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BEYOND TORT REFORM: FIXING REAL PROBLEMS

Randall R. Bovbjerg*

Today's frequent mention of malpractice always brings to mind three persistent policy problems, especially for a health policy analyst of a certain age. The first is the difficulties that physicians and other medical providers periodically face in finding and financing insurance protection against legal claims of substandard care. The second is the continuing reality that preventable injuries occur much too frequently in the course of health care. The third is that tort litigation fails to prevent these preventable injuries and creates liability risk that is hard to insure. This troika of problems has long dominated the three branches of the malpractice system—medical, legal, and insurance.

Unfortunately, malpractice policy making has always been dominated by two perspectives: activist physicians and plaintiffs' attorneys, each largely acting in self-interested fashion, have battled for thirty years. Also unfortunately, only one solution has dominated these policy battles—"caps" on awards and other conventional tort reforms. These limits on tort remedies are consistently and vehemently promoted by physicians and their insurers, with the most success during periods of rapid price increases of malpractice coverage, like the recent past, which reformers term malpractice "crises." Plaintiffs' attorneys and some consumer advocates have just as vigorously resisted. Tort reform battles were traditionally fought in state legislatures, but have lately become federal as well, even taking center stage in the last presidential election.

Doctors contend that the legal system is broken and can only be fixed with tough tort reform. Lawyers argue that the legal system works well, insurance is what is broken and can only be remedied with tough insurance regulation. However, it is a false dichotomy that either the doctors' or the lawyers' position must be right, and it is also wrong to assume that truth lies between the opposed extremes.

This paper argues that long-term progress requires focusing on more central issues—medical performance and whether tort law improves it. The long-running doctor versus lawyer battle has distracted attention away from the interests of patients and the public at large in medical improvement. The real problems in insurance, medicine, and law are not much affected by the

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conventional solutions offered, and better solutions need to have broader reach. Three types of alternative solutions are described in the conclusion.

I. DOCTORS VS. LAWYERS¹

A. *Heat Versus Light*

The adversarial battle over tort reform mirrors that of the courtroom. On one side stand physicians and their allies, on the other plaintiffs' lawyers and their allies. As in court, each side tries to sell its story to decision makers—and their partisan contentions diverge drastically.² Faced with such opposing contentions in many spheres, policy makers can normally assume that the truth lies somewhere between the extremes. But this comfortable assumption does not hold for medical malpractice. The reason is that doctors as potential defendants and plaintiffs' attorneys as repeat litigators have always "owned" malpractice issues and have cast the debate quite narrowly, either for or against tort reform. Broader concerns about medical quality and patient safety are invoked but not truly addressed. Even apparent outsiders claiming to represent the broader public interest sound very much like the partisan advocates.

The heat of the debate obscures how little light it casts on broader problems. Arguments have become quite routinized, and their repetition often degenerates into sound bites promoting or attacking an anecdote or factoid of the day. Meanwhile, methodologically questionable studies proliferate, many seeming less like peer-reviewed publications than press releases with citations.

Unfortunately, the actual positions being promoted or attacked do not differ that much when considered with some perspective. Lawyers want to maintain the status quo ante of liability rules, while doctors satisfied with the same liability system, just somewhat less of it. Both sides are motivated to exaggerate the legal system's influence on medical care and patient safety: lawyers claim positive impacts to justify the high expense of litigation, and doctors assert deleterious reductions in access to care and wasteful defensive medicine.

1. With apologies for oversimplifying, this paper uses the shorthand "doctor" or "physician" to refer to all medical practitioners and institutions, as well as provider-owned insurers; indeed, it may sometimes include business interests or others that support tort reform. Conversely, "lawyer" or "attorney" stands in for "plaintiffs' attorneys" and also includes their allies among "consumer" groups.

2. Compare e.g., Am. Med. Ass'n, *Medical Liability Reform - Now!: A Compendium of Facts Supporting Medical Liability Reform and Debunking Arguments Against Reform* (Oct. 19, 2005), available at <http://www.ama-assn.org/ama/pub/category/7861.html> (last visited Apr. 7, 2006) with Ass'n of Trial Lawyers of Am., *Press Room: Medical Malpractice News* (2006) (formerly called *Health Care Resource Center: Bringing You the Latest Information on Patient Safety, Medical Negligence, and Dangerous Errors*), <http://atla.org/pressroom/FACTS/health/index.aspx> (last visited Apr. 7, 2006).

B. *Interests and Worldviews*

Why do doctors and lawyers clash? The easy response is that they represent opposing economic interests—potential defendants and likely claimant representatives. Further, the dispute is the worst sort of zero-sum game. Just as in actual litigation, every dollar won by one side comes out of the pockets of the other, and the process is also highly unpleasant. But the differences seem to go even deeper, and an armchair social philosopher cannot resist speculating further.

Law and medicine are both ancient, proud, and “alpha dog” professions—each used to being in charge within its sphere of action. Physicians particularly seem to hate the loss of control they suffer in depositions and in courtrooms.³ Doctors also take lawsuits personally⁴ and despise what they see as the theatricality of well rehearsed testimony and argumentation. Lawyers, on the other hand, are trained to maintain distance from any client and pride themselves on their skills in advocacy, sometimes flamboyantly exercised. For physicians, the “great engine of truth” is science as developed through peer-reviewed literature and expert consensus over time; for attorneys, it is cross-examination.⁵ Although most seem not to realize it, doctors are also accustomed to a different standard of proof. Most of physicians’ diagnostic decision making is governed by a high standard of proof; they want ninety-five percent confidence in a lab’s finding that patient X has condition Y before ordering costly and potentially risky therapy Z. This ninety-five percent standard accords with the criminal-law standard of proof—beyond a reasonable doubt—and physicians implicitly acknowledge this mindset about negligence when they commonly discuss whether someone is “guilty” of malpractice. In the world of personal injury litigation, in contrast, one side must always lose, and for lawyers a nearly fifty-fifty burden of proof seems eminently reasonable.

Doctors and lawyers differ in their life experiences as well as in their worldviews. In practice, they see very different universes of problems. Doctors typically see healthy patients or sick ones who get better. Even where mistakes occur in treatment, patients are often unhurt, and usually recover. Lawyers see would-be clients who remain quite injured, quite angry, quite threatened by high bills—or all three.

3. Randall R. Bovbjerg, *Problems and Solutions in Medical Malpractice: Comments on Chapters Six and Seven*, in *THE LIABILITY MAZE: THE IMPACT OF LIABILITY LAW ON SAFETY AND INNOVATION* 277 (Peter W. Huber & Robert E. Litan eds., 1991).

4. Even those not sued appear commonly to think “there but for the grace of God go I.” Atul Gawande, *The Buck Stops With the Doc: Sometimes Blaming the System is Fair But in Medicine, It Can Be a Dangerous Cop Out*, SLATE, July 23, 1998, <http://slate.msn.com/id/2678> (last visited Feb. 16, 2006) (noting this nearly universal reaction to preventable bad outcome).

5. *State v. Thomas*, 421 S.E.2d 227, 232 (W. Va. 1992) (“[c]ross-examination is the engine of truth”). See JOHN HENRY WIGMORE, *EVIDENCE AT TRIALS AT COMMON LAW* § 1367 (James H. Chadburn rev. 1974).

Physicians are loathe to recognize their own mistakes for many reasons, including fear of being blamed for bad outcomes,⁶ and a pervasive sense of “there but for the grace of God go I,” which makes them reluctant to hold colleagues accountable. Attorneys are more than willing to find blame, as fault-finding is not only a key to their mental model of accident causation but also the mainspring of their business model.

II. THREE SYSTEMS AND THEIR PROBLEMS

Successful solutions start with good assessments of problems. Successful interventions focus on problems that can be solved. Malpractice problems arise in three sectors of policy concern: (a) medical care, (b) liability law, and (c) liability insurance. Medicine is the central social concern; what patients and the public want is access to good quality care. Law purports to ride herd on medical providers, deterring substandard care and assuring compensation for wrongfully injured patients. Insurance is what doctors buy to protect themselves from legal costs, and in practice provides the funding and dispute resolution professionals without which the current scope of tort liability would probably not be possible. The following discussion covers these three systems in turn. It starts with insurance, whose problems are what prompt headlines, headings, and legislation.

A. *Liability Insurance*

The most visible problems in medical liability insurance are its periodic crises—that is, difficulties maintaining availability or affordability of coverage for doctors, hospitals, and other caregivers.⁷ (See box next page).

