffered by a person (Kessler 93–110). For a physician-defendant to be convicted of malpractice, the plaintiff's counsel carries the burden of proving: (1) the relationship between the plaintiff (patient) and defendant (physician) gave rise to a duty, (2) the defendant was negligent—meaning his care fell below the standard expected, (3) the plaintiff suffered an injury, and (4) the injury was caused by the defendant's negligence (Mello, Studdert 11–12).

Medical liability insurance is a commodity health care providers purchase in the event that they need to compensate a patient. Medical liability crises are understood as the result of sharp rises in the cost of liability insurance premiums for health care providers. In recent years, roughly from the years 2002–2005, the United States has experienced a malpractice crisis (Sloan and Chepke). What exactly created the recent medical liability insurance crisis remains in dispute.

Medical malpractice and medical liability insurance have been the topic of American policy debate from time to time. The topic's prevalence in American politics and policy debate result from a unanimous agreement among policy makers, scholars, physicians, and the educated public, that the medical malpractice system as it stands, is operating inadequately. There has been a general agreement as to what the central flaws of the current medical liability system are: (1) heavy financial burdens associated with insurance and (2) a disregard for patient safety and

reducing medical error. Admittedly, these problems are prioritized differently—some view the financial complications associated with medical liability as the most important concern, whereas others view medical error and patient safety as what deserves the greatest attention. Before addressing these concerns with considerable detail, it is first imperative to gain insight on how the litigation process works.

Malpractice Claims and the Litigation Process

Only 1 in 8 people injured by medical negligence file a malpractice claim[a], and of those claims filed, only thirty percent reach court (Mello and Studdert 13). According to the landmark Harvard Medical Practice Study (1990), only 1 in 15 patients who are victims of malpractice receive compensation, and many cases awarded compensation have no evidence of negligence (Kessler 96). Understanding these facts, the problem is obvious: many victims of malpractice are uncompensated, and the money that is given out does not go to the correct beneficiaries. The purpose of medical malpractice litigation is to compensate victims, and to deter physicians from practicing medicine in a complacent manner (Kessler 94; Mello and Studdert 17). Litigation has failed its purpose of providing compensation to those whom deserve it. In addition, litigation does not have the deterrent effect many assume it does; as Mello and Studdert have noted, the deterrent effect of the tort system rests on too many assumptions (17). One of the largest assumptions, *litigation as a form of deterrence,* makes is that physicians are always rational actors, performing some sort of hedonic calculus (Mello and Studdert 18). The second assumption the deterrence claim makes is that physicians internalize the costs of their own negligence (18).

Realizing litigation fails in accomplishing its two core purposes, the question that needs to be asked is: Should the medical malpractice compensation system continue to rely on litigation? Medical malpractice, placed in the context of litigation, is an adversarial process. Is an adversarial process in everyone's best interest? These are important questions policy makers must ask themselves, and they are questions constituents ought to ask policy makers. As it stands, malpractice's confrontational nature is a concern that requires considerable attention, and will be addressed detail throughout this paper.

Common Misconceptions With Respect to Malpractice

[a] American Association for Justice, *Five Myths About Medical Negligence*

Before addressing the two concerns laid out thus far, it is essential to know what scholars widely regard as "misconceptions" with respect to medical malpractice. The first, and perhaps the principal misunderstanding, is that frivolous claims are abundant. "The epidemic is medical negligence, not lawsuits." [b] As already discussed, many victims of negligence do not sue. A study conducted by researchers at the Harvard School of Public Health found that of 1,400 closed medical negligence claims, 97 % were meritorious.[c] In many cases, patients are filing claims in hopes to discover what went wrong during surgery, because the information was not disclosed by the physician.

The presupposition has been made that malpractice claims drive up health care costs. The National Association of Insurance Commissioners (NAIC) finds such a claim baseless, with factual information leading to a contrary finding. "The total spent defending claims and compensating victims of medical negligence in 2007 was $7.1 billion—just 0.3% of health care costs," claims the NAIC.[d] A similar argument, that malpractice claims drive up doctors' premiums, has been widely criticized as well. Medical malpractice insurance is not strongly correlated with experience-rating (history of claims), and many academics and health policy economists see malpractice premiums influenced by insurance cycles more than anything (Mello and Studdert 13–14; Sloan and Chepke 27–31).[e]

Proponents of the Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2012, also referred to as "H.R.5," support the Congressional Bill on the premise "tort reform will lower insurance rates, and improve patient access to health care services."[f] Ironically, the Bill's text seems to protect physicians' self-interest more than patients. Contrary to the notion of "improving the liability system for patients," expressed in the preface of the legislation's text, H.R.5 limits a patient's legal rights by putting damage caps on malpractice lawsuits. It is assumed a bill with such a high marginal cost, limiting patients' rights, would produce an even greater marginal benefit—tort reform lowering insurance rates. The causal relationship between tort reform and a lower insurance rate has been in serious question for many scholars in the health policy field. Obviously, if damage caps are in place, insurers will be paying out less money to victims of malpractice; however, the assumption that they will pass their savings along

