



The Truth About Torts: Defensive Medicine and the Unsupported Case for Medical Malpractice 'Reform'

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Executive Summary

In the debate about health care reform, “defensive medicine” has become a convenient culprit for rising costs and especially rising physician malpractice premiums.¹ Vaguely defined, the phrase, “defensive medicine,” is used to suggest that physicians make medical decisions to avoid potential litigation, instead of with their patients’ health and safety in mind. On the strength of this assertion alone, some policymakers argue for restricting Americans’ right to bring suit to recover damages for medical malpractice. This report demonstrates, however, that the proponents of medical malpractice “reform” lack persuasive evidence that tort litigation against physicians encourages them to make medical decisions that they would not have made otherwise.

Powerful business interests have compelling reasons to perpetuate the “defensive medicine” myth. Because the national health care debate has been framed around costs – not patient health and safety or access to care – the “defensive medicine” message has been successfully deployed to restrict Americans’ access to the courts in many states. Meanwhile, “defensive medicine” also serves as a politically expedient straw man, allowing policymakers and the insurance industry to ignore or obscure the real drivers of rising medical costs, including the high costs of prescription drugs; the high demand for, and increasing use of, state-of-the-art technology; the growing incidence of chronic diseases; and an aging population that lives longer and consumes more medical care.²

This report first establishes that an intact and robust civil justice system is necessary to the health of society and exposes how rarely doctors are actually being sued. Next, it examines *why* doctors order tests and procedures. It then surveys available empirical evidence showing that a supposed “defensive medicine” mindset has little impact on medical decisions or on medical practice costs. The report also exposes extraordinary shortcomings in the methodology and academic rigor of the evidence most frequently cited by civil justice opponents. This report concludes:

- ***Those who blame “defensive medicine” for the health care system’s woes include in their definition procedures performed for reasons unrelated to litigation.***

Opponents of the civil justice system have a strong incentive for the term to be over-inclusive to include any indication that superfluous or “extra” medicine is being practiced, ignoring other motivations such as the desire to maintain a good doctor-patient relationship, the influence of advertising on patient demands, family pressure, financial gain, and the simple availability of technology. Any quantifications of “defensive medicine” must therefore be understood in the context that it is almost impossible to untangle these various motivations.

- ***Preventable medical errors are the real health care crisis, killing at least 98,000, injuring many more, and costing the health care system \$17 to \$29 billion each year.*** The prevalence of medical errors in the United States health care system is unchanged since the Institute of Medicine profiled the problem more than ten years ago and may have been underestimated in the first place. A recent study also shows that people would be willing to pay almost a trillion dollars to avoid the deaths and injuries that result from adverse medical events, both negligent and not.³
- ***The claim that tort “reform” is necessary to end “defensive medicine” ignores the impact of managed care on medical practice.*** Evidence shows that managed care is capable of containing health care spending without keeping deserving plaintiffs out of court. Unlike the fee-for-service model used in Medicare, managed care creates an incentive *not* to utilize care that has little or no medical benefit.
- ***Empirical evidence shows that litigation has a negligible effect on medical practice, and tort reform does nothing to rein in health care costs.*** Studies show that if aggressive civil justice restrictions could reduce malpractice premiums by 10 percent, the savings would equate to just slightly more than one tenth of 1 percent of total health care costs. In comparison, health care expenditures have grown at a rate between 3.6 and 6.5 percent per year over the last four decades.
- ***The leading study cited most often by civil justice opponents estimated the total cost of “defensive medicine” by improperly extrapolating data from a very narrow set of ailments to the entire health care system without justifying the accuracy of the extrapolation.*** The authors also later adjusted their estimate of the potential savings from tort reform downward when they found that managed care can be effective at reducing health care costs without risking patient safety.
- ***Despite finding just a few years prior that the best available evidence on the very existence of defensive medicine was “at best ambiguous,” the Congressional Budget Office (CBO), in a rare departure from its usually rigorous analysis, sent an inadequately supported and surprisingly piecemeal letter to Senator Orrin Hatch claiming that tort reform could save \$7 billion in “defensive medicine.”*** Only ten months earlier, CBO found insufficient evidence that civil justice restrictions would reduce health care costs. CBO’s letter draws conclusions from studies that the authors themselves said are unsupported and makes broad unfounded assumptions about the health care system. CBO also ignores the potential of tort reform to add the costs of thousands of additional unnecessary deaths as well as the increased burden on Medicaid from those who cannot obtain sufficient long-term care from a “reformed” civil justice system.

- ***Physician surveys – the most heavily cited evidence of “defensive medicine” – are so misleading, suggestive, and poorly designed that the Government Accountability Office (GAO) has condemned them as valueless.*** Although a favorite of civil justice system opponents, physician surveys on the topic suffer from dismally low response rates, exploit physicians’ availability bias, offer prompting questions, employ extremely broad questions, and fail to follow up in relevant and meaningful ways. In the end, these surveys only measure the prevalence of physicians’ concerns about litigation and the influence of the availability bias.
- ***Perhaps because of all the attention given to tort reform proposals, physicians greatly overestimate the prevalence of lawsuits and verdicts against them, leading them to support tort reforms that will have little impact on their medical malpractice premiums.*** In fact, the vast majority of victims of malpractice do not sue, and of those who do, most have a valid claim. Most doctors will see, on average, only one malpractice claim in their careers, and just 7 percent may see a claim in any given year. Recent research shows that medical malpractice claims have been in steep decline for more than ten years. Unfortunately, tort reform also has almost no impact on physicians’ fears of litigation, so even severe restrictions will do nothing to change their views of the civil justice system.

The evidence reveals that “defensive medicine” is largely a myth, proffered by interests intent on limiting citizen access to the courts for deserving cases, leaving severely injured patients with no other recourse for obtaining the corrective justice they deserve. These changes would limit the deterrent effect of civil litigation and diminish the regulatory backstop that the civil justice system provides to the professional licensing system, leading to more medical errors. Restricting lawsuits might save doctors a negligible amount on malpractice premiums but the vast majority of any savings will most certainly line the pockets of the insurance companies demanding these restrictions.⁴ On the other hand, buying into this myth has very real and dangerous consequences. Allowing civil justice opponents to pretend that constraining the civil justice system equates to meaningful health care reform distracts us from doing the things that must be done to fix the system, including avoiding the 98,000 deaths caused by preventable medical errors every year⁵ and reducing the unacceptable number of uninsured Americans.⁶

Why the Civil Justice System Matters, and What it Really Looks Like

The civil justice system performs two important roles in society. First, it allows wrongfully injured people to obtain just compensation for their injuries. This compensatory role also performs a corrective justice function, meting out the justice that society has determined the bad actor deserves. Second, civil lawsuits act to deter unreasonably risky or harmful conduct with the goal of preventing similar conduct from occurring in the future. As the experience of the anesthesiologists demonstrates, the deterrent function creates an incentive for improvements in the medical standard of care.