Reduced supply of insurance is a problem because practitioners need coverage to practice, and rapid price increases have increasingly become a problem for practitioners because the advent of managed prices seems to prevent them from quickly passing through increased costs to patients and payors. There is no dispute that since 1999, malpractice premiums have risen markedly.⁸ There has also been a sharp decrease in the number of insurers willing to sell in many areas. Some insurers have failed and others have withdrawn completely from the market, reducing supply.⁹

6. JAY KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* 199 (1984); ROSEMARY GIBSON & J. P. SINGH, *WALL OF SILENCE: THE UNTOLD STORY OF THE MEDICAL MISTAKES THAT KILL AND INJURE MILLIONS OF AMERICANS* xvii (2003) (1992).

7. F. A. SLOAN ET AL., *SUING FOR MEDICAL MALPRACTICE* 5 (1993).

8. U.S. GOVERNMENTAL ACCOUNTABILITY OFFICE (previously U.S. GENERAL ACCOUNTING OFFICE), REPORT NO. GAO-03-702, *MEDICAL MALPRACTICE INS.: MULTIPLE FACTORS HAVE CONTRIBUTED TO INCREASED PREMIUM RATES* 4 (2003), <http://www.gao.gov/new.items/d03702.pdf> (last visited Apr. 7, 2006).

9. Kenneth E. Thorpe, *The Medical Malpractice “Crisis”: Recent Trends and the Impact of State Reforms*, HEALTH AFF., W4-20 (2004).

Cycles or Crises: A Longer Term Perspective

The current period marks the fifth major shock to malpractice insurance since the 1950s.¹⁰ After each, the market adjusted, not with a simple return to normalcy but rather with considerable change in market participants, risk-bearing arrangements, and premiums. In the 1950s, the risk of lawsuits for doctors was about one in seven . . . per *lifetime*. Now, it is closer to one in seven per *year*. Then, million dollar verdicts against doctors were so rare that they won the successful attorney great renown. Now, a million dollars is the median, as (imperfectly) tallied by the *Jury Verdict Reporter*. Then, few hospitals could be sued; today, institutional claims are routine. In the 1950s, medical liability was a sleepy line of coverage, sold by the same carriers that sold doctors other types of insurance to cover their autos, business premises, and so on. In the early and the late 1960s, traditional carriers faced two unexpected rises in claims rates that permanently altered the landscape. In response, first generalist carriers largely gave way to more specialized firms. Then medical societies stepped in and began negotiating for quasi-group rates. These changes occurred privately, with no need for legislative action.

In the mid-1970s and 1980s, problems rose to state and national attention as claims rates again accelerated unexpectedly driving up premiums, driving out carriers, and prompting medical interest groups to proclaim crises. The biggest medical society affiliated carrier quit the line permanently in the 1970s; the gap in capacity was filled by companies started by medical societies and hospitals associations. In the 1980s, there were fewer withdrawals, but premiums rose and a new policy form of “claims made” policies became the dominant mode of coverage. Previously, insurers had sold “occurrence” policies that covered policyholders for all claims arising from occurrences in the policy year—which typically would be filed within two years, but which could under legal exceptions be filed twenty or more years later. The new coverage only paid claims actually filed the same year. This new approach allows insurers to adjust rates to trends more quickly and accurately, but from a policyholder perspective, it offers less protection.

In the latest upheaval of the early 2000s, a number of insurers became insolvent, and some long-time specialist sellers left permanently. Departures included the St. Paul Group, once the world’s largest malpractice insurer. Some hard-hit states took emergency action to keep coverage available. More medical providers have also turned to unconventional, alternative risk mechanisms such as risk-retention groups or, for hospitals, self insurance. Like claims made policies, these arrangements offer somewhat less protection than major carrier coverage: They have less capital for emergencies, and they are not backstopped by state guaranty funds that protect insureds in the case of conventional insurers’ insolvency. As of mid-2005, however, there are signs that the medical liability market is softening and premium increases easing—but premiums will not return to 1990s levels, and providers are bearing more risk themselves.¹¹

10. This account draws upon such sources as PATRICIA M. DANZON, *MEDICAL MALPRACTICE: THEORY, EVIDENCE, AND PUBLIC POLICY* 2-3 (1985); FRANK A. SLOAN, RANDALL R. BOVBJERG & PENNY B. GITHENS, *INSURING MEDICAL MALPRACTICE* (1991); Randall R. Bovbjerg, *Malpractice Crisis and Reform*, 32(1) *CLINICS IN PERINATOLOGY* 203 (2005) [hereinafter *CLINICS*].

11. E.g., M.A. Hofmann, *Med Mal Insurance Line Could Be Improving: Study*, *BUS. INS.*, June 09, 2005, <http://www.businessinsurance.com/cgi-bin/news.pl?newsId=5746> (last visited Apr. 24, 2006).

Whether this state of affairs constitutes a crisis is endlessly debatable, for crisis is a political label that lacks objective definition. This article is not the place for a full airing of the debate over the precise extent and causes of current difficulties.¹² Suffice it to say that both sides of the debate are partly right.¹³ With regard to insurance, a key point to remember is that the main cost of liability insurance is liability, and increased payouts are a key driver of higher rates. Other costs like legal defense and reinsurance also play a role. Prices are also affected by lower investment returns, much as changes in interest rates greatly affect monthly car payments.

Overall, insurance is subject to cycles of underpricing followed by a kind of corrective or catch up, as are all markets where participants make bets on future developments—from bull-to-bear stock market shifts to the business cycle as a whole.¹⁴ All partisans recognize the existence of the cycle, and lawyers implausibly blame all insurance cost increases on the cycle, together with insurer misbehavior. Cyclical swings seem especially wide in medical malpractice, plausibly because risks are very hard to predict (claims rates or size of payouts can shift markedly), claim size is very large, and claims resolution is slow. When insurers' assessments of liability risk shift, they have to revalue all the years of pending claims "in the pipeline," which greatly affects their available capital and ability to underwrite new coverage.

Whether claims or claims payouts are too high is not an insurance issue, per se. The proper level is a matter of social judgment about extent of injury and appropriateness of recompense. The major insurance issues are (1) whether liability insurance correctly prices the cost of defending and paying liability claims and (2) whether the industry will continue to accept legal risk, so that practitioners will be able to continue in practice. Despite the periodic over- and underpricing, there is no real evidence that over time prices are persistently too high or too low. The industry is quite competitive—some would say too competitive during soft markets when prices are shaved.¹⁵ Ease of entry by insurers in response to high profit margins protects against overpricing,¹⁶ and ease of exit in time brakes underpricing. Further, the

12. For a longer discussion, see CLINICS, *supra* note 8.

13. See Randall R. Bovbjerg & Robert A. Berenson, *Myths and Mindsets in Medical Malpractice*, (Urban Inst. 2005) [hereinafter *Myths*]. Both sides exaggerate, occasionally to the point of distortion. Exaggerations on the physician side seem most extreme about liability's impact on access to care and the cost of health coverage, considered below at notes 31-41 and accompanying text. Lawyer greatly exaggerate the mis-pricing of insurance relative to costs, considered below at notes 62-67 and accompanying text.

14. Here too, for fuller discussion see CLINICS, *supra* note 8, at 207-08 and sources cited therein.

15. Rachel Zimmerman & Christopher Oster, *Insurers' Price Wars Contributed To Doctors Facing Soaring Costs: Lawsuits Alone Didn't Inflate Malpractice Premiums; Reserves at St. Paul Distorted Pricing Picture in 1990s*, WALL. ST. J., June 24, 2002, at 1.

16. CLINICS, *supra* note 8, at 208. Indeed, strong competition seems to play a major role in creating the underwriting cycle, in soft markets driving prices below what in hindsight looks to have been the right price for actual costs, once the passage of time makes those clear.

insurance market is dominated by physician and hospital run carriers, which are not motivated to overcharge their owner-customers and also have a mechanism to return excess premiums to policyholders through dividends (as was common in the early 1990s). A final protection against overpricing is that many providers are able to self-insure or use alternative risk mechanisms outside the conventional insurance market if the latter provides a poor value for them.

To date, insurers have always been willing to underwrite coverage, although the industry has restructured and does not accept the full extent of risk it once did. As of early 2006, insurance seems to be becoming more available—in response to higher prices and tort reform in some states—and price increases seem to be moderating.

There are also lesser concerns about how well insurance performs. On one hand, pricing methods may not optimally relate price to underlying risk because physician premiums are determined almost entirely by location, specialty, and types of procedures performed.¹⁷ Actual liability experience does not much affect premiums. Because malpractice claims are infrequent and the extent of payout highly variable, individual experience rating is unusual, although some companies use small surcharges or discounts.¹⁸ Hospitals, in contrast, are generally either experience rated or directly bear their liability risks through self insurance.¹⁹ Not dissimilarly, the number of physicians in each specialty in most states is too small to have multiple rating areas, so that rates are the same in higher-risk urban areas as in less litigious rural ones. Contrariwise, it can be objected that malpractice risk is too narrowly focused. In particular, some specialties like obstetrics and orthopedic surgery face high claims and pay high premiums because they are perceived to be in charge, even though hospitals and multiple other physicians collaborate on providing care, bill independently, and in sum account for a bigger share of health plan reimbursements.²⁰

A final important observation to be made is that insurance crisis makes a bad rationale for changes in public policy. Crises come and go, whereas the underlying problems of medicine and law remain.²¹

17. SLOAN ET AL., *supra* note 7, at 132.

18. Frank A. Sloan, *Experience Rating: Does It Make Sense for Medical Malpractice Insurance?*, 80 AM. ECON. REV. PAPERS 128, 128 (1990).