[b] American Association for Justice, *Five Myths About Medical Negligence*
[c] Mello & Studdert, *Claims, Errors, and Compensation Payments in Medical Malpractice Litigation*
[d] American Association for Justice, *Five Myths About Medical Negligence*
[e] American Association for Justice, *Five Myths About Medical Negligence*
[f] (HEALTH) Act of 2012, Introduction

to doctors by lowering premiums is unsupported[g]. According to research compiled by the American Association for Justice, states that have cap damages and states that do not, have little variance in premiums. The statistics make it clear that the cap-on-damage approach has done nothing to reduce health care costs.

The final issue regarding misconceptions is the concept of "defensive medicine." Also referred to as assurance behavior and avoidance behavior, this term can be understood as the workups physicians do (and do not do), respectively, that are influenced by liability pressures. Some scholars in the field, those very adamant about patient safety and strongly in opposition of tort reform (in other words, the most liberal of health policy scholars), claim defensive medicine is the biggest myth and largest over-exaggeration in the malpractice policy debate. Another thought, one that some reports bring to our attention, speculate that what doctors claim to be *defensive medicine* may be a way physicians generate income.[h] Mello and Studdert, whom could still definitely be characterized as "opposed to tort reform," are a little more diplomatic in their approach to defensive medicine, calling it a "slippery concept" and claiming measuring it is "notoriously difficult" (Mello and Studdert 23). Mello and Studdert make a good point—defensive medicine is a very hard concept to operationalize; after all, when treating a patient, where does "high-quality care" end and "liability motivations" begin? Scholars like Daniel P. Kessler have contributed research on defensive medicine's prominence that has been largely disputed by a wide range of colleagues.[i] With such strong assertions on both ends of the political spectrum, and with no strong methodological process to measure assurance or avoidance behavior's prevalence in medicine, there is no way to truly understand the reality of the "defensive medicine" concept.

The Facts and Figures of Medical Liability

With no clear consensus on the legitimacy of defensive medicine, perhaps it makes more sense to draw our attention to the facts well understood about medical liability and defensive medicine. The fact is, assuming arguendo, that defensive medicine does exist, and it contributes to health expenditures by as much as $50 billion dollars (a very generous estimate), eliminating defensive medicine would be nearly impossible. How can policy makers seek eliminating something of such an abstract form? The supposition is that caps-on-damages will reduce health

[g] American Association for Justice, *Five Myths About Medical Negligence*
[h] Congressional Budget Office, 2004
[i] American Association for Justice, *The Truth About Defensive Medicine*

care providers' fear of medical malpractice claims. The flaw in this reasoning is that doctors fear more than merely economic sanctions; a caps-on-damages proposal does absolutely nothing for the noneconomic costs associated with a malpractice lawsuit (i.e. negative publicity associated with being involved in a malpractice lawsuit). Considering the fact that these risks cannot dissolve with a "caps-on-damages tort reform approach," the practice of defensive medicine will continue.

An undisputed fact of medical liability is that preventable medical errors contribute to billions of dollars in health care expenditures. In 2000, the Institute of Medicine disclosed research regarding the health care system in a report titled "To Err Is Human." The report claimed "at least 44,000 people, and perhaps as many as 98,000 people, die in hospitals each year as a result of medical errors that could have been prevented."[j] The Institute of Medicine reports that the costs associated with these errors are thought to be as high as $29 billion annually.[k] Because "preventable medical errors" is a more concrete, realistic concept than defensive medicine, policy makers ought to focus their attention more effectively on something known to exist, and on something that, if largely resolved, could have the same fiscal effect as "eliminating defensive medicine[l]."

In attempt to resolve any confusion up to this point, while at the same time not over-simplifying the situation and dichotomizing the diagnosis of the malpractice system, obvious points can be made. Those that see the system's flaws, including too many lawsuits and the inner-workings of defensive medicine as a result of "fear of liability," argue for a tort reform approach. Others, those viewing the malpractice system's flaws as disregarding patient safety and not working vigorously enough to limit medical error, advocate for more comprehensive reform approaches. More "comprehensive" reform approaches steer away from tort and litigation in general, viewing the adversarial process skeptically. They see the reform approaches they advocate for limiting liability costs in the long run; the argument goes: obviously, if you reduce the amount of medical error, the amount of liability cases will also subside. Before shifting focus to the two contending approaches of medical liability reform, and examining their differences,

[j] Kohn, L.T., Corrigan J.M., & Donaldson, *M.S.*, *To Err Is Human: Building a Safer Health Care System*
[k] American Association for Justice, *The Truth About Defensive Medicine*
[l] Reducing medical error could directly lower costs by about 30 billion, and indirectly have a large impact as well, way beyond the fiscal benefits of "eliminating" defensive medicine.

analyzing points of consensus among scholars, policy makers, and the educated public is essential to conceptually forming the policy debate.

