U.S. MEDICAL MALPRACTICE AND ITS COSTS: A BRIEF SURVEY[1]

João Pinto Monteiro[2]
Assistant Professor
Faculty of Law of the University of Coimbra
Center for Biomedical Law, Faculty of Law of the University of Coimbra

SUMMARY: 1. American Medical Malpractice Liability and Health Care Costs. 2. Medical Behavioural Changes and their Ramifications. 3. Several solutions under Discussion. 4. Conclusion.

ABSTRACT

This article presents straight forward considerations on the relationship between medical liability in the United States, medical behaviours it incentivizes —with a focus on defensive medicine— and health care costs. First, we present ways in which medical liability contributes to increased health care costs; second, we look at how this influences physicians' behaviours and what consequences this implicates for health care in the United States; third, we talk about specific solutions under consideration; finally, we sum it up.

KEYWORDS

Medical malpractice; defensive medicine; health care costs; United States of America.

1. AMERICAN MEDICAL MALPRACTICE LIABILITY AND HEALTH CARE COSTS

U.S. medical malpractice law revolves around the tort concept of negligence, which is considered to take place when care provided by the physician does not meet what is expected of a reasonable medical practitioner—the standard of care[3].The physician's

1 This article is a product of research project FCOMP-01-0124-FEDER-014435 "*Towards a legal framework of medical malpractice that is less aggressive, more efficacious and more favorable to the reduction of medical error*" (Ref. FCT PTDC/CPJ-JUR/111133/2009), financed with national funds by the FCT/MCTES (PIDDAC), and co-financed by the European Regional Development Fund (ERDF) through the COMPETE – POFC, coordinated by Prof. Guilherme de Oliveira and undertaken at the Center for Biomedical Law, Faculty of Law of the University of Coimbra.

2 João António Pinto Monteiro, LL.B., Faculty of Law of the University of Coimbra (2003); LL.M., Faculty of Law of University of Coimbra (2008); LL.M., Columbia Law School (2009); Visiting Scholar, Harvard Law School (2010-2011), and Columbia Law School (2012); Ph.D. candidate, Faculty of Law of the University of Coimbra; M.D. candidate, Faculty of Medicine of the University of Coimbra. I would like to thank Prof. André Dias Pereira for his helpful insights.

3 Our focus will be trainedon physicians as care providers because, even though they and health care facilities may be jointly and severally liable for medical malpractice, the former are the central defendants in a majority of claims, as it is difficult to hold a hospital or other institution liable, due to limited theories of corporate negligence (for example, in the fulfillment of oversight duties) that have been held in courts. Still, the organization for which the physician works may be more commonly held indirectly (or "vicariously") liable for the acts of their physicians, even if these are not employed by the hospital (which happens quite often, with physicians operating as independent contractors instead), so long as the institution exerts a certain level of control over the practice environment at issue. Michelle M. Mello & David M. Studdert, *The Medical Malpractice System: Structure and Performance*,*in*Medical Malpractice and the U.S. Health Care System 11-12 (William M. Sage & Rogan Kersh eds., 2006).

relationship with his patient must also give rise to a duty to the former, and the patient must suffer an iatrogenic injury (medical in its origin).[4]

There is not much uniformity in the way states tackle medical malpractice, not only in what concerns the standard of care to which physician's behaviour must conform,[5] but also when it comes to matters such as the status of limitations and claim caps.

Generally, the standard of care may be defined as "customary medical practice," (thus making life easier for courts, which generally struggle with the technical complexity of medical care) or as the more objective "reasonable prudence," to which many states have been turning to.[6]

When the issue is whether patient's consent was informed,[7] that is to say whether the physician informed the patient of material risks associated with proposed treatments, there is a requirement of reasonability that has been focusing less on the physician and more on the patient: whereas most states provide that the physician must disclose all the risks that a reasonable physician would divulge, a minority of jurisdictions now prefer to require that the physician disclose all the risks that a reasonable patient would expect to be made aware of before undergoing the treatment.[8]

There are at least a couple of ways in which negligence contributes to health care costs.