19. Hospitals may also use a captive insurer to essentially self insure.

20. William M. Sage, *The Forgotten Third: Liability Insurance And The Medical Malpractice Crisis*, 23(4) HEALTH AFF. 10, 15-16 (2004); See William M. Sage, *Understanding the First Malpractice Crisis of the 21st Century*, in HEALTH LAW HANDBOOK 1 (Alice Gosfield ed., 2003).

21. Moreover, courts may overturn tort reforms enacted to deal with crises as unconstitutional once the crisis is long past. The Supreme Court of Wisconsin remarked upon this in overturning that state's cap many years after passage, *Ferdon v. Wisconsin Patients Compensation Fund*, 701 N.W.2d 440, 468 (Wis. 2005) (noting "A past crisis does not forever render a law valid").

B. Medicine

Since the beginnings of systematic assessment, the quality of medical services has been found to be uneven. Too much medical care comprises under-service, over-service, or the wrong service in a given set of circumstances.²² Medical outcomes have improved by a number of objective indicators, including extended life, reduced disability, and ability to ameliorate conditions once deemed untreatable.²³ Yet reducing the worst outcomes, negligent or preventable injuries, seems an elusive goal. This is the finding of a number of large-scale studies of hospital records in different states from the mid-1970s through the mid-1990s.²⁴ Comparisons across time are problematic because preventing injury is not like running the hurdles but rather like the pole vault—just when you are doing well by one standard, they raise the bar. Smaller, often observational, studies of practitioner behavior also report high rates of error, as do public opinion surveys.²⁵ Dispute remains about the precise extent of problems and the trend over time, but not about the existence of a large number of preventable injuries. Much more prevention should be possible, which is one lesson of the decade-old patient safety movement, discussed in more depth below.²⁶

Lawyers often argue that a small share of doctors is responsible for most negligent injury, implying that if doctors would just police the incompetents among their ranks, problems of medical injury would disappear.²⁷ It is true that physicians with multiple claims account for a disproportionate share of liability cases (most doctors have zero claims, even over lengthy time periods).²⁸ It is also true that a small share of cases account for most payouts (most claims get zero, and the distribution of dollars paid is heavily “skewed”

22. INST. OF MED., *CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY* 2-3 (2001).

23. *Id.*

24. See INST. OF MED., *COMM. ON QUALITY OF HEALTH CARE IN AM., TO ERR IS HUMAN: BLDG. A SAFER HEALTH SYS.* App. C (Linda T. Kohn et al. eds., 2000) (consisting of a twenty-six page chart of numerous studies); see also T.A. Brennan et al., *Incidence of Adverse Events and Negligence in Hospitalized Patients*, 324 *NEW ENG. J. MED.* 370 (1991); Eric J. Thomas et al., *Incidence and Types of Adverse Events and Negligent Care in Utah and Colorado*, 38 *MED. CARE.* 261 (2000).

25. E.g., Robert J. Blendon et al., *Views of Practicing Physicians and the Public on Medical Errors*, 347 *NEW ENG. J. MED.* 1933, 1934-35 (2002) (noting that thirty-four percent of adults said they or a family member have experienced a preventable medical error).

26. See generally Lucian L. Leape et al., *Promoting Patient Safety by Preventing Medical Error*, 280 *JAMA* 1444, 1445 (1998) (founding and articulating the principles of the National Patient Safety Foundation). This paper does not defend any particular estimate of the extent of preventable injury, merely that it is large.

27. See MYTHS, *supra* note 13 and sources cited therein.

28. *BD. OF REGISTRATION IN MED., COMMONWEALTH OF MASS., 2004 MEDICAL MALPRACTICE ANALYSIS*, Nov. 2004, http://www.massmedboard.org/public/pdf/announcements/Med_Mal_2004.pdf (last visited Apr. 24, 2006).

to the right, or high end of dollars per case).²⁹ However, neither small share is typical; most physicians are infrequently sued, and most payouts are smaller than the mega-verdicts that claim headlines.³⁰

Doctors blame several other problems in medicine on the pernicious influence of the legal system. One is that malpractice concerns are reducing access to care.³¹ That is, physicians may retire early, leave a high-risk location, or cease providing high-risk services or seeing high-risk patients in order to reduce increasingly unaffordable premiums and to mitigate their risks of uninsured reputational damage, psychic costs, and verdicts that exceed the limits of insurance. Similarly, hospitals may close their maternity units.³² There are some indications of reduced services in high-risk locations and specialties,³³ and some indications that caps on awards slightly increase the supply of physicians in a state,³⁴ but there is no strong evidence of widespread reductions in patient access to services.³⁵

Second, doctors have long said that they practice defensively, meaning not that they are especially careful like defensive drivers, but that they make decisions or take action mainly for their own legal benefit rather than for the patient's clinical benefit.³⁶ Some of this is characterized as negative defensive medicine, that is, not doing ethically or clinically indicated things for legal reasons—like seeing charity patients or providing obstetrical care to high-risk patients. Most commonly mentioned is positive defensive medicine—such as ordering extra tests, doing unneeded procedures, or adding layers of documentation, because those things are perceived to lower risk of lawsuit or

29. See SLOAN ET AL., *supra* note 7.

30. See *Myths*, *supra* note 13.

31. U.S. DEP'T OF HEALTH & HUMAN SERV., OFFICE OF THE ASSISTANT SEC'Y FOR PLANNING & EVALUATION, CONFRONTING THE NEW HEALTH CARE CRISIS: IMPROVING HEALTH CARE QUALITY AND LOWERING COSTS BY FIXING OUR MEDICAL LIABILITY SYSTEM (2002), <http://aspe.hhs.gov/daltcp/reports/litrefm.pdf> (last visited Apr. 24, 2006).

32. Randall R. Bovbjerg & Anna Bartow, The Project on Med. Liab. In Pa., *Understanding Pa.'s Med. Malpractice Crisis: Facts about Liab. Ins., the Legal Sys., and Health Care in Pa.* (June 2003), <http://medliabilitypa.org/research/report0603/UnderstandingReport.pdf> (last visited Apr. 24, 2006).

33. Robert A. Berenson et al., *Medical Malpractice Liability Crisis Meets Markets: Stress in Unexpected Places*, Ctr. for Studying Health Sys. Change, Issue Brief No. 68 (2003), <http://www.hschange.com/CONTENT/605>.

34. Daniel P. Kessler et al., *Impact of Malpractice Reforms on the Supply of Physician Services*, 293 JAMA 2618, 2620-21 (1998); William E. Encinosa et al., *Have State Caps On Malpractice Awards Increased The Supply Of Physicians?*, HEALTH AFF., W5-250, (2005).

35. U.S. GEN. ACCOUNTING OFFICE, MEDICAL MALPRACTICE: IMPLICATIONS OF RISING PREMIUMS ON ACCESS TO HEALTH CARE 836 (2003), <http://www.gao.gov/new.items/d03836.pdf> (last visited Apr. 24, 2006).

36. See DEP'T HEALTH, EDUC., & WELFARE, DHEW PUB. NOS. 73-88, 73-89, MEDICAL MALPRACTICE: REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE (1973); John R. Ball, *The Malpractice Threat: A Study of Defensive Medicine*, 1971 DUKE L.J. 939 (1971); Laurence R. Tancredi & Jerome A. Barondess, *The Problem of Defensive Medicine*, 200 (4344) SCI. 879 (1978).

facilitate defense if claims are brought.³⁷ Defensive feelings clearly exist and are strongly held. Actual impacts on practice are quite unclear, however, as is the more important issue of how much that defensiveness can be reduced by tort reform or any other policy initiative.³⁸ Most researchers have found only small effects.³⁹

Third, physicians complain that malpractice fears diminish the important therapeutic element of doctor-patient trust, as customers are seen too much as potential plaintiffs rather than patients.⁴⁰ A related concern has surfaced in recent years, that fear of legal reprisal makes physicians reluctant to discuss adverse outcomes with their patients, peers, or safety managers.⁴¹ These concerns are real, although unquantified.