The medical malpractice tort-run system, as it stands, is problematic—this fact has been established by anyone that has invested research in the current medical liability system. The system tries to meet its goals of compensation; deterrence; corrective justice; and efficiency, but fails miserably in most cases. In respect to corrective justice, advocates of both approaches note that medical liability fears inhibit quality of care improvements. Proponents of both reform approaches also agree that the recent medical liability insurance crisis is not a unique experience of the 21st century. Within the past four decades, experts assert that we have experienced three medical liability insurance crises: the first in the late 1960s, and early 1970s; the second during the mid-1980s; and the third crisis occurred approximately from 2002-2005 (Kersh 46–48).

First-Generation Reform Approaches to Medical Liability

Health policy expert Rogan Kersh discusses reform in terms of two categories: first-generation approaches and second-generation approaches. First-generation approaches include reform options such as caps-on-damage awards, whereas second-generation approaches include reform options like alternative dispute resolution (Kersh 43–44). As the title of the chapter implies, Kersh discusses the political dimensions of liability reform in his "Medical Malpractice and the New Politics of Healthcare." According to Kersh, first-generation approaches are supported predominantly by policy-makers, while the academic community generally advocate for second-generation approaches (Kersh 43–67).

The Medical Injury Compensation Reform Act (MICRA) of 1975 and the Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011[m] (hereinafter H.R.5) are two examples of "First-Generation Proposals." These policies seek to "reduce the excessive burden the liability system places on the health care delivery system."[n] H.R.5 draws on the cause-and-effect relationship medical liability has on the health care system. As the argument goes, medical liability holds physicians too accountable; as a result, physicians are forced to practice defensive medicine, and the quality of care improvement is inhibited.[o] H.R.5 plans to resolve the liability system's flaws through imposing limits on medical malpractice litigation through: capping

[m] Also referred to as the Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2012, because the proposed bill is still under Congressional consideration and review
[n] (HEALTH) Act of 2012, Purpose and Summary
[o] (HEALTH) Act of 2012, Background and Need for Legislation

awards and attorney fees; modifying the statute of limitations and "collateral source" rule; and eliminating "joint and several liability." H.R.5 utilizes research conducted by the Pacific Institute, a free-market think tank, which estimates the cost of defensive medicine to be $191 billion dollars.[p] The validity of McQuillan and Abramyan's research and statistics on defensive medicine ought to be seriously questioned—not only is the estimate four times larger than some of the most generous estimates, but their research is based on earlier research that has been largely refuted and criticized by scholars in the field and the Congressional Budget Office (CBO). H.R.5 provides a weak refutation to the argument that defensive medicine may be practiced to increase income, saying that "if an internist orders a CAT scan, the radiologist gets paid, not the internist." This rebuttal does not assume income increases at a systemic level; in other words, hospitals, which are corporations (regardless of our lack of conceptualization as such)[q], may enforce policies that encourage increased income. H.R.5 then makes the assertion that medical liability fears inhibit quality of care improvements, going on to also say the liability system fails to deter medical errors or promote patient safety. These points are duly noted by advocates of second-generation reforms as well. The question is, how will measures taken by H.R.5, which allegedly lower malpractice premiums for physicians, simultaneously result in increased disclosure and less medical error? As discussed earlier, it is naïve to reason that simply lessening the economic consequences a physician will face when disclosing details to a patient will make the physician more prone to disclosure. After all, the non-economic damages a physician endures (i.e., negative publicity and image) are not disappearing once a cap-on-damage award is implemented.

Along with the problems already discussed, the congressional Committee on Energy and Commerce critique H.R.5 in terms of its federal nature. The committee recognizes that the current state-based systems for dealing with medical malpractice are far from perfect; however, the committee claims that modifications and improvements need to be made within the context of this general state-by-state framework. In other words, the national "one-size-fits-all" approach that H.R.5 endorses will not suffice. Within the dissenting views of a national approach, a valid point is made—such a new, "…untested legal structure…" has "…little regard for the potential

[p] McQuillan & Abramyan, *Jackpot Justice: The True Cost of America's Tort System*
[q] G. Annas, personal communication, March 9, 2012

consequences."[r] Furthermore, aside from its highly problematic implementation, attempting to resolve medical malpractice with national legislation is unprecedented—"the principles of medical malpractice liability and the procedures for the conduct of medical malpractice lawsuits have [always] been governed by state law."[s]