CASE STUDY: The Anesthesiologists

In response to the medical malpractice “crisis” of the 1980s, the American Society of Anesthesiologists undertook a massive project to identify every malpractice claim that had ever been made against an anesthesiologist. The anesthesiologists found that over a third of all claims against them sprang from very damaging, but very preventable, adverse events. Rather than fighting to limit patients’ rights, however, the professional organization instead pushed for better equipment, improved guidelines, and physician education. Today, anesthesiology has achieved the lowest error rate of any medical specialty – just four deaths per million exposures – and practitioners’ premiums are around the same levels they were in the 1980s. The anesthesiologists’ experience shows that reducing needless harm to patients serves everyone’s interests by reducing the number of negligent injuries and deaths while decreasing physicians’ malpractice insurance premiums dramatically.

See TOM BAKER, *THE MEDICAL MALPRACTICE MYTH* 108-11 (2005); Stephen Schoenbaum & Randall R. Bovberg, *Malpractice Reform Must Include Steps to Prevent Medical Injury*, 140 *ANNALS OF INT. MED.* 51, 51-52 (2004).

In the health care sector, the deterrent function also reinforces the professional licensing system. Malpractice suits ensure, and improve, patient safety beyond what the professional licensing system is able to provide, which is important because the regulatory framework, including state medical licensing boards, is slow to discipline physicians.⁷ The civil justice system fills the gap left by licensing boards, adding an additional incentive to improve patient safety and providing for more protective and progressive compensation and justice. In addition, the civil justice system, including medical malpractice litigation, reveals underlying problems with private organizations, signaling regulators and legislators of the need for reform.⁸

Notwithstanding the important role of civil litigation, medical malpractice litigation is infrequent. Every year, fewer than 85,000 total medical malpractice lawsuits are filed,⁹ less than the number of deaths due to preventable medical errors alone. In 2010, the National Center for State Courts reported that, at the same time that civil caseloads have been increasing by up to 5 percent every year, malpractice claims are in steep decline, down 15 percent from 1999 to 2008.¹⁰ In fact, “just as torts typically represent a single-digit proportion of civil caseloads, medical malpractice cases comprise a similar proportion of torts. Despite their continued notoriety, rarely does a medical malpractice caseload exceed a few hundred cases in any one state in one year.”¹¹ Lawsuits are simply rare events in a physician’s career, notwithstanding the horror stories they may hear from their colleagues.¹²

It is actually a small group of negligent doctors that is responsible for most of the malpractice claims made every year. Since its inception in 1990, the National Provider Data Bank has tracked all malpractice payments from insurers, physicians, and hospitals to injured patients. Between 1990 and 2005, 82 percent of physicians made no malpractice payments while 5.9 percent were responsible for 57.8 percent of all payments.¹³ Moreover, according to the Henry J. Kaiser Family Foundation, the average number of malpractice claims per doctor dropped from 25 claims per 1,000 active physicians in 1991 to 18.8 in 2003.¹⁴

As the authors of the Harvard Medical Malpractice Study observed, “medical malpractice litigation infrequently compensates patients injured by medical negligence and rarely identifies, and holds providers accountable for, substandard care.”¹⁵ The best empirical research shows that most victims of medical malpractice never even make a claim, let alone sue. Indeed, studies over the last three decades suggest that less than 20 percent of victims of medical negligence file a lawsuit.¹⁶ Moreover, Professor Tom Baker, of the University of Pennsylvania Law School, says that “because hospital record reviews miss so much medical malpractice,” the real rate is likely even smaller than such studies show.¹⁷ Looking at these types of studies deeper shows that patients who suffer a serious injury from medical malpractice sue less than 5 percent of the time. In a hospital observation study in Chicago, the researchers found that 185 of 1,047 patients suffered a preventable serious injury. Of those 185, just 13 asked the hospital or doctor for compensation and just 6, or less than 4 percent, filed a lawsuit.¹⁸

**More than
180,000
people suffer
severe medical
injuries and
98,000 people
die every year
due to medical
negligence.
This is more
than die from
auto accidents,
breast cancer,
or AIDS.**

Other evidence shows that a majority of those victims who do file a claim have suffered an injury for which they are eligible for compensation. In fact, just 3 percent of claims have no verifiable injuries.¹⁹ Finally, the vast majority of malpractice claims that lack evidence of negligence are not compensated, and many of those claimants may have simply used litigation as their sole source of information about their injury. What is most likely in those cases, which research suggests may account for a third of claims,²⁰ is that a patient who suffered an adverse event sued, only to find out during discovery or negotiations that, although there was a bad outcome, there was no error.²¹ These findings do not support “the notion of opportunistic trial lawyers pursuing questionable lawsuits” but rather “underscore how difficult it may be for plaintiffs and their attorneys to discern what has happened before the initiation of a claim and the acquisition of knowledge that comes from” the process of litigation.²²

This data shows that when a healthy civil justice system and regulatory framework are working in tandem, robust “regulatory pluralism” flourishes, patient safety becomes paramount, and justice is served.²³ Given the importance of the civil justice system, policymakers should be skeptical of proposals to restrict citizen access to the courts and other efforts to hobble this institution. Opponents of the civil justice system should face a high bar to justify their effort to eliminate civil justice opportunities for medical malpractice victims. As we will show, they have not met that burden.

Physician Behavior and Motivation

Opponents of the civil justice system place the blame for variations in medical decisionmaking squarely on the civil justice system. However, such variations are actually the result of differences in medical judgment and other motivations such as the influence of advertising and the Internet on patient demands, financial gain, and the simple availability of technology, among others. Efforts to estimate the extent of “defensive medicine” have been unable to untangle these various motivations. Moreover, physician decisionmaking is subject to insurance company and government oversight, which requires standardized approaches and certification as to the medical necessity of physicians’ decisions.

What is Medical Malpractice?

Medical malpractice is a form of tort liability under which doctors are liable for injuries to their patients caused by the doctor’s failure to meet the high standard of care expected of medical professionals. The standard of care applicable to medical malpractice is that of a reasonable physician under the same or similar circumstances. However, regarding some medical presentations, there may be no “scientifically proven, universally agreed-upon treatment.” Faced with the exact same medical circumstances in the same patient, two physicians may respond in significantly different ways, neither of which is negligent. While opponents of civil justice may draw on these variations to bolster their “defensive medicine” claim, they often simply reflect acceptable differences in medical judgment.

Complicated Motivations to Practice ‘Extra Medicine’

In order to understand physician behavior, we must first understand that the incidence of “defensive medicine” as a behavior is very hard to quantify, because the concept itself lacks a clear and consistent definition. Despite serious flaws, the most widely used definition comes from a 1994 U.S. Congress Office of Technology Assessment (OTA) report on the topic. According to the OTA, positive “defensive medicine” occurs when physicians “order tests, procedures, or visits, or avoid certain high-risk patients or procedures, primarily (but not solely) because of concern about malpractice liability.”²⁴ When applied to the real world, however, the OTA definition of “defensive medicine” is over-inclusive, because it cannot account for the various motivations that may lie behind medical decisions. Civil justice opponents, meanwhile, have exploited this imprecise definition to exaggerate the extent to which the practice occurs.

Although it used an over-broad definition of “defensive medicine,” the OTA’s 1994 report is nevertheless instructive when it comes to explaining physician behavior. In that report, the OTA conducted clinical scenario surveys in which physicians were asked how they would respond to hypothetical patient scenarios. Importantly, physicians were told the survey

When the Office of Technology Assessment conducted clinical scenario surveys, just 8 percent of physicians said they would order a procedure for defensive reasons.

was designed to study decisionmaking and made no reference to medical malpractice, thus eliminating any bias on the part of the respondents.