C. Law (i.e., Tort Liability)

Tort law theory is logical:⁴² Liability process is to *compensate* negligent injuries, so as to *deter* potential tortfeasors from negligent behavior and thereby prevent injury, while providing *justice* to litigants.⁴³ If liability achieved all these goals, it would easily be worth its share of health spending, just over two percent.⁴⁴ But the theory has many practical weaknesses and evidence is sparse.⁴⁵

37. OFFICE OF TECH. ASSESSMENT, OTA-H-602, DEFENSIVE MEDICINE AND MEDICAL MALPRACTICE (1994) [hereinafter OFFICE OF TECH. ASSESSMENT], http://www.wws.princeton.edu/ota/disk1/1994/9405_n.html (last visited Apr. 24, 2006).

38. See OFFICE OF TECH. ASSESSMENT, *supra* note 37; *Myths, supra* note 13.

39. The highest estimate is a net savings of about four percent, although only one pair of researchers have found such a sizeable amount.

40. Mark A. Hall, *Law, Medicine and Trust*, 55 STAN. L. REV. 463, 486 (2002); Michelle M. Mello et al., *Caring For Patients In A Malpractice Crisis: Physician Satisfaction And Quality Of Care*, 23(4) HEALTH AFF. 42 (2004).

41. Randall R. Bovbjerg, *Patient Safety and Physician Silence*, 25 J. LEGAL MED. 505, 511 (2004).

42. This subsection draws heavily upon Randall R. Bovbjerg & Laurence R. Tancredi, *Liability Reform Should Make Patients Safer: "Avoidable Classes of Events" Are a Key Improvement*, 33 J.L. MED & ETHICS 478, 480 (2005).

43. Randall R. Bovbjerg, *Medical Malpractice on Trial: Quality of Care Is the Important Standard*, 49 LAW & CONTEMP. PROBS. 321, 326 (1986).

44. This is an imprecise estimate. In 2003, the best estimate is that premiums for malpractice were \$14.8 billion for physicians and \$6 billion for hospitals (including retained risk in lieu of premium), compared with total national spending on physician and hospital services of \$369.7 billion and \$515.9 billion. The percentages are thus about 4% for physicians and 1.2% for hospitals, or a combined 2.3%. See U.S. Tort Costs: 2004 Update, available at http://www.towersperrin.com/tillinghast/publications/reports/Tort_2004/Tort.pdf (last visited Apr. 24, 2006); Ctrs. for Medicare and Medicaid Servs., Source of Funds and Type of Expenditure: 1998-2003, available at <http://www.cms.hhs.gov/statistics/nhe/> (last visited Apr. 24, 2006).

45. Clark C. Havighurst & Lawrence R. Tancredi, "Medical Adversity Insurance"—A No-Fault Approach to Medical Malpractice and Quality Assurance, 51 MILBANK MEM'L FUND Q., 125, 158 (1973); Randall R. Bovbjerg, *Medical Malpractice: Folklore, Facts, and the Future*,

Compensation falls far short of jurisprudential aspirations. Few injured patients sue and fewer collect, payouts are slow and somewhat erratic, and overhead costs take well over half of each dollar.

Deterrence is at best piecemeal.⁴⁶ The system is unsystematic because it reviews so few cases, standards of fault and causality are vague and often inconsistent, experts routinely disagree, results are unpredictable, and deterrence signals are confounded by liability insurance. There are no strong indications that medicine is safer or of higher quality where tort law is most stringent (or least tort reformed). Clinicians see liability as arbitrary and unfair, not authoritative, and so tend to respond defensively rather than constructively. There are occasional exceptions; advances in anesthesia since the mid-1980s were triggered by high liability; the profession responded as a whole, not as individual defendants. Finally, the weakest points in the argument for deterrence are that high rates of preventable error and injury persist,⁴⁷ notwithstanding many years of intensifying legal exposures, and that quality of care varies markedly from place to place with no known relation to liability pressures.

Justice is offered in the form of individual procedural fairness for litigants—that is, full opportunity to make their best case—and individual disputes are resolved better than physicians typically appreciate.⁴⁸ But system justice is poor: the legal process omits most injuries, resolves disputes slowly and somewhat haphazardly, and pays out hugely variable amounts in similar cases—hardly attributes of a fair injury-resolution system.⁴⁹ Indeed, liability is less a system than a set of processes and a framework for peaceful resolution of disputes. Some litigants have been found to be satisfied,⁵⁰ but others are very critical of the legal process.⁵¹

These deep-seated, severe and ongoing problems with tort are much stronger policy grounds for reform than are periodic and impermanent liability insurance crises.

117 ANNALS OF INTERNAL MED. 788, 789 (1992); David M. Studdert, Michelle M. Mello, & Troyen A. Brennan, *Medical Malpractice*, 350 NEW ENG. J. MED. 283, 289 (2004).

46. Michelle M. Mello & Troyen A. Brennan, *Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform*, 80 TEX. L. REV. 1595, 1603-06 (2002). There is weak and conflicting evidence that automobile tort liability may make driving safer, but none for medical care. See discussion in Randall R. Bovbjerg & Frank A. Sloan, *No Fault for Medical Injury: Theory and Evidence*, 67 U. CIN. L. REV. 53, 73-79 (1998).

47. See *infra* Part III.B.

48. See, e.g., Tom Baker, *Reconsidering the Harvard Medical Practice Study: Conclusions about the Validity of Medical Malpractice Claims*, 33 J. L. MED. ETHICS 501, 507 (2005).

49. Randall R. Bovbjerg & Brian Raymond, *Patient Safety, Just Compensation and Medical Liability Reform*, http://www.kpihp.org/publications/docs/patient_safety.pdf (last visited Apr. 24, 2006); *Medical Malpractice*, *supra* note 43, at 290.

50. SLOAN ET AL., *supra* note 7, at 5.

51. See, e.g., GIBSON & SINGH, *supra* note 6, at 213 (quoting anonymous patient family members).

To be fair, part of the problem with tort's fault-finding system is the imprecision of medical fault as a standard. Unlike such problems as low birth-weight or death under anesthesia, for example, negligent behavior, medical error, and medical injury are not objective occurrences but rather subjective conclusions from some process. Reviewers largely apply implicit standards of care, whether through root-cause analysis, peer review, research panel, licensure hearing, or jury trial.⁵² Making judgments is a time- and resource-intensive process, and reasonable people very often disagree.⁵³ There appears to be substantial hindsight bias, and judgments about negligence tend to be influenced by how severe an ensuing injury turned out to be.⁵⁴ This subjectivity is a significant problem for tracking trends over time, drawing comparisons across institutions, determining best practices, and monitoring for enforcement rather than learning. A highly desirable reform would be to make standards more objective.⁵⁵

III. SOLUTIONS FOR INSURANCE, MEDICINE, AND LAW

A. Improvements for Insurance

Policy makers have had to respond to upheavals in malpractice insurance since the mid-1970s. The most common fix for availability problems has long been for the state to form a "joint underwriting association" (JUA) of existing insurers to offer coverage to those unable to find it in the open market.⁵⁶ JUAs charge above-market rates, seldom account for a large market share, and usually but not always tend to wither away as market conditions improve. Another approach has been to create a publicly overseen "patient compensation fund" (PCF) to supply high-level coverage above the

52. See Bovbjerg, *Patient Safety and Physician Silence*, *supra* note 41.

53. A. Russell Localio et al., *Identifying Adverse Events Caused by Medical Care: Degree of Physician Agreement in a Retrospective Chart Review*, 125 ANNALS OF INTERNAL MED. 457, 464 (1996); Eric J. Thomas et al., *The Reliability of Medical Record Review for Estimating Adverse Event Rates*, 136 ANNALS OF INTERNAL MEDICINE 812 (2002) *erratum* at 137 (2002): 147.

54. See Robert A. Caplan, Karen L. Posner, & Frederick W. Cheney, *Effect of Outcome on Physician Judgments of Appropriateness of Care*, 265 JAMA 1957 (1991); Amy Bradfield & Gary L. Wells, *Not the Same Old Hindsight Bias: Outcome Information Distorts a Broad Range of Retrospective Judgments*, 33 MEMORY & COGNITION 120 (2005); Thomas B. Hugh & G. Douglas Tracy, *Hindsight Bias in Medicolegal Expert Reports*, 176 MED. J. OF AUSTL. 277, 278 (2002).

55. See Saul N. Weingart & Lisa I. Iezzoni, *Looking for Medical Injuries where the Light Is Bright*, 290 JAMA 1917, 1919 (2003) (concluding "Developing and validating a robust set of measurement tools is essential to move patient safety information out of the shadows and into the light").