The Committee of Energy and Commerce also critique the causal nature of H.R.5's proposition. H.R.5's logical train-of-thought flows in the following way: implement damage caps. As a result of damage caps there will be a reduction in premiums, and as an indirect result, medical error will diminish and high quality care will flourish. Critics of H.R.5 point out the flaw in the H.R.5 proponents' reasoning by stating the following:

> Yet, data indicate[s] that today, the overall medical liability insurance market is not in crisis. They also show it is the direct regulation of insurance companies—and not a cap on non-economic damages (one of the core elements of H.R.5)—that is responsible for the reductions in insurance premiums that have been seen.[t]

In light of what an overwhelming amount of data indicates, in which the above cited data concurs, caps-on-damages resulting in premium reduction is not realistic, and caps having such an intended impact is *indeterminate* at best. Logically, it follows that the causal link between caps-on-damages and a reduction in medical error is equally weak, if not weaker. Taking this data into consideration, instead of relying on damage caps to indirectly solve the severe problems the United States faces with medical error, it makes more sense that reducing medical error should be legislation's first step, its direct intention, and reduction in premiums, if at all influenced by medical malpractice lawsuits, flow from a reduction in medical error.

Problems in terms of constitutionality and fairness arise with H.R.5's caps-on-damages approach also. Lawyers representing patient-plaintiffs have argued caps are not only unfair, they are also unconstitutional. The caps are claimed to be such because they "[discriminate] between patients with minor medical injuries and those with severe injuries." The reasoning here is simple: people with minor injuries have the potential to receive full compensation, whereas people with more serious injuries might get only a fraction of their owed compensation under capped damages.[u] Employing this argument, the caps-on-non-economic-damages have been

[r] (HEALTH) Act of 2012, Dissenting Views
[s] (HEALTH) Act of 2012, Dissenting Views
[t] (HEALTH) Act of 2012, Dissenting Views
[u] Gallegos, A., *Caps Under Fire: The Fight for Medical Liability Reform*

successfully declared unconstitutional by some states' Supreme Courts, due to the fact that the statutes are inherently discriminatory. Maxwell J. Mehlman, a prominent scholar in the health policy field, advances another argument discussing the statues' unfairness.

> … [It] seems unfair to limit the recoveries of one class of victims—those injured by malpractice—while permitting other tort claimants to recover more fully. Why should someone whose leg is mistakenly amputated, for example, get less than someone who loses a leg when they are run over by a negligent, insured motorist (153).

As Mehlman describes in a couple of sentences above, caps-on-damages in medical malpractice tort cases are unfair because they prevent a victim of injury from receiving the same compensation they might have otherwise gotten had the tort been of a different nature (e.g. as the example used above proposes, compensation resulting from the negligence of a motorist).

For the reasons listed and described above, first-generation reform approaches to medical malpractice are less promising than the latter, second-generation reform approaches. While the different first-generation approaches to reform are limited, most are simply different variations of damage cap proposals, second-generation reform approaches, which position medical error as their top priority, are large in number and diverse. Equally important to note is that second-generation approaches are not mutually exclusive; in fact, advocates of each approach list other reform policies that ought to be adopted in conjunction with what they are discussing. In the next section of this paper, contending second-generation reform options are described, and the section concludes with a proposal to policy makers of the best second-generation reform package.

Second-Generation Reform Proposals: An Abundance of Reform Proposals That Solve the Right Problems

Unlike the simple solution first-generation reform approach, damage caps, second-generation reforms vary a great deal specifically in terms of the way they aim to resolve their fundamental concern, which is medical error. The various proposals' degree of projected influence also varies significantly. This paper considers some of the most popular second-generation proposals; these include litigation reform; alternative-dispute resolution; and enterprise liability reform.

Litigation Reform

It makes sense to first discuss reform proposals that aim at altering the litigation system; before discussing more drastic measures, let us first discuss the least intrusive reform approach,

and the one most similar to the current system. Catherine T. Struve suggests the first measure that needs to be taken, one that at least seventeen states have already adopted, is implementing certificate-of-merit provisions (174). Such a provision would ensure that the case a plaintiff's lawyer files is potentially meritorious. The certificate to file would be provided once an expert approves of the case at hand.

Another litigation reform measure, also directed at experts, would change the nature of expert testimony. As Struve suggests, much expert testimony relies on medical experts describing what they would have done in a given situation, as opposed to what the general health care professional would have done; litigation reform needs to address this issue and provide modifications that would allow for a more robust systemic analysis.