One major issue is the difficulty knowing when negligence is present, which leads to an especially marked uncertainty in its practical application,[9] clearly shown for the first time by the Harvard Medical Practice Study, which reviewed medical records of patients hospitalized in the State of New York in 1984 to assess the quality of care provided and correlate it with subsequent malpractice litigation. As William M. Sage reveals, this study *"radically changed the academic understanding of medical malpractice by revealing a two-sided mismatch between malpractice litigation and underlying negligence ... [and] confirmed that malpractice awards are frequently unjustified, in that most successful claimants, though suffering from substantial physical infirmities, had not been treated negligently and often had not even been injured by medical care."*[10]

This means costs associated with compensation and administrative expenses become particularly difficult to predict for insurance companies, making them uneasy, which in turn makes medical liability insurance mercurially more expensive. Uncertainty has already proven to be deadly more than once in recent American history, when the unexpected surge in claim costs generated crises in liability insurance markets in the mid-1970s and mid-1980s.[11] This, in turn, nudged many states to adopt tort reforms designed to reduce claim costs;[12]below we will see an instance in the shape of a Californian tort reform.

A more recent study, published in The New England Journal of Medicine in 2006, in which trained physicians pored over 1,452 claims from five liability insurers, presents a generally rosier outlook of this matter.[13] However, its results indicate that 28%

4 *Id.*at 12-13.

5 The Restatement (Third) of Torts: General Principles does not seem to be particularly helpful in the case of medical malpractice.John C. P. Goldberg & Benjamin C. Zipursky, *The Restatement (Third) and the Place of Duty in Negligence Law*,54 Vand. L. Rev. 657,675 (2001).

6 Troyen A. Brennan, Just Doctoring: Medical Ethics in the Liberal State 100(1991).

7 This is a fundamental problem in medical malpractice in general, given the information asymmetry between consumers (patients) and producers (physicians and hospitals) of medical services. A misperception of risks on the part of the patient could be conducive to too little care per procedure and to too many risky procedures. Medical liability complements other mechanisms (such as altruism, professional and ethical concerns, peer review and professional licensure) and would ideally erase any negligent behavior by making it cheaper for the physician to prevent it rather than to risk paying damages. For a deeper discussion of the matter, impossible to follow through with here, *see*Patricia M. Danzon, *Medical Malpractice*,*in*2 The New Palgrave Dictionary of Economics and the Law 624, 624 (Peter Newman ed., 2002).

8 Arnold J. Rosoff, Informed Consent: a Guide for Health Care Providers 38(1981).

9 *See*Frank A. Sloan, Penny B. Githens & Gerald B. Hickson, *The Dispute Resolution Process*, *in*Suing for Medical Malpractice 153, 153 (Frank A. Sloan, Penny B. Githens, Ellen Wright Clayton, Gerald B. Hickson, Douglas A. Gentile & David F. Partlett eds., 1993): *"Some assert that [the system to resolve medical malpractice claims] operates like a lottery, both in determining liability and setting damages. Liability determination is thought to be particularly suspect in a field such as medical malpractice where the causation issues are often complicated*."

10 William M. Sage, *Malpractice Reform as a Health Policy Problem*,*in*Medical Malpractice and the U.S. Health Care System, *supra* note 3,at 32.

11 Paul C. Weiler, Howard H. Hiatt, Joseph P. Newhouse, William G. Johnson, Troyen A. Brennan & Lucian L. Leape, A Measure of Malpractice: Medical Injury, Medical Litigation, and Patient Compensation(1993).

12 Danzon,*supra* note 7,at 626.

13 David M. Studdert, Michelle M. Mello, Atul A. Gawande, Tejal K. Gandhi, Allen Kachalia, Catherine Yoon, Ann Lou-

of claims involving injury to the plaintiff without involving medical error still resulted in compensation—mostly settled out of court. The converse is also true: 27% of claims involving error were not compensated. Together, these two figures amount to a total of 381 (26%) of the 1,452 claims.[14] While it is true that medical error "*is not identical to the legal concept of negligence ... the two cleave so closely that experts in both medicine and law have trouble explaining the difference.*"[15] Our point is that this does not significantly change the fact that there is still plenty of unpredictability in medical malpractice liability and that this contributes to ramping up health care expenditure and costs in the United States.[16]

