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Medical Malpractice, Health Care Quality And Health Care Reform

The discussion below is based on a presentation by ***Gordon Schiff****, MD on May 20, 2003*

Notes and reflections by ***Oliver Fein****, MD, Chair, NY Metro Chapter, PNHP*

A **crisis in medical malpractice** is much in the news these days. The premiums that physicians pay for their malpractice insurance have been escalating in many parts of the country. **What are the causes of this crisis, and how does it relate to health care reform?**

The most important goals of a medical malpractice system are (1) to reduce preventable medical injury; and (2) to provide fair and timely compensation to injured persons. But several studies (Brennan TA, N Engl J Med 1991; 324:370) show:

• 98% of patients who have been negligently harmed receive no compensation.

• 83% of physicians who are sued for malpractice have not acted negligently.

Conclusion: Our present malpractice system is not working, either for patients or physicians.

There is no consensus on the cause of the malpractice crisis or its cure: The AMA feels the causes are: (1) increased frivolous law suits, (2) excessively high monetary settlements and jury awards, (3) greedy trial lawyers, and (4) irrationally angry patients. The AMA's solution is to cap the non-economic component of awards, given for pain and suffering, at $250,000.

Limits on awards are not the solution. Numerous studies show that excessive awards are not the cause of the problem:

• Only two states with caps have experienced flat or declining premiums; 19 states that have implemented these limits have seen premium increases from 1991 to 2002 averaging 48.2%; 32 states without caps saw premium increases of only 35.9% over the same period (Weiss Ratings, Inc. in *Crain's Health Pulse*, June 9, 2003).

• In New Jersey, where doctors and insurers have been vociferous in blaming rising malpractice premiums on skyrocketing payouts, data on settlements, awards, and other payout for 2001-2003 shows that "the total payout declined [by 24%] even as doctors saw steep increases in their malpractice premiums." (Newark Star-Ledger, June 9, 2004)

• In Texas, where caps on non-economic damages have just been passed, one of the nation's largest medical-malpractice insurance companies told regulators they would save only 1% in total payouts. (Wall Street Journal, October 28, 2004)

• New York has more malpractice awards than any other state, but the number of such awards has remained about the same during the last decade, both in New York and nationwide. The data shows steady increases in the size of malpractice awards over this period, but these rose no faster than the overall cost of medical care. (Perez-Pena R, *NY Times*, May 21, 2003)

A more comprehensive approach is necessary. It should recognize that (1) malpractice premiums are rising because insurance companies lost investment income in the recession, not because of extravagant awards; (2) increased use of technology in medicine contributes to the higher incidence of adverse events; and (3) negligence may reflect system failures as a result of the way medical care is organized and paid for. As an example, for-profit HMOs force doctors to see more patients per hour and provide them with financial incentives to withhold care, contributing to growing distrust in the doctor-patient relationship.

Some facts are not disputed:

• The cost of malpractice premiums is less than 1% of total national health expenditures. In 2000, the average premium was $18,400 per doctor per year, but this varies by state and specialty — some

(over)

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obstetricians and neurosurgeons pay over $100,000/year. (AMA, *Trends in the Physician Market*, 2003)

• The total cost of "defensive medicine," i.e., unnecessary care provided solely to look good in case of a malpractice claim, is about 2% of national health expenditures. (Bodenheimer TS, Grumbach K, *Understanding Health Policy*, Lange Medical Books, 2002)

PNHP has not adopted a formal position on malpractice reform. However, we must not advocate taking away patients' legal rights, particularly when these are perceived as the only way to hold doctors, hospitals, HMOs, and other providers accountable for medical errors and negligence. We must focus our fight on equitable access to quality health care for all — that is, on a single payer national health insurance (NHI) program, recognizing that such a program promises to significantly reduce the malpractice problem:

1) Single payer NHI will reduce malpractice costs, because the costs of any medical care needed as a result of an injury will be covered within the NHI system.

2) Single payer NHI will foster a single data system, which has the potential to improve patient safety by enabling the disclosure and tracking of systems problems and thereby reducing medical errors.

3) Single payer NHI will eliminate financial barriers to access as well as any incentives for providers to avoid seeing complicated and sick patients or to withhold care. This will lead to increased trust between doctor and patient.

4) Options other than caps on non-economic damages must be explored including: (a) use of practice guidelines to help reduce negligence; (b) alternative dispute resolution mechanisms such as mediation and arbitration; (c) no-fault reform, providing compensation to patients whether or not the injury is due to negligence; (d) enterprise liability making institutions such as hospitals, large group practices, and HMOs responsible for compensating medical injuries, thereby creating incentives for institutions to improve the quality of care offered in their institution.

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Fair — all contribute/all benefit	Rationed by ability to pay
Generous	Mean spirited/arbitrary
Frugal	Wasteful
Inclusive	Exclusionary
especially the sick	*avoid the sick*
Choice/autonomy	Restrictions
Access	Barriers
Trust	Rules
Accountability	Unregulated
Commitment	Flexibility
Longer time horizons	Short-term profitability
Public/open/sharing	Trade secrets
Academic/Professional values	Commercial (near criminal) values

Chart by Gordon Schiff, MD

There are, then, two contrasting approaches to the health care system, and these lead to very different views of and approaches to the malpractice problem:

While each of these dichotomized one-word soundbite-concepts simplifies complex issues and debates, analysts of the U.S. health system and advocates for reform are converging in a critique of those people and ideas on the right. Malpractice — both poor care and a climate generating lawsuits — is only exacerbated by market approaches to the provision of care, and they can only be fundamentally addressed by non-market professional values and approaches.

Conclusions:

1. **The medical malpractice crisis is real**: High premiums are driving doctors to retire early, move to states with lower premiums, and limit procedures they perform. This limits patients' access to health care.

2. **The solution must be comprehensive reform, *not* caps on non-economic damages**. PNHP supports increasing patients' access to health care rather than taking away patients' legal rights.

3. **Single payer NHI will go a long way toward solving the malpractice crisis** by removing the cost of medical care from malpractice settlements, enhancing "systems approaches" to improving patient safety, and improving trust between doctor and patient.

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