Other litigation reform provisions take the importance of the judicial function into account. Emphasis on the judicial function is important, especially considering their important roles as gatekeepers throughout the course of a trial. If judges are to employ tests that assess technical or scientific expert testimony, the judge needs to understand the basic concepts of scientific evidence. Some people have advocated for specialized health courts that would only hear medical malpractice cases (Struve 176). However, the problem with this idea is that the selection and retention of judges may become too politicized, and interest groups' interests may coincide with judicial decision-making. Yes, the same argument could be made with regard to general courts, but by its nature a specialized court would be more prone to such influence. Instead, "specialized divisions within a state's trial court of general jurisdiction would be a better option," claims Struve (177). As judges rotate into this division of the trial court, they receive special training through a "continuing judicial education" program that states could implement.

Considering the above proposals, litigation reform, in general terms, attempts to address the claims process, the evidence process, and judicial decision-making, respectively. While reforms in these three areas are all necessary, these reforms alone are insufficient. The litigation reform measures laid out would aim to fulfill the reform goals of compensation and efficiency, but how would these policies significantly reduce medical error? Furthermore, this reform policy fails to consider the fact that a litigation process, in general, will discourage *real change* in medical liability from occurring; as discussed earlier, litigation, an adversarial process by nature, does not encourage disclosure—and disclosure is absolutely necessary if we are to see a significant reduction in medical error.

Struve's suggestions are thoughtful and well noted. Trial reform is attractive, because it is a "less invasive procedure," compared to other second-generation alternatives. Trial reform should be further researched and considered as a legitimate end to a better medical liability system. However, in light of the reservations already made about litigation, it is important not to presuppose that the court remains the predominant institution in instances of medical malpractice. In other words, litigation needs to be seen as a subsequent method of resolution, and not the primary approach to reform.

Alternative Dispute Resolution

The American Academy of Orthopedic Surgeons (AAOS) sees the medical liability system for what it is. The organization understands that a majority of the money medical professionals pay out in malpractice cases go to the costs of litigation. In light of their understanding, these physicians wish to see broad-based liability reforms; in their opinion, second-generation reforms have the ability to fairly compensate patients while reducing liability costs and increasing patient safety. The AAOS argues for alternative dispute resolution (ADR)—or "non-litigious means of resolving conflict."

In the article "The Limits of Apology Laws," published by the Hastings Center Report, Rebecca Dresser discusses how an initiative implemented to reduce medical error and apology laws have had a questionable impact. Medical error is reduced by coming to terms with, and discussing, mistakes (i.e. disclosure), and proposing ways to prevent those mistakes from occurring again in the future. Malpractice lawsuits deter physicians from pursuing disclosure. Theoretically, apology laws encourage physicians to disclose information to their patients, because the law prevents an apology or a sympathetic expression from being used as evidence of negligence in court. As Dresser points out, the majority of states that adopt apology laws only have provisions that "eliminate expressions of sympathy, not admissions of fault…" Dresser's point illustrates the limits of apology laws; her point also implies that disclosure and litigation are mutually exclusive concepts. If methods other than litigation were embraced, however, and apologies were encouraged, results might include increased disclosure and more compensated patients. One critique of these ADR methods is that widespread disclosure and compensation would result in too much money being paid out. This point is well noted; however, are we to assume disclosure will always result in large payouts?

Research conducted within the past decade has made the point clear that patients mostly sue for non-monetary reasons. In light of these findings, ADR has become more prominent and popular in recent years. Patients sue mostly for disclosure (they want to discover what exactly happened to them), desire for an apology, and prevention of future errors to other patients. Different forms of ADR make these desires of patients possible, while compensating patients for experienced injuries at a much lower rate than would be the case with litigation. With mediation, patients get the remedy sought—an explanation and apology—while physicians get the satisfaction of a clear conscience, and the learning experience. The nature of litigation's adversarial process is that there is a winner and a loser; someone at the end of the trial will be satisfied, while the other person is unsatisfied and will most likely become resentful of the legal system. ADR creates the possibility that both parties will walk away content with what was discussed, and what deal was obtained.

Enterprise Liability Reform

A well-known and frequently cited statistic released by the Institute of Medicine claims "as many as ninety-eight thousand people die in hospitals each year as a result of medical errors that could have been prevented." A less familiar fact: systematic malfunctions are responsible for ninety percent of that medical error.[v] The keyword "systematic" means that the medical errors are a result of the system, the institution, as opposed to the individual, the physician. On this basis alone, if we are to assume the Institute of Medicine's figure to be correct, the current medical liability system is wrong in targeting the physician.

Bovbjerg and Berenson claim "[the] most important legal rationale for imposing liability on physicians and other medical providers is that doing so deters substandard practice." In light of the fact that information already discussed refutes the deterrent effect of liability, imposing liability on physicians does not make much sense. It is particularly interesting that while a broad array of research mentions the predominance of systematic errors as opposed to individual errors in medical error, both first- and second- generation reform policies take the existence of the "physician"-defendant for granted— caps-on-damages, litigation reform, and alternative dispute resolution, are three examples of reforms that all fail to address the question of who the defendant is: an individual or an institution? A comprehensive approach to medical liability reform needs to, at the very least, reconsider what entity should be held accountable for medical

[v] Obama and Clinton, *Making Patient Safety the Centerpiece of Medical Liability Reform*

error. Enterprise liability, considering the high proportion of systematic error involved in medical error, argues for the liability system to make health care organizations (e.g. hospitals) the respondent.