Another problem is the extensive discovery and testimony of multiple experts required to prove physician's negligent behaviour. These experts very often disagree even in the more controlled and less adversarial context of research studies, like the studies we have just mentioned. Unsurprisingly, the requirement of negligence represents roughly 40%of the malpractice insurance premium.[17]

In conclusion: as it is problematic to look at an iatrogenic injury and ascertain whether it was negligent or not —making this a particularly challenging requirement to apply in practice— negligence is very expensive and time-consuming to prove in court, and the likelihood of the outcome of a claim is particularly challenging to foresee. This means insurance companies are not able to properly estimate how much money they will spend on medical liability awards—only that they will spend a lot of it on proving the claims that are actually brought to court wrong. This, in turn, makes medical liability insurance erratically expensive. Physicians and hospitals will therefore have to pay a steeper price for coverage, which, in turn, will cause them to increase their fees.[18]

The legal system of the United States also contributes tothe phenomenon we have been describing by the way incentives are put into place in litigation related to medical malpractice.

The current system makes it relativelyeasy for a plaintiff to file a claim because he is not required to reimburse defendant's legal costs even if the latter prevails in the case.[19] Moreover, normally the plaintiff does not even pay his own legal fees; instead, his lawyer shoulders them. This means a patient is not subjected to that particular financial deterrent when he is considering suing a physician for malpractice. In turn, the plaintiff's lawyer recoups his fees by receiving a percentage (normally up to 40%) of the amount awarded to his client, and filters out patients' frivolous claims because they are unlikely to lead to compensation.[20]

In a meritorious claim the lawyer has a powerful incentive to file suit due to the hefty compensations usually awarded to plaintiffs: while it is difficult to accurately average their dollar amounts, a study in 2003 estimated this average to fall somewhere between $260,000 and $310,000.[21] This would put estimates of total annual awards at about $5.8 billion nationwide. However, even though this contributes to increasing the total spent on health care, in the same study it represented less than 0.3%of spending. Even if we include estimates of administrative expenses (involving lawyers, experts and courts), the figure still amounts to less than 1%.[22]

ise Puopolo & Troyen A. Brennan, *Claims, Errors and Compensation Payments in Medical Malpractice Litigation*,354 New Eng. J. Med. 2024, 2024-33 (2006).

14 *Id.*at 2028.

15 *Id.*at 2032.

16 *See*Allen Kachalia& Michelle M. Mello, *New Directions in Medical Reform*, 364New Eng. J. Med. 1564, 1564 (2011).

17 Ellen Wright Clayton & David F. Partlett, *Lawyer-Client Relationships*,*in*Suing for Medical Malpractice,*supra* note 9, at 77.

18 *See*George L. Priest, *The Current Insurance Crisis and Modern Tort Law*,96 Yale L.J. 1521,1522 (1986-1987) (explaining the repercussions of increased premiums on sustained price increases).

19 Florida was an exception because it awarded fees to the prevailing party to deter claims and defenses without merit, but it later scrapped this Anglo-Canadian rule. Paul C. Weiler, Medical Malpractice on Trial 29(1991).

20 Douglas A. Kysar, Thomas O. McGarity & Karen Sokol, *Medical Malpractice Myths and Realities: Why an Insurance Crisis is not a Lawsuit Crisis*,39 Loy. L.A. L. Rev. 785,806-07.

21Michelle M. Mello & David M. Studdert, *The Medical Malpractice System: Structure and Performance*,*supra* note 3,at 13. Ideally this kind of compensation would have been at the reach of a high proportion of patients negligently injured, by eliminating deterrents to claims while at the same time screening out those lacking in merit, preferably before they were even filed. It should also deter iatrogenic injuries that stem from negligent behavior, all the while avoiding transaction costs.

Several studies, however, offer empirical evidence that the current system does not conform to these expectations, including two thorough surveys of medical records of hospitalized patients. A particularly important one is the abovementioned Harvard Medical Practice Study. William M. Sage, *Malpractice Reform as a Health Policy Problem*,*supra* note 10,at 32.

22Michelle M. Mello & David M. Studdert, *The Medical Malpractice System: Structure and Performance*,*supra* note 3,at 13.