In their responses, physicians were asked to indicate all their reasons, including the most important, for their clinical decision. Surprisingly, just 8 percent of responses indicated that they would order a procedure for defensive reasons. Even more interesting, physicians said that litigation fear was the single most important reason for their decision in just 0.5 percent of the responses. Indeed, those numbers are likely to be even less than reported because the study was “specifically designed to increase the likelihood of defensive response by physicians.”²⁵ Finally, some of the surveys were open-ended, in which doctors were given a blank space to list the reasons for their clinical decision. In those surveys, even fewer physicians listed litigation fears as a reason behind their medical decisionmaking than did when that explanation was offered as one of several boxes the physicians could check.²⁶ In the end, the OTA concluded that their clinical scenario surveys support the “large body of evidence that there is a great deal of variation in how physicians practice medicine.”²⁷

So what drives physician decisionmaking? Although it is very challenging to unravel, motivations such as financial gain, the desire to maintain a good doctor-patient relationship, acceding to patient demands due to the influence of advertising by the medical industry, “the simple availability of sophisticated technology, . . . time constraints that limit the physician’s willingness to contemplate data before ordering a test, the fear of missing a crucial diagnosis, and simple zeal for the attainment of diagnostic certainty” are some of the largest drivers.²⁸ The CBO notes, “some so-called defensive medicine may be motivated less by liability concerns than by the income it generates for physicians or by the positive (albeit small) benefits to patients.”²⁹ The follow-up study by Kessler and McClellan, discussed below, supports this conclusion, that extra medicine as we know it may just as likely be “an artifact of the traditional fee-for-service payment system,”³⁰ driven more by financial incentives than litigation. The GAO also recognized the potential for profit motives to alter medical decisionmaking in its critique of physician surveys regarding “defensive medicine.” In that report, GAO conducted interviews with AMA officials, hospital administrators, and physicians around the country in which one administrator in Montana admitted that “revenue-enhancing motives can encourage the utilization of certain types of diagnostic tests.”³¹

In a now widely cited article for *The New Yorker*, Atul Gawande, a surgeon and professor at Harvard Medical School, provided insight into the profit motive that is enmeshed in parts of medical practice in this country.³² Gawande visited McAllen, Texas, a mid-size city that has the honor of being one of the most-expensive health care markets in the country. Years before his visit, Texas passed aggressive tort reforms that were sold on the premise that they would reduce the cost of health care for everyone in the state. Instead, what Gawande found in McAllen were high medical costs, low quality care, and a culture of overutilization driven by profit. In El Paso, a similarly situated city with nearly equivalent socio-economic metrics, Medicare spending was half that of McAllen’s. Since both cities are in Texas, litigation could

not be driving these differences; after all, malpractice litigation had declined severely in the state by the time of Gawande's article.³³ In short, what Gawande found was that a significant expansion of physician-owned imaging and surgery centers and hospitals in McAllen means physicians there are more invested in the marginal profits from increased medical care than their counterparts in El Paso without being sensitive to the marginal benefits of that care to their patients. As a result, patients in McAllen receive significantly more operations, hospital admissions, diagnostic imaging, and specialist referrals. This is consistent with other high-cost regions where patients get substantially "more high-cost care across the board, but less low-cost preventive services and primary care, and equal or worse survival, functional ability, and satisfaction with care."³⁴

Although the profit motive and patient demands certainly influence physician behavior, many motivators – including the culture of medicine itself, an overly complex insurance structure, and a distorted financing system – combine to drive physician behavior toward "overuse" of medical testing and procedures. A physician who has had to discuss their mistakes in a morbidity and mortality conference – where physicians discuss their failed medical cases – will likely avoid making the same mistake ever again, but may also begin overusing certain medical procedures and tests to avoid it. This is different than defending herself against a potential lawsuit; she is rightly trying to avoid a mistake because doctors are expected to do no harm. Physicians also now operate in a culture of testing, taught to see testing as a standard way of achieving diagnostic certainty, sometimes using overtesting as a crutch, or even influenced by patients' perceptions that more testing means better care.³⁵ In short, medical decisionmaking is subject to a complex web of motivations, yet advocates for civil justice restrictions focus on the theory of "defensive medicine" while ignoring other incentives such as the fear of making a mistake, technology availability, and a fee-for-service system that rewards the wrong behavior.

Surgery at the End-of-Life

End-of-life decisions by patients, their families, and their physicians are an additional example of just how hard it is to untangle the varied motivations underlying medical decisionmaking. A recent *Lancet* study found that one in three patients had surgery in the last year of their life, one in five in the last month, and one in ten in the last week of life.³⁶ While the study has its limitations – many of these surgeries may have had very real benefits – any doctor will acknowledge that some surgeries are undertaken that may remedy one ailment or another but that will not extend the life of a patient. In fact, end-of-life surgeries can expose a patient to additional pain and risk. Yet, because surgery can be tempting as a silver bullet, it can stand in as a substitute for frank discussion about a patient's end-of-life goals. Civil justice opponents might call end-of-life surgeries "defensive medicine." What they represent, instead, is the diverse set of motivations influencing medical practice today.

Limiting Extra Medicine with Managed Care

In light of this evidence, extra medicine “may represent physician conduct that would have occurred for other reasons even in the absence of sincere legal fears.”³⁷ Whatever the motivation, physicians are highly trained experts who are paid to exercise their judgment efficiently and cost-effectively. If they fail to do so, Medicare or the insurance company, both very sophisticated actors, will take notice.

The variation in physician decisionmaking is significantly limited by the growth of managed care and the restrictions imposed by insurance companies, which require physicians to offer medical reasons for their decisionmaking. Managed care plans “limit the use of services that have marginal or no benefit to patients (some of which might otherwise be provided as ‘defensive medicine’).”³⁸ The financial interest of insurance companies in minimizing costs provides an institutional counter-weight to extra medicine. In fact, the GAO’s analysis of current research found that “managed care provides a financial incentive not to offer treatments that are unlikely to have a medical benefit.”³⁹ Those claiming that “defensive medicine” is caused by litigation fears ignore the important impact of managed care in limiting extra medicine.

Medicare should provide a second countervailing force against unnecessary testing and procedures intended to temper the incentives for overutilization that its fee-for-service structure creates. Providing care that is not aimed at benefitting the patient, and then billing Medicare, is fraud. Medicare requires physicians to certify that services they bill for were medically indicated and necessary. If the services were not, and the doctor still bills Medicare, they can be prosecuted for fraud. As one former physician puts it, “[i]f tests are being performed that assist the doctor in determining a diagnosis or treatment, then they are not unnecessary . . . If doctors perform unnecessary tests, they are likely doing it for the money . . . This practice is nothing new. It used to be called fraud; now the [American Medical Association] calls it defensive medicine.”⁴⁰ As the experience in McAllen, Texas showed, however, this oversight function may not always be as effective as it should be.