56. See Randall R. Bovbjerg, *Legislation on Medical Malpractice: Further Developments and a Preliminary Report Card*, 22 U.S. DAVIS L. REV. 499 (1989) *reprinted* in 3 NAT'L. INS. L. REV. 217 (1989).

primary coverage routinely purchased by providers, often as part of limiting payouts to the maximum available from the fund. A number of PCFs were begun in the 1980s, and some never operated or closed down. Pennsylvania's fund undercharged physicians for its coverage, and its deficits had become a major problem in their own right by 2000,⁵⁷ but performance in other states has pleased stakeholders.⁵⁸ A more recent approach to affordability problems is simply to subsidize physicians,⁵⁹ which has a certain appeal as a temporary, counter-cyclical intervention; in the longer run, it seems somewhat questionable to ask taxpayers of all incomes to subsidize largely higher income physicians.

Can the wide swings of the insurance cycle be moderated? Conceptually, it would seem that reforms could be helpful by making liability risk more predictable and claims resolution faster. This would greatly ease insurers' difficulties of prediction and keep more insurers in the liability market. Caps on awards would serve to increase predictability by lopping off the high end of many recoveries. Some suggest that caps helped maintain insurance availability in the 2000s, but strong evidence is lacking.⁶⁰ What caps do accomplish is to reduce claims rates and payouts—and thereby premiums, probably by about a third, other things equal.⁶¹ Caps thus work as intended, that is, they reduce the amount of money moving from defendants and their

57. Bovbjerg & Bartow, *supra* note 32.

58. Frank A. Sloan et al., *Public Medical Malpractice Insurance: An Analysis of State-Operated Patient Compensation Funds*, 54 DEPAUL L. REV. 247, 254 (2005).

59. New Jersey, for example, runs a Medical Malpractice Liability Insurance Premium Assistance Fund. See New Jersey Dep't of Banking and Ins., Questions and Answers on the MMLIPA Fund, <http://www.njdobi.org/mmliipafund.htm> (last visited Apr. 24, 2006). Some hospitals have also sought to subsidize premiums for physicians important to the functioning of the hospital, which can be possible without running afoul of anti-kickback strictures. John W. Jones, *Implications of Malpractice Insurance Subsidies*, PHYSICIAN'S NEWS DIGEST, July 2005, available at <http://www.physiciansnews.com/law/705jones.html> (last visited Apr. 24, 2006); see also IG Says Medical Center Can Subsidize Malpractice Premiums for Obstetricians, 8(18) HEALTH CARE FRAUD REPORT, <http://healthcenter.bna.com/pic2/hc.nsf/id/BNAP-64UJPG?OpenDocument> (last visited Apr. 24, 2006).

60. The AMA's initial July 2002 list of twelve crisis states included only one state with a cap on awards, West Virginia, which had an ineffective cap of \$1 million. *Provider News - Malpractice: Premiums Reach 'Crisis' Levels in 12 States*, AM. HEALTHLINE, June 18, 2002, <http://www.americanhealthline.com>. The crisis list was expanded by six additional states in March 2003, again, only one with any form of cap, Missouri, which applies caps per defendant not per incident. E.g., *New AMA Analysis Shows 18 States Now in Full-Blown Medical Liability Crisis*, AM. MED. NEWS, Mar. 3, 2003. The AMA's 2005 report lists twenty states in crisis and no longer includes Texas which is said to be recovering because of effective reforms including a cap. Am. Med. Ass'n, *Medical Liability Crisis Map*, Mar. 2005, <http://www.ama-assn.org/ama/noindex/category/11871.html> (last visited Apr. 24, 2006).

61. E.g., CONGRESSIONAL BUDGET OFFICE, LIMITING TORT LIABILITY FOR MEDICAL MALPRACTICE, <http://www.cbo.gov/ftpdocs/49xx/doc4968/01-08-MedicalMalpractice.pdf> (last visited Apr. 24, 2006). CONGRESSIONAL BUDGET OFFICE, THE EFFECTS OF TORT REFORM: EVIDENCE FROM THE STATES, <http://www.cbo.gov/ftpdocs/55xx/doc5549/Report.pdf> (last visited Apr. 24, 2006).

insurers to claimants and their lawyers. Lawyers assert that caps do not work, but they are wrong.⁶²

Many trial lawyers and some consumer groups assert that strong regulation is needed to rein in a profiteering insurance industry that exploits its customers.⁶³ This solution has several problems. First, while one can readily expect insurance regulators to resist rapid rises in prices during a hard market, it is difficult to imagine elected or politically appointed commissioners reliably denying price decreases when times are good. Second, regulatory resistance to price increases may actually exacerbate the insurance cycle (and the need for higher prices) by driving insurers out of the market.⁶⁴

It has often been suggested that physicians should be insured along with the hospitals in which they practice. First promoted as a way to stabilize insurance availability and pricing by giving it a larger economic base,⁶⁵ joint insurance became a part of broader proposals for enterprise liability in which not only risk bearing but also legal responsibility, defense, and risk management would be conjoined.⁶⁶ Joint insurance appears to occur today mainly within academic medical centers and affiliated institutions, where hospitals and physicians have a natural community of interest. Further voluntary spread of the practice seems unlikely given current market trends away from closer integration between doctors and hospitals. Some hospitals in the current crisis have sought to subsidize premiums, but not to merge risk sharing.⁶⁷

B. Improvements for Medicine

Two approaches seem noteworthy. First, the most promising difference between today's malpractice crisis and earlier ones is that a new approach to

62. Attorneys have argued that caps do not work because they disadvantage seriously injured patients. This is quite true. But more often, lawyers argue that caps fail to affect premiums—implying that insurers must continuously make excess profits. Such a worldview is inconsistent with observed insurer behavior.

63. See Ass'n of Trial Lawyers of America, *supra* note 2.

64. This was the conclusion of a classic study of the 1970s crisis. Patricia M. Danzon, *The Medical Malpractice Insurance Crisis Revisited: Causes and Solutions* (Hoover Inst. Duplicated, no. E-83-11); see also DANZON, *MEDICAL MALPRACTICE: THEORY, EVIDENCE, AND PUBLIC POLICY*, *supra* note 8; SLOAN ET AL., *supra* note 7.

65. Myron F. Steves, Jr., *A Proposal to Improve the Cost to Benefit Relationships in the Medical Professional Liability Insurance System*, 1975 DUKE L. J. 1305, 1324-31 (1975) (explaining programs of joint insurance are sometimes termed channeling, evidently because separate physician liability risk is channeled into the same insurance program with hospitals).

66. E.g., Kenneth S. Abraham & Paul C. Weiler, *Enterprise Medical Liability and the Evolution of the American Health Care System*, 108 HARVARD L. REV. 381 (1994). For a current discussion, see Randall R. Bovbjerg & Robert A. Berenson, *Enterprise Liability in the 21st Century*, in *MEDICAL MALPRACTICE AND THE U.S. HEALTH CARE SYSTEM: NEW CENTURY, DIFFERENT ISSUES* 219 (William M. Sage & Rogan Kersh eds., 2006).

67. See Jones, *supra* note 59.

medical injury has emerged, one that directly addresses processes that underlie injuries. This is the patient safety movement,⁶⁸ which seeks to fix problems rather than blame by adapting systems approaches from industrial quality improvement and catastrophic accident avoidance.⁶⁹ Safety analysts believe that most mistakes occur because people are human, not because they are incompetent or insufficiently penalized for mistakes. Indeed, they have found that blaming individuals seldom fixes problems; what is needed is simpler, more robust systems within which people work, along with processes for learning from accidents in order to re-engineer the administrative and clinical processes underlying the care provided. Such approaches have had striking successes in reducing accidents in airplanes and factories, and there are promising indications that safety innovations can work in hospitals and other medical settings as well.

Promoting patient safety ought to have high social priority. Public policy can promote safety in many ways, including provision of funds for research and demonstrations, promoting information transfer, modification of public health plans' payment methods, and pioneering ideas in federal health systems like the Veterans Agency system.

What relationship is there with liability reform? Safety analysts say that fear of liability inhibits sharing of information and thus the learning that would result from assessing problems. But conventional tort reform is not known to encourage patient safety initiatives nor to improve clinical outcomes. The top legislative priorities for safety reformers are to further curb the reach of conventional liability by keeping safety reports and analyses confidential, shielded from discovery in litigation, and by barring any use of provider apologies in litigation.⁷⁰ A better, fairer, and more effective approach would seem to be to combine safety improvement with just compensation, as detailed below. This seems especially important given that an unintended side effect of patient safety successes and publicity has been to convince the public

68. See Leape et al., *supra* note 26.

69. See generally Symposium, *Reducing Error, Improving Safety*, 320 BRIT. MED. J. 725 (2000), <http://www.bmj.bmjournals.com> (last visited May 10, 2006). See also INST. OF MED., TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM (Linda T. Kohn et al. eds., 2000), <http://www.nap.edu/books/0309068371/html/> (last visited Apr. 24, 2006); ROBERT M. WACHTER & KAVEH G. SHOJANIA, INTERNAL BLEEDING: THE TRUTH BEHIND AMERICA'S TERRIFYING EPIDEMIC OF MEDICAL MISTAKES (2004).