Nonetheless, incentives to litigate against perceived malpractice also put stress on the court system, contributing to clogging it, and thus increasing transaction costs in general (including in the acquisition of medical services by the patient and the purchase of insurance by the physician) because the parties to a contract, when defining their performances, have to take into account the possible need of legal enforcement and the expenses they would then incur.

2. MEDICAL BEHAVIOURAL CHANGES AND THEIR RAMIFICATIONS

All this sways the way American physicians provide their services because they are likely to perceive patients as a potential source of very expensive legal trouble. They then react by shielding themselves from the seeming threat in many distinct ways.

One of these ways is a deep transformation of the main priorities presiding the medical relationship between physician and patient: patient's health is no longer the physician's sole priority, for he is also concerned with protecting himself from liability. This obviously sows distrust towards the patient and hardens the physician.[23] It also makes it more likely for a physician to avoid disclosing his mistakes (because even if he is confident he has not been negligent in causing them, he might still fear being held accountable against a somewhat murky legal standard), which impairs patients' access to compensation when there might indeed have been a negligent medical injury.[24]

In the United States communication between physicians and their patients appears to beparticularly fraught. In a 2009 survey of almost 1,891 practicing physicians, more than 10% confessed to having told patients something untrue in the previous year, and about one-third did not completely agree with disclosing serious medical errors to patients, even though the vast majority admitted that physicians should fully inform patients about the risks and benefits of interventions.[25]

Other behavioural changes—generally classified as "defensive medicine"—include situations where the physician overprovides medical services, including diagnostic tests, procedures and medications. This practice is pervasive in the United States[26] where (as we have already established) medical malpractice litigation is common and very expensive, compensation awarded to plaintiffs is high, and where the outcome of malpractice lawsuits is rather hazy. A physician will thus give his patient every exam, procedure and medication related to his condition (regardless of how vaguely related), even if there is only little—or even no—marginal utility. This way the physician shows the patient he did absolutely everything that was required by his medical duty, thus allaying his own fears of being successfully sued.

This represents a substantial increase in medical expenditure for patients and the companies that insure them, since they will be the ones picking up the tab for services that were of scant value.[27] This increases health care costs —and therefore insurance premiums— without producing a significant quality benefit. Actually, the quality of care provided might even diminish, considering that patients will be given medication with potential side effects and subjected to tests and procedures that might be invasive, painful, or at least generally unpleasant.

Overprescribing medication might also increase drug prices by intensifying demand, thus placing yet another financial strain on American health care without palpableimprovements in quality. There is broad consensus that this practice is widespread.[28]

Further changes in medical behaviour include avoiding provision of high-risk procedures, dodging difficult cases,eschew high-risk specialties (thus leading to a dearth of physicians in them)[29], moving

23 William M. Sage, *Malpractice Reform as a Health Policy Problem*,12 Widener L. Rev. 107, 115-17 (putting forward the Pennsylvanian example as a possible solution to making physicians more open, candid and empathetic with patients whom they might have injured).

24 *See*Tom Baker, The Medical Malpractice Myth178(2005).

25 Lisa I. Iezzoni, Sowmya R. Rao, Catherine M. DesRoches, Christine Vogeli & Eric G. Campbell, *Survey Shows that at Least Some Physicians Are Not Always Open or Honest with Patients*,31 Health Aff. 383, 383-91.

26 Daniel Kessler& Mark McClellan, *Do Doctors Practice Defensive Medicine?*,111 Q. J. Econ. 353, 358 (1996).

27 Troyen A. Brennan, Michelle M. Mello & David M. Studdert, "Liability Patient Safety, and Defensive Medicine: What Does the Future Hold?",*in*Medical Malpractice and the U.S. Health Care System, *supra* note 3,at 93-114.

28 Michelle M. Mello & David M. Studdert, "The Medical Malpractice System: Structure and Performance",*supra* note 3,at 23.

29 The choice of a particular medical specialty might entail having to pay exorbitant insurance premiums, which is what happened to Floridian obstetrician/gynecologists (some of which were charged $174,000 per coverage year), leading up to the introduction of no-fault liability for certain injuries in this

to a different state[30] or even leaving the practice of medicine.