The Absence of a Case for Civil Justice Restrictions

The evidence supporting the incidence of “defensive medicine” is remarkably weak considering the widespread acceptance of the myth. Reliable estimates put the total cost of defending malpractice suits and paying injured victims at less than 0.3 percent of all health care spending,⁴¹ yet opponents of the civil justice system make the unsupported claim that “defensive medicine” – in theory practiced in response to those same small malpractice costs – is responsible for 30 times that amount.⁴² As will be discussed, the real drivers of health care spending and malpractice premiums – an aging population that requires increasingly more complicated care and insurance market cycles that drive industry business decisions – are unrelated to litigation or “defensive medicine.” Further, this section surveys the empirical evidence showing that “defensive medicine” has little impact on health care costs and that civil justice restrictions save very little money while hurting many people. Finally, we review the evidence marshaled by opponents of the civil justice system and show how little it actually proves. Those opponents rely primarily on a study that the CBO and others have disputed and that the authors themselves substantially revised, and on surveys of physicians that are hopelessly unreliable.

Medical Malpractice Litigation is Not Responsible for Rising Health Care Costs or Physician Premiums

Opponents of the civil justice system contend that “defensive medicine” is driven by physicians’ perceptions of their litigation risk, for which their premiums serve as a proxy.⁴³ When premiums rise, physicians, medical societies, and politicians complain about a “tort crisis,” and seek draconian civil justice restrictions in response. The available evidence suggests, however, that their ire is misplaced and the requested prescription will not alleviate their pain. The sometimes-high costs of medical malpractice insurance are driven almost entirely by the economic behavior of insurance companies themselves, not medical malpractice litigation, which has been in decline for years. Meanwhile, exploding health care costs are barely affected by the small contribution of the medical liability system, which is, again, not growing.

Rising Health Care Costs Have Little to Do with Malpractice Litigation

The rhetoric about an alleged malpractice litigation “crisis,” appeals to very real concerns about the escalating cost of health care in this country, and the diminishing returns from those expenditures. The United States today spends more on health care than any other country, approximately 17.6 percent of GDP or \$8,086 per capita. What’s more, this huge expenditure has grown at an average of 5 percent per year for the last four decades.⁴⁵ However, only a very small portion of health care spending is attributable to medical malpractice litigation or “defensive medicine.” A recent study suggests that the entire

medical liability system, including costs attributable to “defensive medicine,” costs the nation \$55.4 billion, or about 2.4 percent of all health care spending.⁴⁶ While acknowledging that the data on “defensive medicine” is weak, the authors attributed 80 percent of the total to “defensive medicine.” Since, as shown below, the evidence used by opponents of civil justice greatly overestimates the frequency and, therefore, costs of “defensive medicine,”⁴⁷ that percentage is very likely much smaller.

What is really driving the rapid growth of health care costs are a host of factors that include technology gains, chronic disease, an aging population, and runaway administrative costs. The development of more expensive state-of-the-art medical technology is by far the largest contributor to increases in health care spending, contributing between 38 and 65 percent of all growth in health care spending.⁴⁸ This is due, in part, to the industry’s desire to recover the costs of technology development and the influence of advertising on consumer demand.⁴⁹ The development of new prescription drugs has had a similar influence on costs.

Additional growth in spending is also the result of an aging population and the greater prevalence of chronic disease, including heart disease, diabetes, cancer, and respiratory diseases. As life spans have increased and lifestyles have become unhealthier in the United States, chronic disease has had a greater influence on health care costs. The Centers for Disease Control and Prevention estimate that, between 1987 and 2001, “increases in obesity prevalence alone accounted for 12 percent of the growth in health care spending.”⁵⁰ Today, up to 75 percent of all health care dollars are spent on people with chronic conditions.⁵¹ Moreover, as baby boomers age, and become eligible for Medicare, their health care costs are increasing, though this factor has a smaller influence on rising health care costs than either technology or chronic disease among the general population.⁵²

Finally, the combined private-public insurance model currently employed in the United States leads to wasteful and inefficient administrative costs due to high overhead and huge insurance industry profits.⁵³ Some estimates put the cost of administration at 7 percent of all health care costs. Other inefficiencies, such as the prevalence of fee-for-service payment models that create the incentive for physicians to provide more services rather than practice efficiently, also drive up costs.⁵⁴ On the other hand, evidence that malpractice litigation “perceptibly raises the growth of health care spending is almost nonexistent.”⁵⁵

Even as the United States far outpaces all other countries in health care spending, we still fail to provide insurance to more than 50 million citizens.⁵⁶ Meanwhile, adverse events in hospitals, both negligent and not, lead to as many as 187,000 deaths and up to 6.1 million injuries every year, according to a 2011 study.⁵⁷ Yet, neither the discussion about health care spending nor the red herring arguments about tort reform and “defensive medicine” consider the value of avoiding such adverse events. One recent study did just that, estimating the annual social cost of adverse medical events at between \$393 and \$958 billion, or the equivalent of 18 to 45 percent of all health care spending in the United States.⁵⁸ Even the

lower estimate far exceeds the annual measurable cost of medical errors, or preventable adverse events, of \$17 to \$29 billion.⁵⁹ Since the best estimates of the costs of malpractice litigation and so-called “defensive medicine” are a fraction of these figures, it is readily apparent that tort reformers are not really concerned with patient safety or health care costs. They are simply opponents of the American civil justice system and interested only in ensuring corporate and individual immunity from lawsuits.

The Malpractice Insurance Market is What Really Drives Physician Premiums

What really influences the medical malpractice insurance market is not lawsuits but the nature of the insurance industry itself. In fact, malpractice claim payouts are not solely, or even primarily, responsible for how insurance companies base malpractice premium rates.⁶⁰ When insurance companies take in physician premiums, they know that they will not pay money out for claims on those premiums for several years. Instead, they invest that money, hope to get high returns before they have to pay claims, and, meanwhile, try to predict their future losses. Those predictions, in turn, influence how much money insurers set aside to pay future claims, what the industry calls “reserves.”

The “loss” reported by an insurance company in a given year is just an estimate because of the time it takes to resolve a claim. Thus, an insurance company may report a loss that year that it later adjusts significantly once it knows exactly how much it had to pay out. If a company finds that its losses will not be as high as predicted, and has over-reserved in anticipation thereof, it will incur a profit.

The insurance underwriting cycle is characterized by a fluctuation between “soft” and “hard” markets. During a soft market, insurance is easier to get because insurance companies are competing for market share and premium rates decline. Insurers are also less restrained, overly optimistic about their future losses, and tend to hold lower reserves. As the market becomes saturated, rates decline too much, insurance profits fall, and a hard market ensues. Premium rates skyrocket as insurers begin over-reserving, become more conservative in predicting their losses, and more selective in whom they choose to insure. The transition from a soft to a hard market is hard to predict, but the shift is obvious. More importantly, analysts suggest that the cycle is unavoidable.⁶¹

Malpractice “crises” arise after a soft market, when insurance companies are overly optimistic about their predicted losses, leading them to sell underpriced policies and to under-reserve. When, a few years later, actual losses exceed their predictions, insurers have to recover, leading them to charge higher prices for premiums in order to expand their reserves. This is precisely what happened in the crises of the late 1980s and early 2000s.⁶²

When the most recent “crisis” occurred, in the early 2000s, the end of the particularly competitive soft market of the 1990s happened to coincide with September 11th, the bursting of the Internet bubble, and subsequent declines in the stock market. During that soft market, new entrants to the malpractice insurance market initiated a price war as they tried to undercut each other and win a market share of what appeared to be a lucrative industry but was really an industry fueled by inflated profits secured through accounting gimmicks.⁶³ The industry then exploited news of their declining investment returns from the contracting stock market and predicted steep incurred losses for the early 2000s. Premiums went up, physicians got angry, and calls for tort reform were renewed. Importantly, those incurred losses were later significantly revised downward – by an average of 12.6 percent – suggesting that insurance companies had sufficient funds and were simply over-reserving even during the highly competitive soft market of 1990s. In short, the most recent medical malpractice insurance “crisis” was entirely fabricated by the insurance industry itself, exaggerating their losses while enjoying some of the highest profits among all American businesses. Meanwhile, the civil justice system, and restrictions put in place in response to the “crisis,” have had little to no effect on insurance premiums. After all, there was no sudden explosion of jury verdicts or malpractice settlements to accompany the crisis.