70. On shielding safety data, see Patient Safety: Instilling Hospitals with a Culture of Continuous Improvement, Before the Senate Comm. on Govt. Aff., June 11, 2003, (testimony of Dennis O'Leary, Pres. of Joint Comm. on Accreditation of Healthcare Organizations), http://hsgac.senate.gov/_files/061103oleary.pdf (last visited Apr. 24, 2006). See Patient Safety and Quality Improvement Act, H.R. 663, (108th Congr.), 720 (2003) S. R. 196; H. R. 128; see States with Apology Laws, <http://www.sorryworks.net/media25.phtml> (last visited Apr. 24, 2006); Thomas H. Gallagher, M.D., Content of Medical Error Disclosures, AM. MED. ASS'N (2004), <http://www.ama-assn.org/ama/pub/category/12053.html> (last visited Apr. 24, 2006).

that too much medical error exists and that practitioners ought to be held more accountable through lawsuits and discipline.⁷¹

Second, state medical boards' discipline of providers should be improved. Observers have long agreed that some proportion of doctors practice beyond their competence, and that such problem physicians need to be dealt with.⁷² This is the traditional role of the state medical board, the only entity with the ability to bar a doctor from practicing medicine or to restrict a physician's scope of practice across institutional settings. Unfortunately, traditional methods of discipline often fail to reach many problem doctors. Also unfortunately, constructive suggestions for improvement are rare. Many simply assert that physician-dominated medical discipline puts the foxes in charge of the chicken coop.⁷³ Not only is this metaphor wrong on its face—what the foxes oversee is the fox hunt⁷⁴—but, worse, the popular policy conclusion is also inapt: It is not enough simply to empanel some non-foxes, as so many licensure reforms have done over the past twenty years.⁷⁵ The key issues are how to improve boards' complaint-driven traditional disciplinary processes, for example with more resources, what new methods like re-education to try in lieu of discipline, and whether society can rely more on other entities or methodologies, such as specialty societies' testing of practitioners' continuing competence. Much more work remains to be done here.

Improving upon boards' traditional, complaint-driven disciplinary processes is an area where most doctors and lawyers ought to be able to agree. Attorneys are already vehement about the need for more vigorous discipline, although they exaggerate the extent to which truly incompetent providers account for most errors or medical injuries, as already noted. Safety theorists should also recognize that despite the value of a blame free culture of safety for most practitioners, some practitioners simply are unwilling or unable to

71. Robert J. Blendon et al., *Views of Practicing Physicians and the Public on Medical Errors*, 347 *NEW ENG. J. MED.* 1933, 1938 (2002); Thomas H. Gallagher et al., *Patients' and Physicians' Attitudes Regarding the Disclosure of Medical Errors*, 289 *JAMA* 1001, 1006 (2003).

72. R. C. Derbyshire, *What Should the Profession Do about the Incompetent Physician?*, 194 *JAMA* 1287, 1287 (1965).

73. STANLEY J. GROSS, *OF FOXES AND HEN HOUSES: LICENSING AND THE HEALTH PROFESSIONS* (1984); Yann H.H. van Geertruyden, Comment, *The Fox Guarding the Henhouse: How the Health Care Quality Improvement Act of 1986 and State Peer Review Protection Statutes have Helped Protect Bad Faith Peer Review in the Medical Community*, 18 *J. CONTEMP. HEALTH L. & POL'Y.* 239, 243-44 (2001).

74. The traditional metaphor more aptly applies to the tradition of letting physicians decide what medical care is needed, at what price. Cf. J. M. Eisenberg & S. V. Williams, *Cost Containment and Changing Physicians' Practice Behavior. Can the Fox Learn to Guard the Chicken Coop?*, 246 *JAMA* 2195 (1981).

75. Andis Robeznieks, *Public Active on Medical Boards, But Not Always Tougher on Doctors: Having Nonphysicians on State Medical Boards, However, Is Seen as a Credibility-Builder for Panels Seeking More Public Trust*, *AMERICAN MEDICAL NEWS*, Nov. 11, 2003.

cooperate in developing and following new safety norms. For such practitioners, there seems little alternative to state medical board intervention.⁷⁶

C. Improvements for Law

Two comments about improving legal performance should have highest priority, one negative and one positive. First, conventional tort reforms like caps on awards, more stringent statutes of limitation, and limits on lawyers' fees are the standard medical prescription for legal ills.⁷⁷ They are just what the doctor ordered, because as noted above, reforms generally improve the liability experience of physicians.⁷⁸ Conventional reforms may also make liability risk somewhat more insurable,⁷⁹ and surely a cap on awards must ease medical providers' fear of bankruptcy from a huge verdict that far exceeds the limits of liability coverage. It is possible that tort reform slightly reduces provider defensiveness and keeps a small share of providers more accessible to patients.⁸⁰

However, tort reform directly hurts injured patients who litigate—a tiny minority—and does very little to help injured patients with legitimate claims who do not sue—the majority. Most important is the impact on all patients, pre-injury. Patients are the ones meant to benefit from tort law's prevention of injury, and they (as patients and as taxpayers) ultimately pay for both medicine and its liability system. Alas, while there is little enough evidence that liability itself makes patients safer, there seems to be no evidence that tort reform improves safety or even makes doctors more willing to embrace patient-safety methods or improvements.

One reason must be that conventional liability reform leaves conventional legal process in place—just about a third less of it. Historically, doctors have been complaining about deleterious impacts of liability on their

76. One quite intriguing idea of "institutional licensure" was suggested in an era before national malpractice concerns. See Nathan Hershey, *An Alternative to Mandatory Licensure of Health Professionals*, 50 HOSP. PROGRESS 17, Mar. 3, 1969, <http://www.ncbi.nlm.nih.gov> (last visited Apr. 24, 2006). The state would license only hospitals, relying on hospitals to oversee those practicing under their aegis. While conceptually appealing for an era when most consequential medicine occurred within hospital walls, the idea (i) has always lacked political "traction" given how jealously professions guard their traditional prerogatives and (ii) fits much less well for current and emerging patterns of practice in which hospital play a lesser roles, as noted about institutional liability above.

77. Randall R. Bovbjerg, *Medical Malpractice: Folklore, Facts, and the Future*, 117 ANNALS OF INTERNAL MED. 788, 789-790 (1992); Eleanor D. Kinney, *Malpractice Reform in the 1990s: Past Disappointments, Future Success?*, 20 J. HEALTH POL. POL'Y & L. 99, 101 (1995).

78. See CBO REPORTS, *supra* note 68.

79. See CLINICS, *supra* note 8.

80. E.g., Encinosa et al., *supra* note 34.

practices for over thirty years, starting in eras when liability was far smaller than now achievable by the strongest current tort reform.⁸¹

Today, even in California, which has physicians' ideal package of tort reforms, physicians note continuing problems of defensiveness and erosion of trust.⁸² It would be good to do better. First, it would be good if liability signals could be made more credible to physicians, who are the main people that liability is meant to influence.

Second, there ought to be more even-handed tort reform. Conventional tort reforms all seek to favor defendants at the expense of plaintiffs. Even-handed reform would seek to improve the process rather than the prospects of either side. Law should just work better, that is, faster, at lower overhead cost, and with results that are more predictable and consistent across cases.

One area ripe for improvement is the use of expert witnesses. Perceptions that experts are for hire feed medical mistrust of the judicial process and the accuracy of its liability signals. These perceptions likely undercut whatever useful deterrent law might provide. The conventional response has been to make it more difficult to qualify outside experts to testify on local standards of care and to seek sanctions against experts perceived to provide partisan rather than objective testimony.⁸³ Why is there no effort to promote availability of good witnesses? Why cannot ways be found to reduce partisanship in shopping for experts? Why can the law not do more to rely upon scientific medical evidence rather than individual testimony of experts?⁸⁴

Reform might address the unpredictability of damage awards that can impede prompt settlement, raise costs of disputation, and lead to disparate results in similar cases. Proposals to reduce the wide variations in legal treatment of non-pecuniary losses are a good example. They could improve proportionality and consistency of results,⁸⁵ but have never advanced far in policymaking because they lack political support. Doctors prefer unfair, flat

81. Defensiveness and loss of trust were centerpieces of the first national hearings held on medical malpractice—in 1969. SENATE SUBCOMM. ON NUTRITION AND HUMAN NEEDS, 91ST CONG., *MEDICAL MALPRACTICE: THE PATIENT VERSUS THE PHYSICIAN* (Comm. Print 1969).