In sum, defensive medicine consists of behaviours undertaken to assuage the physician's apprehension about liability, and which are of little benefit (compared to their cost), no benefit, or just outright harmful.[31]The fluidity of the concept is sure to make American efforts to quantify the financial impact of defensive medicine on health care costs face the same difficulties as other countries. Nonetheless, the aforementioned 2003 study estimated that if we add costs associated with defensive medicine to those of medical liability and its administrative costs, we may reach a grand total amounting to as much as 1.5%of health care spending in the United States.[32] It is therefore no wonder that the newly published sixth edition of the American College of Physicians' Ethics Manual urges practitioners to use resources parsimoniously.[33]

3. SEVERAL SOLUTIONS UNDER DISCUSSION

These are all good reasons why tort reform has regularly been such a hot topic in U.S. politics. As of late it has been especially persistent among politicians affiliated with the Republican Party, who felt disillusioned with its absence from the Patient Protection and Affordable Care Act (PPACA),[34] sometimes referred to (usually by opponents) as Obamacare, which was enacted in March 2010. In fact, many of its goals might be imperilled by the spiralling health care expenditure.[35] So what is keeping American politicians from reforming malpractice laws?

There are several constraints to malpractice reform. One limitation is the other issues usually considered more preeminent, such as access to affordable health care, which has been at the centre of the PPACA. Malpractice reform truly comes to the foreground of political debate only when the malpractice insurance market makes it too costly—and in some cases even impossible—for physicians to acquire insurance, thus causing them to protest more vehemently and some hospitals to threaten closing their doors.[36] Otherwise, the main reason for malpractice reform is the omnipresent issue of defensive medicine, a concept too flexible and difficult to quantify to directly be a part of health policy.

Another difficulty is that the debate over medical tort reform is so burdened with professional rivalries between physicians, lawyers and organizations related to them that outsiders avoid meddling. Of course the microeconomics of the market for services related to health care go far beyond physicians and lawyers, so it is no surprise that there are also business interests on both sides that try to have their opposite goals prevail.

In the end, all this means the malpractice debate has tended to focus on reforms of the legal process and neglect problems pertaining to the assurance of quality in medical care and to liability insurers, who are only paid attention to during the downturns of the insurance cycle.[37] An excellent example of this is California's Medical Injury Compensation Reform Act of 1975, which consists of a cap on noneconomic and punitive damages, the possibility of reducing certain other types of damages, a sliding scale for plaintiff's lawyers' contingent fees, and a shortening of the statute of limitations for filing claims.[38] Clearly, the intention here was chiefly to reduce claim costs.[39]

state in 1988, which we will analyze below.

30 Joanna M. Shepherd,*Tort Reforms' Winners and Losers: the Competing Effects of Care and Activity Levels*,55 UCLA L. Rev. 905, 942-43 (2008).

31 Michelle M. Mello & David M. Studdert, "The Medical Malpractice System: Structure and Performance",*supra* note 3,at 23.

32 *Id.*at 13.

33 Peter J. Neumann, *What we Talk about When we Talk about Health Care Costs*,366 New Eng. J. Med. 585,585-86 (2012) (for a succinct analysis of this exhortation).

34 For the position of some of the (currently) most prominent Republican politicians, *see*Newt Gingrich & Vincent L. Frakes,*Incomplete Reform: How the Patient Protection and Affordable Act Fails to Achieve True Health Transformation*,25 Notre Dame J.L. Ethics& Pub. Pol'y 329, 329-36 (2011); and Paul Ryan, *Health Care Reform: The Way Forward*,25 Notre Dame J.L. Ethics& Pub. Pol'y 337,337-53 (2011).

35 Michael Lee, Jr., *Trends in the Law: The Patient Protection and Affordable Care Act*,11 Yale J. Health Pol'y L.& Ethics 1,5 (2011).

Nevertheless, the current impact of this act on health care cannot be overstated. Among other changes that are already being enjoyed by Americans, the PPACA forbids insurance companies from denying payments for health services by retroactively finding an error or other technical mistake on the patient's previously accepted application; eliminates lifetime dollar limits on essential benefits, such as hospital stays; and forbids insurance companies from denying coverage to children under the age of nineteen due to a pre-existing condition.

36 William M. Sage, *Malpractice Reform as a Health Policy Problem*,*supra* note 10,at 30.

37 *Id.*at 30.