The California Tort Reform Experience: Saved by Proposition

In 1975, California passed a major tort reform package in response to one of the first malpractice insurance “crises.” The Medical Injury Compensation Reform Act (MICRA) serves as the model for the federal legislation proffered during each crisis and is the source of civil justice opponents’ preferred, and unadjusted-for-inflation, cap of \$250,000 on non-economic damages. Yet, while opponents of the civil justice system contend that MICRA is proof that civil justice restrictions work the way they say they do, malpractice insurance premiums in California continued to increase – by 450 percent – for 13 years after MICRA was passed. Notably, it was only after Californians passed the nation’s most stringent insurance reforms, by proposition, that premium rates finally stabilized.

See Assessing the Need to Enact Medical Liability Reform: Hearing Before the House Subcomm. on Health of the Comm. on Energy and Commerce, 108th Cong. (Feb. 10, 2003), at 3, 8-10 (statement of Harvey Rosenfield, President of the Foundation for Taxpayer and Consumer Rights).

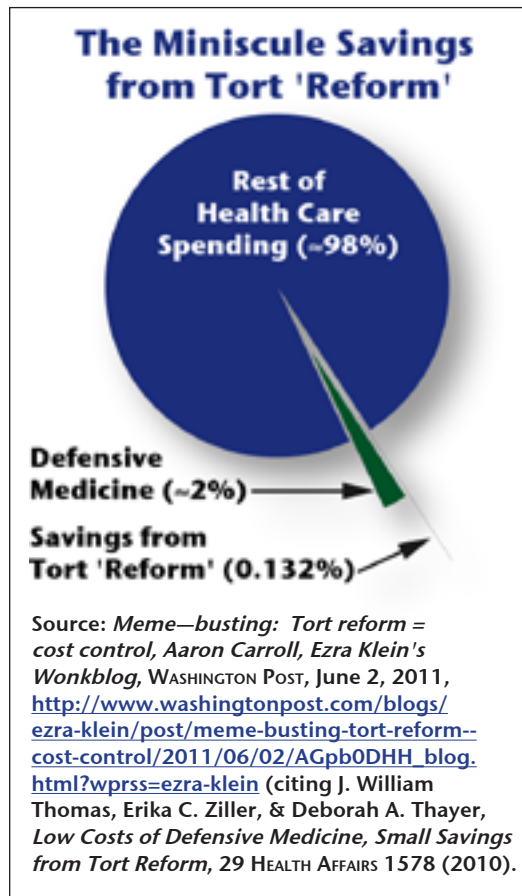
Recent work by economists at Dartmouth confirms that malpractice payments do not drive increases in provider premiums, that changes in premium costs do not affect the overall size of the physician workforce, and that there is no evidence that increases in premium costs change the use of treatments.⁶⁴ Instead, the authors posit that what drives premium changes are industry competition and the nature of the insurance underwriting cycle. In other words, the threat of litigation is not affecting medical malpractice premiums.

Empirical Evidence Shows 'Defensive Medicine' Has Little Impact on Either Health Care Costs or Malpractice Premiums and is Not Influenced by Tort Reform

A review of the empirical evidence indicates that litigation has a negligible impact on health care costs. In the study mentioned earlier, the OTA also found very small costs from defensive radiology in children and caesarean sections in difficult pregnancies. However, the OTA concluded, "it is impossible in the final analysis to draw any conclusions about the overall extent or cost of defensive medicine."⁶⁵ Today 37 states have passed some limit or cap on damages,⁶⁶ including Texas and California, states with some of the highest health care costs and physician premiums, and still opponents of the civil justice system claim that both litigation and "defensive medicine" are rampant. There is simply no reliable evidence that malpractice litigation creates "defensive medicine" or raises the level of health care spending.⁶⁷

In a comprehensive review of New York doctors, the Harvard Medical Practice Study observed that, despite being told by physicians that lawsuits affected their practice, there is not a strong relationship between the threats of malpractice litigation and medical costs.⁶⁸ In 1999, researchers at the Urban Institute found a small correlation between malpractice premiums and cesarean rates. However, they also found that if civil justice restrictions were capable of reducing premiums by half – an unlikely proposition, though not unheard of from civil justice opponents – it would lead to a cost savings of just 0.27 percent,⁶⁹ demonstrating how little impact so-called "defensive medicine" has on the cost of medical practice.

A more recent review of more than 400 million health care claims found further evidence that "defensive medicine" contributes an almost imperceptible amount to health care costs and is susceptible of very little influence from trends in physicians' malpractice premium costs.⁷⁰ The authors found that a 10-percent reduction in malpractice premiums was associated with a savings of just 0.132 percent. Even a 30-percent reduction in malpractice premiums would lead to just a 0.4-percent decrease in health care costs.⁷¹ In other words,



if the country cut back significantly on the rights of medical malpractice victims to sue and recover for their injuries, and this produced a 30-percent reduction in medical malpractice premiums (which is unlikely since premiums are a function of insurers' business practices), the nation would save only a tiny fraction of health care costs.

The Kessler & McClellan Study Does Not Support Civil Justice Opponents' Claims

In their battle to restrict plaintiffs' access to the courts, civil justice opponents have relied heavily on a study by Daniel P. Kessler and Mark McClellan estimating that civil justice restrictions could save "well over \$50 billion per year without serious adverse consequences for health outcomes."⁷² In fact, the study's economic analysis is only applicable to a very narrow set of heart ailments and outside researchers have been unable to verify the estimate. Even its authors have subsequently revised their findings to a significant extent, an inconvenient fact that civil justice opponents ignore.