82. *Myths*, *supra* note 13, at 17.

83. Michelle Andrews, *Making Malpractice Harder to Prove*, N.Y. TIMES, Dec. 21, 2003, at 8.

84. *Cf.* Charles M. Clark & Eleanor D. Kinney, *Standards for the Care of Diabetes: Origins, Uses and Implications for Third-Party Payment*, 15 DIABETES CARE 10 (Supp. 1992) (discussing the extant medical practice guidelines regarding the treatment of diabetes); Todd Feinman, *Malpractice: A Different Kind of Tort Reform*, MED. ECON., Aug. 5, 2005, <http://www.memag.com/memag/article/articleDetail.jsp?id=172910&&pageID=2>. (last visited April 24, 2006) (“This internist uses evidence-based medicine to help lawyers handle malpractice cases.”).

85. Proportionality means vertical equity—providing larger awards for larger injuries; consistency means horizontal equity—similar awards for similar injuries. Traditional legal practice has few tools for achieving either form of equity. The reader is encouraged to use Google to search <proportionality consistency fair equitable> and observe how many enforcement processes aspire to these standards . . . but not the U.S. personal injury system.

caps on awards, and lawyers resist any change in the open-ended traditional system for assessing the severity of injury and value of loss.⁸⁶

Another area that seems overdue for practical rather than ideological improvement is judicial administration. How is it that cases involving medical injuries take twice as long to resolve in the slowest states compared to the fastest?⁸⁷ A start in the right direction would be to maintain much better data on lawsuits and their resolution and to support much more management-relevant analysis.⁸⁸

These comments merely scratch the surface. A great deal more could be done here to develop a better, more balanced tort reform agenda.

IV. COMBINING PATIENT SAFETY AND LEGAL REFORM

This paper contends that the best reform would seek to promote both patient safety and better legal compensation for injury. Tort law is so attractive to many thinkers in part because it purports to deter by compensating, and reforms that can both deter and compensate are highly desirable. Safety advocates have generally shied away from such an approach.⁸⁹ In a more ideal world, caregivers would tell patients and families whenever medical errors or overreaching occur. Reasonable compensation would follow for those with preventable injuries. Patient-safety management would thus learn of problems and be able to continuously improve the clinical and administrative processes that support high-quality, low-error provision of services. Practitioners would worry more about patient outcomes than legal outcomes, and outside systems of accountability would make it easier, not harder, for caregivers and medical institutions to do the right thing.⁹⁰ This section discusses several approaches that might move practice in this direction.

86. Frederick S. Levin, *Pain and Suffering Guidelines: A Cure for Damages Measurement "Anomie,"* 22 U. MICH. J. L. REFORM 303, 303 (1989); Randall R. Bovbjerg et al., *Valuing Life and Limb in Tort: Scheduling "Pain and Suffering,"* 83 NW. U. L. REV. 908, 968 (1989).

87. The four fastest states in payouts of physician malpractice claims in 2003 had median delays between incident and payout of three years or less. The four slowest all took five and a half years or more. Delays in average payouts are half a year to a full year longer in each state because a small share of very slow cases make the average longer than the typical case. Delays for the five percent or so of cases litigated to trial are presumably much longer still. NAT'L PRACTITIONER DATA BANK, 2003 ANNUAL REPORT, TABLE 13, http://www.npdb-hipdb.com/pubs/stats/2003_NPDB_Annual_Report.pdf (last visited Apr. 24, 2006).

88. Randall R. Bovbjerg & Joel M. Schumm, *Judicial Policy and Quantitative Research: Indiana's Statute of Limitations for Medical Practitioners*, 31 IND. L. REV. 1051, 1051 (1998).

89. For a fuller treatment of this line of reasoning, see Bovbjerg & Tancredi, *supra* note 42; see also Bovbjerg & Raymond, *supra* note 49.

90. See Bovbjerg, *Patient Safety and Physician Silence*, *supra* note 41.

A. Enterprise Responsibility

Holding enterprises responsible for patient injuries has appeal because patient safety calls for a systems approach, suggesting that legal responsibility should fall to a system—that is, an enterprise. Success stories about advances in patient safety to date almost all come from hospitals and other organized systems.⁹¹ Some of them organize hospitals and medical staffs together to bear risk of litigation, defend claims, and manage risks and patient safety. Thus, the rise of patient safety approaches seems to support dusting off the earlier theory that enterprises should have sole responsibility for legal liability, under the fault system or any replacement injury resolution system. This would require legislative reform of tort liability, but not to restrict plaintiffs' accustomed prerogatives, only the focus of responsibility.

Enterprise responsibility has several good features: It would allow institutions to create cultures of safety within themselves by sheltering individual caregivers from liability fears (at least the monetary aspects of liability), thus possibly encouraging more internal reporting of problems. Larger institutional scale for insurance would assure a good price for liability coverage for whatever rate of claims and payouts the enterprise develops. Conjoined responsibility would reduce finger pointing among defendants, which they would probably like, although plaintiffs' attorneys would not. Finally, it would encourage collective, institution-wide monitoring and quality feedback and also allow attention to systems errors going beyond the individual that affect individual practice.

Enhanced institutional responsibility also has a downside: It could lead to a deep pocket increase in claims and awards without regard to actual losses. It would make physicians more dependant on hospitals, which might reduce their sense of personal responsibility and willingness to help defend the enterprise. The collective incentive for joint defense could recreate the old-time conspiracy of silence—the dark side of non-finger-pointing. Practitioners outside institutions would likely escape effective oversight from enterprises. Overall, enterprise responsibility seems unlikely to promote greater compensation of injured patients.⁹²

In practice, being able to move to enterprise liability presupposes the existence of effective medical enterprises, mainly hospitals that have common interests and coordinated organization with attending physicians. It is this type of integration that encourages physician involvement in patient safety interventions, yet medicine has retreated from a mid-1990s flirtation with more integrated forms of medical organization. Outpatient and inpatient

91. See Kohn et al., *supra* note 24; WACHTER & SHOJANIA, *supra* note 69.

92. Randall R. Bovbjerg, *Medical Malpractice: Problems & Reforms: A Policy-Maker's Guide to Issues and Information*, in WASHINGTON, DC: THE URBAN INSTITUTE AND THE INTERGOVERNMENTAL HEALTH POLICY PROJECT (George Washington Univ. 1995), <http://www.urban.org/url.cfm?ID=1000414> (last visited Apr. 24, 2006).

practices are now more separated from each other. Many traditionally inpatient procedures can be done on an outpatient basis, and many community practitioners are handing over inpatient care of their patients to hospitalists. Moreover, hospitals also control less of the healthcare dollar, as spending has shifted in the direction of pharmaceuticals and other non-hospital therapy. Joint responsibility of physicians and their hospitals makes good sense where they are voluntarily organized to act jointly, but attempting to force them together by liability reform seems problematic.⁹³ Those enterprises that have integrated, however, would be good locations for experimentation with patient safety-oriented liability reform.

B. Enhanced Disclosure Plus Patient Safety

A second approach could also occur under today's liability system. That is, for potential defendants (hospitals and physicians) to openly disclose medical injuries to patients and their families—a reversal of the traditional legal advice never to discuss such problems. The goals of enhanced disclosure are to speed compensation and improve patient relations, reduce litigiousness, and encourage better patient safety and provider cooperation in disclosure of and learning from problems.⁹⁴ Given that safety analysis starts with disclosure of problems, better disclosure will plausibly be helpful for safety.

If caregivers fully disclose errors and also offer recompense, this approach would reform compensation as well.⁹⁵ But disclosure need not involve accepting responsibility, including for monetary losses, and many providers remain concerned that disclosure will simply facilitate lawsuits.⁹⁶ Only one published study, from a Veterans Affairs (VA) hospital, supports the belief that patients treated right will be less vengeful and more willing to settle for a relatively low dollar figures.⁹⁷ Some additional, unpublished accounts corroborate the VA hospital's experience, notably at the University of Michigan.⁹⁸ Where injuries are very costly, as in many newborn cases, large settlements seem likely to be needed, yet even for them, disclosure-enhanced trust could facilitate a reduction in costs of prolonged disputation.⁹⁹

93. For a full discussion see *Myths*, *supra* note 13.

94. Nat'l Patient Safety Found., Talking to Patients About Health Care Injury: Statement of Principle (Oct. 2005), <http://www.npsf.org/html/statement.html> (last visited Apr. 24, 2006).

95. It is quite possible to disclose a medical problem without taking responsibility for it. Much of the discussion of apologies at least implies that this is the advisable course of action for physicians to follow.

96. See Bovbjerg, *Patient Safety and Physician Silence*, *supra* note 41.

97. See Steve S. Kraman & Ginny Hamm, *Risk Management: Extreme Honesty May be the Best Policy*, 131 ANN. INTERN. MED., 963, 963 (1999).