According to Michelle Mello, professor of law and public health at Harvard University, "[p]hysician insurers consider it infeasible to individually experience rate their subscribers. Physicians are sued too infrequently, and their claims experience varies too much over each three- or five-year period, to make experience rating actuarially feasible" (14). Institutions that have adopted enterprise liability, however, have insurance premiums that are experience-rated, because at the institutional level, experience-rating is practical. Experience-rating is a very attractive feature of enterprise liability; a reduction in insurance premiums as a result of safe practice gives a health care institution just another reason to take patient safety very seriously—in this case, an economic incentive is present, enough to encourage any corporation (such as a hospital). Although the public does not like to consider them in such terms, hospitals are corporations, and their economic interests and perspectives regarding the administration of health care could facilitate great measures to improve patient safety. Hospitals with enterprise liability now employ workers to assess the degree of quality improvement occurring at the institution, and they implement policies that further encourage quality improvement.

Hospitals, the institutions themselves, need to lead campaigns for reducing medical error, because systems can do more than any individual can—"health care organizations are in a far better position than individual providers to see opportunities to improve patient safety and to act on those insights."[w] Disclosure needs to be enthusiastically encouraged if we are to see great reductions in medical error. With respect to enterprise liability, Philip G. Peters, Jr. says the following:

> [Enterprise liability] in malpractice law will help hospitals create 'blame free' cultures that encourage open discussion of errors. As long as physicians remain at risk of individual malpractice liability, they can legitimately scoff at the notion that disclosure will be 'blame free.'[x]

When mistakes are made, the institutions need to take the blame. The system consuming the responsibility for medical error prevents physicians and other health care professionals from having to claim responsibility themselves, making them reluctant to the discussion of errors.

[w] Peters, *Resuscitating Hospital Enterprise Liability*
[x] Peters, Resuscitating Hospital Enterprise Liability

A Comprehensive Reform Proposal

A policy proposal with a one-size-fits-all approach, assuming the liability concerns of all states could be treated with the same solution, would be just as flawed as first-generation reform's federal legislation H.R.5. With that being said, the policy recommendations provided here should be analyzed in a broad manner, understanding the intended goals each portion of the proposal is trying to uphold.

What conditions does the medical liability reform system need to fulfill in order to be considered "successful?" If the goals of reducing medical error, upholding a patient's right to safety and compensation, and resolving problems with liability insurance premiums are adequately met, the reform proposal is adequate—and may very well become a "success." Absolutely essential to reducing medical error is disclosure; therefore, unless reform measures encourage professionals to disclose error, reform will not be successful. Reform measures will be equally flawed if they attempt to resolve fiscal concerns and in the process, limit patients' legal rights (i.e., caps-on-damages). Adequate and efficient compensation is also important and needs to be included in proposals; compensation needs to be negotiated outside the court room if possible, because litigation costs increase the amount paid out significantly, which increases health expenditures and ultimately, insurance premiums.

In prescribing liability policy, it makes sense to begin with how health care professionals are being insured. Medical liability reform proposals that wish to assure success need to include an enterprise liability solution, with experience-rating whenever feasible. Adopting enterprise liability ensures physicians they will not have to deal with the heavy financial burdens of the liability process, and that their time will not be taken from them. With these two burdens taken into account and resolved, physicians will be less prone to keep from disclosing errors. Disclosing errors at a more frequent rate might not only reduce medical error, but also might decrease the number of malpractice suits being filed. After all, "malpractice suits often result when an unexpected adverse outcome is met with a lack of empathy from physicians and a withholding of essential information."[y] Adopting a liability system that could actuarially handle experience-rating, like enterprise liability, would also provide yet another reason for health care organizations to make patient safety its top priority.

[y] Obama & Clinton, *Making Patient Safety the Centerpiece of Medical Liability Reform*

For the reasons listed above, under the "Alternative Dispute Resolution" heading, it makes sense for litigation to be a secondary instrument in disputes, and for some form of ADR to be used first. A no-fault liability payout system may be a good approach to compensation under an alternative dispute resolution. The "no fault" approach to compensation utilizes an administrative agency or "health court"[z] to evaluate claims without reference to whether negligence occurred. Critics oppose the notion of no fault because they feel creating such low standards for compensation would not work—there is no way the number of payouts would be affordable. Advocates of the no-fault approach argue that even though it compensates a larger percentage of injured patients, it also generates lower overhead costs, and the money used to otherwise pay for litigation could go to compensating injury. Although a no-fault system is vastly different from the current liability compensation framework, the policy seems feasible and is worthy of consideration. All in all, no-fault liability (and systems similar to it), with quick and efficient payout systems, need to be endorsed by liability reform proposals. Admittedly, more experience with such administrative models is needed; more experimentation in general is necessary for no-fault liability and the alternative compensation approaches it competes with.