The Original Study

In 1996, Kessler and McClellan released a paper that looked at three years of Medicare data for elderly heart patients who received a number of specific treatments.⁷³ The authors concluded that states that enacted certain civil justice system restrictions saw declines in the use of "defensive medicine" of 5 to 9 percent, but that those savings diminished within a few years.⁷⁴ The authors then extrapolated those findings to the entire health care system and speculated that such savings would be uniformly realized regardless of differences in ailments, physician specialties, or insurance structures. This wholly unjustified extrapolation has become the source of one of the most prominent estimates used by civil justice opponents in their effort to take away citizens' rights: that "if" their findings were generalizable, civil justice restrictions could save the health care system "well over \$50 billion per year."⁷⁵

The extrapolation is highly problematic. Unlike the remainder of the paper, it is mere conjecture, a profoundly big "if" embedded in a conclusion with no empirical basis for support of any kind. The actual analysis, while sound so far as it goes, is too narrow to be extended beyond its limits. The authors focused only on elderly Medicare patients, with heart conditions, in hospital settings, in one state, Florida.⁷⁶ No effort was made to control for patient age, the widespread shift toward managed care (and away from fee-for-service arrangements), other medical conditions, different health care settings, or differences among states. Moreover, the authors admit that the procedures they examined were particularly susceptible to overuse. Even so, the authors suggested that generalizing their findings to the entire national health care system was both logical and reasonable.⁷⁷

Finally, another failing of Kessler and McClellan's paper is that it applied then-current and evolving standards of treatment to care that was provided years earlier. Dr. McClellan's

own research suggests that heart conditions in elderly patients are “unusually prone to wasteful defensive medicine” and that many of the most expensive treatments for heart conditions have very small marginal benefits.⁷⁸ However, this research on the marginal benefits of expensive heart treatments was not published until well after the years that Kessler and McClellan studied for their 1996 paper.⁷⁹ Thus, the physicians who ordered the expensive treatments upon which the 1996 paper was modeled were not aware of the fact that they were ordering additional, unproductive medicine. They were treating heart conditions according to the medical knowledge and the standard of care at the time. What McClellan’s subsequent research demonstrates is that medical research, not tort reform, can limit the overuse of expensive procedures by improving medical knowledge and thus aiding the evolution of the standard of care.

The Updated Study

In 2002, Kessler and McClellan revisited their work, evaluating more data and controlling for managed care. This led to a downward adjustment of their original estimate and a conclusion that direct tort reforms reduce health care costs for elderly heart patients in Medicare by only 4 percent.⁸⁰ The authors attributed this reduction in heart disease expenditures to the “spillover effect” of managed care on traditional Medicare. In other words, managed care’s focus on cutting costs while providing more benefits is effective at reducing excessive medical procedures and tests, without inducing declines in patient safety or enacting draconian civil justice restrictions. Despite this downward adjustment, the 1996 paper carries much more weight among civil justice opponents, even today.

The Extrapolation Cannot Be Verified

The 1996 study suffers from another critical shortcoming: neither government agencies nor academic researchers have been able to extrapolate Kessler and McClellan’s findings to other ailments or to more recent years. In 1999, the GAO issued a report on malpractice laws in the District of Columbia, Maryland, and Virginia in which it reviewed the Kessler and McClellan paper, among other studies, and concluded that, “[g]iven the limited evidence, cost savings estimates [from civil justice restrictions] cannot be developed.”⁸¹ Indeed, the GAO pointed out “[b]ecause [the Kessler and McClellan] study was focused on only one condition and on a hospital setting, it cannot be extrapolated to the larger practice of medicine.”⁸²

In 2004, the CBO tried to extend Kessler and McClellan’s study.⁸³ Applying the same methods Kessler and McClellan used in their study to a broader set of ailments, the CBO “found no evidence that restrictions on tort liability reduce medical spending.”⁸⁴ Additionally, using a different set of data, the CBO “found no statistically significant difference in per capita health care spending between states with and without limits on malpractice torts.”⁸⁵

In 2004, the Congressional Budget Office “found no evidence that restrictions on tort liability reduce medical spending.”

The Congressional Budget Office's letter cites studies that suggest that civil justice restrictions are, in fact, unlikely to have major impacts on health care spending or outcomes, may not be cost-effective, might increase procedure use in some cases, and could increase mortality rates.

Additional academic work has failed to support the findings of Kessler and McClellan's original claims. In 2009, Frank Sloan and John Shadle utilized 15 years of data to try to replicate Kessler and McClellan's 1996 findings. Adopting the same distinctions between "direct" and "indirect" reforms, but looking at other ailments in addition to heart problems and using patient data from both Medicare and private insurance, the authors failed to find significant effects of tort reform on cost or patient outcomes.⁸⁶ The authors concluded that "tort reforms do not significantly alter medical decisions, nor do they have a systematic effect on patient outcomes."⁸⁷ Similarly, Katherine Baicker and Amitabh Chandra, economists at Dartmouth University, found little or no relationship between medical practice and malpractice litigation risk. In fact, they concluded that "[t]he fact that we see very little evidence of . . . dramatic increases in the use of "defensive medicine" in response to state malpractice premiums places the more dire predictions of the malpractice alarmists in doubt."⁸⁸

CBO Letter Contradicts Prior CBO Reports

In 2009, civil justice opponents received an unexpected gift from the CBO, which, after completing an analysis at the request of Sen. Orrin Hatch, sent a surprisingly brief letter claiming that significant savings could be realized from civil justice restrictions.⁸⁹ In his letter, the Director of the CBO, Douglas Elmendorf, suggests that a package of aggressive civil justice restrictions would reduce national health care spending by about \$11 billion or 0.5 percent.⁹⁰ Of that total, the CBO states that 40 percent is from lower liability premiums and 60 percent is from slightly reduced utilization of health care services attributable to what might be characterized as a reduced level of "defensive medicine."

The CBO's letter relies almost exclusively on Medicare research, including resurrecting the study by Kessler and McClellan that the CBO itself dismissed in 2004.⁹¹ The letter fails to address the limits of comparing Medicare, with its emphasis on fee-for-service, to private health care providers, which have moved more heavily toward managed care. Because the data is more readily available, researchers tend to use Medicare data for economic research. However, as the limitations of Kessler and McClellan's work show, Medicare has a different structure, different incentives, and different spending patterns than private health care. This makes generalizations based on Medicare data inapt, at best. Indeed, the CBO's letter, while singularly focusing on Medicare research, failed to find evidence of "defensive medicine" in private managed care. If "defensive medicine," as defined by the CBO, existed to the extent that the CBO suggests, this disparity would not be expected. After all, the civil justice system applies to everyone, regardless of age, so the fact that a litigant might come out of Medicare or not is inapposite. Doctors should theoretically be practicing "defensive medicine" universally, unless there are other explanations, such as Medicare's emphasis on a fee-for-service payment structure, which the CBO essentially admits in the letter.⁹²

The CBO's package of civil justice restrictions it would need to accomplish the savings it predicts is also very aggressive, and unrealistic. The proposals include a \$250,000 cap on

non-economic damages which is based, without adding 35 years of inflation, on California's 1975 MICRA law;⁹³ a one-year statute of limitations for adults; and a repeal of the centuries-old tort doctrine of joint-and-several liability.⁹⁴ These are not middle of the road suggestions, they are cruel limits on the rights of plaintiffs to seek justice which have been rejected, or found unconstitutional, by many of the states that have considered tort "reform."⁹⁵

Surprisingly, for the usually meticulous agency, several of the studies cited by the CBO in its letter directly contradict its conclusions, suggesting that the CBO was over-reaching in finding support for its thesis. Some of the cited studies suggest that civil justice restrictions are, in fact, unlikely to have major impacts on health care spending or outcomes, may not be cost-effective, might increase procedure use in some cases, and could increase mortality rates.⁹⁶ One paper cited by the CBO states that civil justice restrictions are "likely to be cost-ineffective" and "more likely to harm than improve social welfare."⁹⁷ Another states unequivocally that the authors' estimates "do not imply that any change in spending was necessarily 'defensive medicine'" and that "additional procedures may be protective of patient health or valued regardless of therapeutic properties."⁹⁸ The CBO even cites Frank Sloan and John Shadle's 2009 study, which weakened Kessler and McClellan's findings, but ignores the authors' conclusion that "it seems inappropriate to conclude that tort reforms implemented to date succeed in reducing non-beneficial care as their proponents would have it."⁹⁹ Finally, the CBO also ignores the potential for civil justice restrictions to lead to additional deaths and injuries from medical malpractice, which one paper cited by the CBO suggests could be as high as 5,000.¹⁰⁰