98. See The Sorry Works! Coalition, <http://www.sorryworks.net> (last visited June 12, 2006).

99. Precisely to deal with very expensive cases, one long-time reform proposal would allow defendants to avoid any liability recovery for pain and suffering if they promptly offer an injured patient complete compensation of the patient's ongoing out-of-pocket injury costs as

The largest boost to disclosure has come from the rules of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) that call for hospitals to adopt disclosure policies as well as to investigate significant errors or injuries dubbed “sentinel events.”¹⁰⁰ If such hospital-led disclosure becomes common, it seems likely to bring physicians and hospitals together, perhaps facilitating a more enterprise-based approach in the future.

C. *Alternative Non-Tort System I: Administrative Compensation*

This alternative would in many ways resemble workers compensation. Virginia and Florida have run such non-tort compensation systems with some success for severely neurologically impaired newborns. Private insurers or self-insured groups would bear risk and pay claims. Disputes would be resolved by an expert administrative agency. Lawsuits would be limited to very unusual circumstances, as would recoveries for damages.¹⁰¹ To maintain affordability of coverage, most proposals assume that the new injury coverage would be secondary to existing health insurance plans, disability coverage, and other payors. Non-liability payors pay for most medical injuries today; maintaining this financing role is important for transitioning to a new medical injury system. Over time, these traditional payors and the new injury system would benefit from improved prevention of injury and faster remediation of injuries.

Most proponents of administrative compensation would replace fault with a standard of avoidability or preventability of injury.¹⁰² This standard is easier to apply than fault, as reviewers more readily agree about which injuries are preventable than about which are negligent. Preventability would make more events eligible for compensation, and it would be more consistent with patient safety’s focus on prevention. The pattern of claims resolutions would

they are incurred (net of any other insurance coverage or public program). Jeffrey O’Connell, *Offers That Can’t Be Refused: Foreclosure of Personal Injury Claims By Defendants’ Prompt Tender of Claimants’ Net Economic Losses*, 77 NW. U.L. REV. 589 (1982); J. O’Connell & P.B. Bryan, *More Hippocrates, Less Hypocrisy: ‘Early Offers’ as a Means of Implementing the Institute of Medicine’s Recommendations on Malpractice Law*, 15 J.L. HEALTH 23 (2000-01).

100. Rae M. Lamb et al., *Hospital Disclosure Practices: Results of a National Survey*, 22(2) HEALTH AFF. 73, 73 (2003); Randall R. Bovbjerg, *Liability Problems and Transparent Disclosure to Patients as a Solution*, in FINAL NARRATIVE REPORT TO THE JOHNSON FOUNDATION’S PROGRAM ON CHANGES IN HEALTH CARE FINANCING & ORGANIZATION (unpublished, 2005), summarized in *Malpractice Tort Reform & Safety*, in CHANGES IN HEALTH CARE FINANCING & ORGANIZATION NEWS & PROGRESS (Washington, DC: AcademyHealth online newsletter, June 2005), <http://www.hcfo.net/pdf/news0605.pdf>.

101. See David M. Studdert & Troyen A. Brennan, *No-Fault Compensation for Medical Injuries: The Prospect for Error Prevention*, 286 JAMA 217 (2001); David M. Studdert & Troyen A. Brennan, *Toward a Workable Model of “No-Fault” Compensation for Medical Injury in the United States*, 27 AM. J. LAW MED. 225 (2001).

102. The approach has long been known as “no fault,” Studdert & Brennan, *supra* note 101 at 219, which wrongly implies no accountability. Supporters of administrative compensation say, to the contrary, that well-decided findings of preventability would more readily support remedial action and prevention of future problems.

thus be more useful for safety improvement than are current tort outcomes. The system would remain claims-driven, however, formal adjudications would remain prominent, and administrative costs would still be significant.

D. Alternative Non-Tort System II: Avoidable Events

This approach would pay automatically for injuries listed in advance as avoidable events.¹⁰³ Experts would develop these Avoidable Classes of Events (ACEs) based upon epidemiological evidence and expert consensus. These ACE listings would promote disclosure or discovery of worthy cases and encourage prompt resolution thereafter, with little need for formal adjudication, judicial or administrative. ACEs would also constitute much more objective indicators of problems than do liability outcomes, which should facilitate patient safety analysis and response. One existing analogue to ACEs is the list of compensable events used to resolve injuries related to administration of childhood vaccines, although that listing is not based on preventability of injury.¹⁰⁴

ACEs could probably cover most injuries, and payment rules could be standardized. Disputes over ACE status and non-ACE injuries would be resolved through mediation and arbitration or some other agreed private process. ACE listing takes the place of an adjudication of liability or responsibility; ACE damage rules could also be standardized, as discussed above for administrative compensation. ACEs could be implemented as part of private reforms under which providers and patients or health plan enrollees would agree in advance to resolve injuries within the new system. Alternatively, they could be used to make administrative compensation systems more efficient and consistent in operations.

Supporters of administrative compensation and of ACEs recognize that these approaches would constitute very large changes and that they would be based on relatively little experience to date. They accordingly tend to promote testing out actual implementation through demonstration projects, an approach supported by an Institute of Medicine committee and promoted by a current congressional bill.¹⁰⁵ Demonstrators could be states, large integrated medical systems, or Medicare.¹⁰⁶

103. A long line of scholarly articles has developed this concept. See Bovbjerg & Tancredi, *supra* note 42, reviews and updates ACE research.

104. See Health Resources and Services Administration, U.S. Dep't of Health & Human Servs, *National Childhood Vaccine Injury Act: Vaccine Injury Table*, <http://www.hrsa.gov/vaccinecompensation/table.htm> (last visited Apr. 24, 2006).

105. The Fair and Reliable Medical Justice Act., S. 1337, 109th Cong. (2005); INST. OF MED., *Liability: Patient-Centered and Safety-Focused, Nonjudicial Compensation*, in *FOSTERING RAPID ADVANCES IN HEALTH CARE: LEARNING FROM SYSTEMS DEMONSTRATIONS* (Janet M. Corrigan et al. eds, Nat'l Acad. Press 2002), <http://www.nap.edu/books/0309087074/html> (last visited Apr. 24, 2006).

106. INST. OF MED., *supra* note 105. The IOM committee emphasized states. ACE reformers have emphasized private contractual arrangements involving medical systems. *E.g.*,

V. CONCLUDING OBSERVATIONS

Your commentator's career in health law and policy has been enlivened by the opportunity to witness and write about three national upheavals in medical liability insurance since the mid-1970s.¹⁰⁷ Early on, almost all policy-relevant information came from interested parties.¹⁰⁸ Over time, a very encouraging development has been substantial growth in knowledge about malpractice.¹⁰⁹ Even more encouraging has been the rise of patient safety methods as a preventive alternative to the retrospective blame-finding of conventional litigation. However, a discouraging note is that the centerpiece of today's national debate about malpractice is federalization of the same state tort reforms that were first enacted in California in 1975. Very similar points are still being made for and against these reforms—albeit with more factoids used by both sides—despite the passage of thirty years.

The likelihood seems high that the opportunity will come to comment on another malpractice crisis in the foreseeable future. One can only hope that before then some farsighted actors will have shown how injury compensation and deterrence can work better, whether using ideas noted in this essay or developing better ideas of their own. If such encouraging developments do occur, then the fourth national upheaval may be less threatening to providers and patients alike, and public policymakers will have improved new models of response that go beyond the 1970s' invention of conventional tort reforms.

Bovbjerg & Tancredi, *supra* note 42. Medicare oriented reform is promoted by William Sage & Eleanor Kinney, *Medicare-Led Malpractice Reform*, in *MEDICAL MALPRACTICE AND THE U.S. HEALTH CARE SYSTEM* (Sage & Kersh eds., Cambridge Univ. Press forthcoming).

107. E.g., Randall Bovbjerg, *The Medical Malpractice Standard of Care: HMOs and Customary Practice*, 1975 *DUKE L. J.* 1375 (1975); Randall R. Bovbjerg, *Medical Malpractice on Trial: Quality of Care Is the Important Standard*, 49 *LAW AND CONTEMP. PROBS.* 321 (1986); *CLINICS*, *supra* note 8.

108. The first significant effort was the SECRETARY'S COMMISSION REPORT, *supra* note 36. Most subsequent work was not federally funded.

109. Compare Stephen Zuckerman et al., *Information on Malpractice: A Review of Empirical Research on Major Policy Issues*, 49 *LAW AND CONTEMP. PROBS.* 85 (1986) (complaining of dearth of good studies) with Bovbjerg, *Policy-Maker's Guide*, *supra* note 92 (précis of relevant knowledge).