38 *Id.*at 31.

39 However, such caps are not without problems: *see*Patricia J. Chupkovich, *Statutory Caps: An Involuntary Contribution to the Medical Malpractice Insurance Crisis or a Reasonable Mechanism for Obtaining Affordable Health Care*, 9J.

To this aim there has also been talk of adopting a no-fault liability system, which would render the negligence requirement unnecessary for the patient to be compensated, and which the American College of Physicians advocated broad experimentation with.[40] It is argued that a no-fault standard would improve disclosure of medical errors by removing incentives to hide them, since injuries would be compensated either way.[41] Promoters of versions of this standard also point out that this would increase the quality of medical care.[42] On the other hand, a no-fault standard might increase health care costs by compensating all medical injuries. However, this argument must be confronted with the savings that would derive from decreased administrative costs with litigation and a diminished need for defensive medicine: for example, physicians would not need to overprescribe diagnostic tests, procedures and medications because that would have no impact on a decision to compensate medical injury.

Florida is an example of a state with some experience with no-fault liability, albeit only for specific procedures. In 1988 it passed a bill oniatrogenic newborn infants' neurological injuries, with compensation to be paid by the Neurological Injury Compensation Association. The initiative has been successful for the most part, although its narrow scope means we should not carelessly adopt a more encompassing approach of no-fault liability.[43] The same thing might be said of New Zealand's general no-fault system of accident compensation: the particularities of this country's system do not make it readily available for import into the United States.[44]

4. CONCLUSION

The United States are particularly remarkable in the way so much of the nation's gross domestic product is allocated to expenditure on health care (the highest figure in the World Health Organization's 2011 health statistics with 15.2%in 2008, up from 13.4%in 2000).[45]This can be explained, at least in part, by medical liability and the defensive medicine it gives rise to. Tort reform could help tackling these problems, but political stalemate has predominantly led to marginal reforms to reduce the filing of claims by patients. Other approaches like no-fault liability are still in their infancy in the United States and thus need to be given broader and deeper consideration before they can be generally adopted.

Contemp. Health L.& Pol'y 337, 337-75 (1993).

But see Robert S. Peck, *Violating the Inviolate: Caps on Damages and the Right to Trial by Jury*,31 U. Dayton L. Rev. 307, 310 (2005-2006) (strongly contending that caps do not have the positive effect on health care costs so commonly assigned to it, and supporting his position with several court decisions, including a particular insightful one from the Wisconsin Supreme Court); and F. Patrick Hubbard, *The Physicians' Point of View Concerning Medical Malpractice: A Sociological Perspective on the Symbolic Importance of "Tort Reform"*,23 Ga. L. Rev. 295, 296 (1989)(presenting physicians' sociological cry for tort reform as a means to vent their disagreement over a plethora of changes in the American health care system).

40 American College of Physicians, *Exploring the Use of Health Courts – Addendum to "Reforming the Medical Profession Liability System"*(2006), http://www.acponline.org/advocacy/where_we_stand/policy/health_courts.pdf.

41 David M. Studdert, Eric J. Thomas, Brett I. W. Zbar, Joseph P. Newhouse,Paul C. Weiler, Jonathon Bayuk & Troyen A. Brennan, *Can the United States Afford a No-Fault System of Compensation for Medical Injury?*,60 Law & Contemp. Probs. 1,31-34 (1997).

42 David M. Studdert & Troyen A. Brennan, *No-Fault Compensation for Medical Injuries: The Prospect for Error Prevention*,286 JAMA 217,221 (2001).

43 *See*J. Horwitz & Troyen A. Brennan, *No-Fault Compensation for Medical Injury: A Case Study*,14 Health Aff. 164,176-77 (1995).

44 *See*Peter Davis, Roy Lay-Yee, Julie Fitzjohn, Phil Hider, Robin Briant &Stephen Schug,*Compensation for Medical Injury in New Zealand: Does "No-Fault" Increase the Level of Claims Making and Reduce Social and Clinical Selectivity*,27 J. Health Pol. Pol'y & L. 833,833-54 (2002).

45 World Health Organization, *World Health Statistics 2011,* at 134, http://www.who.int/gho/publications/world_health_statistics/EN_WHS2011_Full.pdf.