What is perhaps most striking about the CBO letter, though, is the rare departure from years of careful analysis. The CBO's past work found small savings from civil justice restrictions and declared the evidence on "defensive medicine" to be "weak or inconclusive" and "at best ambiguous."¹⁰¹ Another CBO report, in 2004, described the limits of Kessler and McClellan's 1996 Medicare research by concluding, "those studies were conducted on a restricted sample of patients, whose treatment and behavior cannot be generalized to the population as a whole."¹⁰² In fact, just ten months before its letter to Senator Hatch, the CBO concluded that there is insufficient evidence that civil justice restrictions would reduce health care costs.¹⁰³ The past work speaks for itself. Little changed in the research on defensive medicine in the years between CBO's prior analyses and its letter to Senator Hatch.

Physician Surveys are the Most Unreliable – but Most Cited – 'Evidence' of 'Defensive Medicine'

Opponents of plaintiffs' access to courts often cite physician surveys to support their desired restrictions on civil justice, but such surveys are highly susceptible to manipulation aimed at generating desired results. These casual surveys are so flawed that they provide no reliable evidence regarding "defensive medicine," and have been condemned as valueless by the GAO.¹⁰⁴ They are often poorly designed, casting a wide net not intended to capture a representative sample; ask leading questions; and fail to ask relevant follow-up questions.

They are also susceptible to bias: Those that respond do so because they are vested in the outcome, while others respond with the answer they believe is being sought. Some surveys do not even feign objectivity, asking physicians whether they agree with statements about the widespread practice of “defensive medicine” or the effects of civil justice restrictions on the practice of “defensive medicine.”¹⁰⁵

Considering the aggressive misinformation campaigns run by “AstroTurf” groups and other organizations, the responses of physicians to affirmatively misleading and suggestive surveys are not surprising. Worse, immediately after the surveys are released, conservative media rush to announce that widespread defensive medicine is running our national health care system into the ground.¹⁰⁶ Civil justice opponents then point to these surveys in renewed efforts to compromise plaintiffs’ rights across the nation, and the cycle starts anew. For example, in 2010, Representative Tom Price (R-GA) cited a single Gallup poll to suggest that 21 percent of all physician activity is defensive and costs the nation \$650 billion.¹⁰⁷

Since physician surveys became commonplace, their results have varied wildly. For example, depending on the survey, from 21 to 98 percent of respondents claim to practice defensive medicine.¹⁰⁸ Yet these surveys all suffer from the same infirmities, including an availability bias, a strong response bias, a professional bias, unacceptably low response rates, lack of follow up questions, prompting, the failure to distinguish between purely defensive practices and medically appropriate practices, and a failure on the part of researchers to examine medical files of responding physicians.

Availability Bias

Like all of us, doctors are susceptible to psychological limitations that lead us to misperceive the frequency of events based on how recently we have seen examples of them. Ordinarily, people’s assessment of the frequency of events is governed by “the ease with which instances or occurrences can be brought to mind.”¹⁰⁹ This “availability” heuristic tends to break down, though, when people try to estimate the probability of events that are highly emotional, like being sued or dying of a shark attack. The problem with physician surveys is that, when asked about litigation or defensive medicine, the scariest anecdotes of seemingly unfair lawsuits that physicians, or their colleagues, have experienced may come to mind. With those emotional experiences or anecdotes fresh in their minds, survey respondents tend to overestimate the frequency of malpractice litigation and of their own “defensive” practices.¹¹⁰

As discussed above, the best empirical research shows that doctors are not sued very often. Most victims of malpractice do not sue, and the majority of those who do file a claim have suffered an injury for which they are eligible for compensation. Indeed, the Harvard Medical Practice Study, discussed above, suggested that as few as 1.5 percent of medical injuries lead to a lawsuit.¹¹¹ This is a far cry from a litigation crisis. What these surveys are really doing is testing physicians’ perceptions, and the availability bias explains why those perceptions are unlikely to be reliable indicators of anything other than physicians’ exaggerated fears.

Physicians' Malpractice Fears are Unresponsive to Tort Reform

Recent work by public health researchers at the Center for Studying Health System Change and Harvard University explored physicians' perceived levels of litigation risk compared to objective measures of actual litigation risk. The authors found that malpractice fears are "relatively insensitive" to civil justice constraints implemented in a given state. Fears of malpractice litigation, precisely what civil justice opponents claim drives the practice of "defensive medicine," remain unreasonably high even in states with aggressive tort reforms in place. "The level of liability concern reported by physicians is arguably out of step with the actual risk of experiencing a malpractice claim." In other words, availability bias drives the fear of litigation.

See Emily R. Carrier, James D. Reschovsky, Michelle M. Mello, Ralph C. Mayrell, & David Katz, *Physicians' Fears of Malpractice Lawsuits are Not Assuaged by Tort Reforms*, 29 HEALTH AFFAIRS 1585 (2010).

Physician Surveys are Poorly Designed and Scientifically Unreliable

An example of the failings of physician surveys, a 2008 survey by the Massachusetts Medical Society, "found" that 83 percent of doctors in the state practice "defensive medicine," 18 to 28 percent of all testing is defensive, and the practice of "defensive medicine" costs the state over \$1.4 billion a year.¹¹² While this study was neither peer-reviewed nor published, it garnered substantial attention and was presented, uncritically, in testimony by Dr. Stuart L. Weinstein to the House Committee on the Judiciary in January 2011.¹¹³ Although the authors quietly acknowledged the numerous limitations of their work, including a low response rate, recall bias, validity and reliability issues in self-reporting, and social or professional pressures to over-report,¹¹⁴ their preferred message was that "83 percent of the physicians surveyed reported that they practice defensive medicine."¹¹⁵ This study, and others like it, suffers from four common defects that make such surveys especially unreliable.

Low Response Rates. Most physician surveys have unacceptably low response rates, ranging from 5 to 20 percent. Such low response rates can lead to what is known as "nonresponse bias" – when the only responses are from physicians who are inclined to respond due to bias or political motivations. The respondents are more likely to be those who agree with the myths about "defensive medicine" and wish to influence the debate. If survey responses were compulsory instead of voluntary, response rate and bias problems could be alleviated.

In 2003, the AMA performed a national survey asking doctors whether they had made any practice changes and whether malpractice pressure motivated any of those changes.¹¹⁶ Well over 90 percent of respondents said that litigation pressures were responsible for referrals, while 81.6 percent said malpractice concerns were responsible for ending certain services. However, when the GAO reviewed this survey in its 2003 report on malpractice and access to health care, it remarked that the survey had a surprisingly low response rate of just 10 percent and “did not identify responses associated with any particular service.”¹¹⁷ Tellingly, the GAO reported that the AMA refused to release its data because, while touting the results, it felt the response rates were “unacceptably low.”¹¹⁸ Nevertheless, the survey is routinely cited as evidence of the widespread practice of “defensive medicine.”¹¹⁹

Response Bias. A similar problem is response bias, which, as the OTA pointed out in 1994, results from “the attention paid to defensive medicine by physician organizations, the news media, and policy makers” and leads to “physicians . . . exaggerat[ing] the impact of liability concerns on their practices in the hopes of eliciting a favorable political response.”¹²⁰ Self-reporting by physicians is likely biased toward politically or socially acceptable responses, especially in light of the prompting that is typical of these surveys.¹²¹ Driven by the misinformation campaigns of their medical associations, the insurance lobby, and conservative think tanks, physicians come to accept as true the premise that “defensive medicine” is a problem and therefore respond in predictable ways to surveys. No surveys mention this potential for bias or adjust their conclusions in kind.