Predictable, reliable compensation for medical error depends on injury compensation tables and guidelines. Legislation enacted could make it that experts—including actuaries, economists, physicians, insurers, and judges—establish tables of injury cost data. Although every injury is different, general guidelines, regardless of whether they have a binding or non-binding effect, produce compensation that is more efficient and predictable, as opposed to arbitrary and slow-paced. Tables that illustrate the average an injured patient receives in relation to their injury, facilitates in the negotiation process and prevents patients from being under- or over-compensated. Considering no evidence suggests medical malpractice is malicious in nature, compensation tables would not consider "punitive damages" when appraising injuries. Compensation tables ensure, as George A. Huber puts it, that in most cases "settlement is only a matter of using predetermined information to establish the compensation necessary to cover damages resulting from injury" (Huber 41–43). Because the injury suffered is only one element in the compensation equation, and the other elements vary greatly from patient-to-patient, tables should be used as guidelines as opposed to being used as mandates.

[z] As opposed to a judicial court

The final policy recommendation this paper chooses to discuss is seldom talked over in medical liability reform proposals. Nonetheless, physician work hours, and the influence this has on avoidable errors committed, requires our attention. In Mark R. Mercurio's *A Day Too Long: Rethinking Physician Work Hours*, an article published by a bioethics institution, The Hastings Center in its *Hastings Report*, Mercurio considers the logic of long work hours for physicians. Mercurio claims there is ample evidence that long work hours can lead to increased chances of medical and surgical error.[aa] In light of this evidence, residents' and fellows' work hours have been significantly reduced. Mercurio explains that the current limits still seem inconsistent with "what is known about human physiology and performance," however, "[in] any case, the present limit is an improvement over the old system."[bb] Surprisingly to Mercurio, despite concerns and an eventual limit on residents' and fellows' hours in the hospital, there are no hour rules regarding attending physicians. Ironically, the workers that have no hour limitations are the oldest, and those with "final responsibility for patient management in the unit."[cc]

The rationale for no time limitation may be "'continuity of care'—trying to avoid passing a patient from one physician to another."[dd] Yet the same concerns with respect to residents' assignments to patients was trumped by the greater concern of declining performance and medical error; it seems difficult to understand why continuity of care would not be trumped by concerns of medical error for physician work hours as well. Mercurio makes his point clear when he concludes by saying, "if allowing a twenty-eight-year-old resident to work around the clock and beyond is unsafe for patients…then allowing a fifty- or sixty-year-old attending to do so makes little sense."[ee] All of the safe-practice standards and paper pushing in the world is not going to resolve medical error if physicians are incompetent due to exhaustion. Medical liability reform, in addition to resolving inefficiency at the systemic level, needs to seriously consider implementing legislation that limits physician work hours under certain circumstances.

The Hurdles of Implementation

Regardless of how great the intended prospects of a given liability reform proposal is, reforms obviously require implementation, a mechanism that puts the policy into effect. Some great reform proposals are disregarded and do not receive much appraise at all, because of their

[aa] Mercurio, *A Day too Long: Rethinking Physician Work Hours*
[bb] Mercurio, *A Day too Long: Rethinking Physician Work Hours*
[cc] Mercurio, *A Day too Long: Rethinking Physician Work Hours*
[dd] Mercurio, *A Day too Long: Rethinking Physician Work Hours*
[ee] Mercurio, *A Day Too Long: Rethinking Physician Work Hours*

inability to be implemented. Some reforms that have great prospects, and receive great reviews during experimentation, still have trouble with being implemented. The reasons that reform proposals have trouble being implemented are plentiful.

Second-generation reform proposals have difficulty receiving the attention they deserve because medical malpractice is chiefly understood as a "legal problem." Too often, medical malpractice is viewed primarily as a legal problem, and attempts to resolve the problems are aimed at methods of reducing litigation. For this reason, first-generation reform proposals, i.e. caps-on-damages, have been more successful than second-generation reform proposals. Reducing litigation as the intended goal, however, fails to recognize medical error in itself is intrinsically a problem, not just medical error's impact on the litigation system. Research that suggests up to 98,000 avoidable deaths occur is being ignored. Perhaps because they take the harsh realities of medical error for granted, policy-makers do not see reducing medical error as the top priority. Medical malpractice needs to be understood by policy makers as a "health policy problem" first-and-foremost. Focusing effort on the adversarial legal process will not help medical professionals learn from their mistakes; the only impact litigation will have on physicians is building more resentment towards the medical liability system.

To really understand the true difficulty of implementing malpractice reform proposals, the politics of malpractice need to be discussed. Rogan Kersh provides an interesting, insightful, and unconventional perspective of liability reform by discussing medical malpractice's political nature. Malpractice policies, like all policies, are influenced by interest groups. Some interest groups that benefit greatly from the current malpractice system are reluctant to endorse reform measures, and others go so far as using their fiscal capabilities to ensure reform measures will not be taken. President Bush made this obvious point during a 2004 speech, saying "trial lawyers pursuing their own agenda have continued to block this much-needed reform" (Kersh 60). The effects of malpractice reform on their profession are obviously a concern of considerable weight for plaintiff lawyers. First-generation reforms limit the amount some plaintiff-victims will be compensated, which therefore decreases the amount the plaintiff's lawyer can make off of the case. Second-generation reforms go as far as considering alternatives to litigation, which obviously could greatly impact medical malpractice injury lawyers across the country.

American policy-making, in general, also has something to do with the limits of implementation. "Incrementalism," a term adopted by Rogan Kersh, "explains most American

policy making—including health policy. Ambitious malpractice reforms, in this perspective, will almost inevitably be whittled down to minor changes, as has happened in most health care debates over the past thirty years" (65). Albeit very skeptical, this view of implementation makes a valid point: until the vitality of broad reform measures is understood, only minor changes to the current system will be implemented. First-generation reforms are very mild with respect to the changes they prescribe, and because of this, they are more likely than second-generation reforms to be implemented.

Because all states have different experiences with medical malpractice, it is important that malpractice reform be implemented at the state level. A one-size-fits-all approach to reform, whether it is first- or second-generation reform, is not the correct way to proceed. The Affordable Care Act, legislation the Obama Administration has been advocating for, will in effect nationalize health care in the United States. If the bill, which is under Supreme Court consideration now for allegedly being unconstitutional by nature, is upheld, nationalized medical liability reform might be worthy of reconsideration. But as of now, if the federal government were to create legislation that reflected some sort of second-generation reform proposal, judicial action would be likely to follow (Kersh 66). H.R.5, the HEALH Act of 2012, is one example of national legislation that, if it became law, may be struck down for going beyond the reach of the Commerce Clause (the Commerce Clause is how national malpractice reform would be justified) (66).

The final issue this paper addresses can be understood by asking the question: can we mandate compassion? Ron Paterson asks this exact question in *Can We Mandate Compassion*, an essay he wrote published in *The Hastings Report*. Paterson, a former Health and Disability Commissioner of New Zealand, wrestled with this question as a result of a New Zealand statute that demands compassion. Although his article is not directly related to the issue of medical malpractice, his inquiry forces us to reflect on, and perhaps come to terms with, the limits of the law. Yes, there is a chance, as small as it may be, the legislature could enact legislation that embraces all of the concerns and viewpoints of second-generation reform. Even if the best attempts to reduce medical error were implemented, does that ensure change will, in fact, occur?

Reform proposals that encourage disclosure are valuable. The thought is that an increased level of disclosure will result in less future error. In most cases this antecedent-consequent relationship holds true. Disclosure, however, does not simultaneously lead to less error;

disclosure enables physicians to learn, and from the experience, errors of that kind do not reoccur. Turning medical error into a learning experience for physicians is important. This learning experience, however, is capable of being hindered if physicians are not receptive to the mistakes being made. The "culture of medicine," as it stands, encourages physicians to rationalize and excuse their mistakes, not to embrace them and encourage improvement. If we are to see a serious reduction in medical error, mistakes need to be confronted and discussed in a passionate manner no legislation can ensure. Certainly, for medical liability's sake, the "culture of medicine" needs to change—medical schools, teaching hospitals, along with other educational institutions, need to emphasize the process of atonement through self-improvement.

Conclusion

The aim of this paper was to discuss the highly problematic nature of the current medical liability system, resolve some of the most common misconceptions medical malpractice is prone to, and suggest reform measures that address the key concerns of the current medical liability system. More specifically, this paper attempted to focus on what issues are important, and the mechanisms by which these concerns could be addressed, and perhaps even resolved. It cannot be stressed enough that reform proposals, regardless of how great their resolutions are, all face the reality of implementation.

Finally, the need for more experimentation has been discussed rather briefly. It should be made clear, that conducting more experiments on the various reform proposals is absolutely essential to correctly resolving the medical malpractice system. If proposals with little influence are implemented, it will be a waste of both money and time, and the flawed liability system will continue to operate in a dysfunctional manner. The empirical research that experimentation provides will contribute more insight and guidance as to what contending reform options are most suitable for the medical malpractice system.

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