Bad Questions, Lack of Follow Up. Many surveys use imprecise questions and then fail to ask relevant follow-up questions such as “If you indicated that you practice defensive medicine, how frequently, and with which patients?” Instead, surveys will simply ask whether the doctor has ever ordered unnecessary tests or procedures based on a threat of litigation. In spite of their training as scientists, survey designers never ask how frequently those tests or procedures were ordered, or whether they were ordered for certain ailments or for certain patients. Nor do surveys ever ask if other justifications contributed to, or even were the primary reason behind, a physician’s decision. Because surveys are often designed with a political purpose, follow-up questions that aim to distinguish between differences in reasonable medical judgment and litigation-inspired “defensive medicine” would be inconvenient.

For example, in 2002, the American Academy of Orthopedic Surgeons released a report entitled “Medical Malpractice Insurance Concerns,” which garnered a tiny 15 percent response rate.¹²² Among those who responded, 48 percent said that the costs of malpractice insurance had caused them to change their practice, and 64 percent said that the change was to order more diagnostic tests. The survey did not ask what types of diagnostic tests are ordered; whether they were unnecessary or had actual benefits for the patients; whether, if completely unnecessary, patients were still billed for those additional tests; or even how frequently the additional diagnostic tests were ordered.

Prompting. Finally, most surveys expressly focus on “defensive medicine,” using the phrase throughout the survey. Because of their past success, civil justice opponents have cemented the negative connotations of the phrase “defensive medicine” in the national psyche. Surveys that use the phrase place the topic of malpractice in the respondents’ minds, triggering a recall of their negative views about litigation. In other words, the questions are specifically designed to exploit availability bias. As the OTA clinical scenario study discussed above showed, when doctors are not informed that “defensive medicine” is the subject of a survey, they will report a much lower frequency of the practice.¹²³

One recent survey took prompting to extraordinary heights. The AMA’s *Archives of Internal Medicine* published a survey that asked whether physicians agreed with the following two statements: “Doctors order more tests and procedures than patients need to protect themselves against malpractice suits” and “Unnecessary use of diagnostic tests will not decrease without protections for physicians against unwarranted malpractice suits.”¹²⁴ The results were not unexpected: 91 percent of physicians believe that doctors practice “defensive medicine” and 90.7 percent of physicians believe that “defensive medicine” will not decrease without protections for physicians from unwarranted malpractice suits.

The Texas Experience: Tort Reform Fails to Improve Worst Health Care System in U.S.

Civil justice opponents routinely laud Texas as a model for the supposed success of restricting medical malpractice plaintiffs’ access to the courts. In 2003, Texas voters responded to a multimillion-dollar advertising campaign and passed Proposition 12, amending the Texas constitution to allow the legislature to cap non-economic damages in medical malpractice suits. Prior to passage, Proposition 12 supporters contended that high medical malpractice rates and “frivolous” lawsuits were responsible for the – very real and very problematic – doctor shortage in rural Texas.¹³¹ Four years later, more doctors had begun to practice in Texas, but, contrary to the claim that this was a vindication for supporters of Proposition 12, those increases were being seen exclusively in wealthy counties.¹³² Of the 152 counties that did not have an obstetrician in 2003, not one had gained the services of an obstetrician by September 2007 and just 13 have today.¹³³ In fact, according to Texas Medical Board data, before the caps were implemented, the number of doctors in Texas grew faster – at twice the rate of population growth – than after Proposition 12 passed, when that growth began to level off to match population growth.¹³⁴ The surprising conclusion is that the increased number of doctors practicing in Texas would have occurred in the absence of Proposition 12, and possibly at a higher rate.¹³⁵

Meanwhile, after Texas gave lobbyists the tort reform they worked so hard to win, the state’s health care system is still in shambles. Total health care costs in the state – as measured by Medicare reimbursements – have risen at a rate twice the national average.¹³⁶ Texas also has the highest percentage, 26.8 percent, of uninsured citizens in the nation, including more than 1.3 million children.¹³⁷ Texas’ experiment should be a model for the nation, in what not to do.

There is no persuasive evidence that litigation against physicians changes their behavior in any meaningful way.

Conclusion

The United States spends more per capita on health care than any other nation – twice the average of the ten richest countries – and yet we suffer from an epidemic of medical errors that leads to the unnecessary deaths of too many of our citizens every year. Roughly 17 percent of our citizens lack health insurance,¹²⁵ our infant mortality is only slightly better than Serbia's,¹²⁶ and our life expectancy ranks 50th in the world.¹²⁷ We most certainly are not getting our money's worth. And while the civil justice system may be frustrating, it is the victims who suffer. Claims are processed at an exceedingly slow pace, administrative costs can be prohibitive, and the system sometimes fails to compensate the victims of medical malpractice as often, or as fully, as they deserve. Tort reform will do nothing to fix these flaws. But rather than focus on legitimate issues, the medical and insurance lobbies have chosen to pick a fight over the less than 3 percent of health care spending that may be attributable to medical malpractice litigation.

This report shows there is no persuasive evidence that litigation against physicians encourages them to practice defensively and make medical decisions solely, or even significantly, to avoid potential litigation. The best that opponents of the civil justice system can do to support their cause is cite unscientific surveys and severely limited economic research. The hard truth is that the benefits of tort reform accrue almost exclusively to corporate interests.

The real crisis in health care is the unacceptable number of medical errors killing and injuring hundreds of thousands every year. The latest research from the Department of Health and Human Services found that 15,000 Medicare patients die every month from adverse events and that 44 percent of those deaths are preventable, i.e. medical errors.¹²⁸ This equates to 79,200 *preventable* deaths each year in the Medicare system alone, far exceeding the shocking findings from the Institute of Medicine report a decade ago.¹²⁹

Recently the RAND Institute for Civil Justice published its findings linking adverse events with malpractice litigation. RAND researchers found that when the rate of adverse events decreased, so did malpractice litigation.¹³⁰ Not surprisingly, the reverse held true as well: when the rate of adverse events increased, so too did malpractice litigation. The civil justice system is not the cause of any alleged malpractice crisis; it merely sends a message to the health care system that it is not carefully enough monitoring for and preventing medical errors. Sadly, opponents of the civil justice system continue to focus on litigation and patients injured by medical malpractice as the problem. Yet the medical malpractice “reforms” they offer will not save a single patient from death or injury due to medical negligence. They should stop blaming the messenger and return to the business of putting their own houses in order.

Endnotes

- 1 See, e.g., RANDOLPH W. PATE & DEREK HUNTER, THE HERITAGE FOUNDATION, CODE BLUE: THE CASE FOR SERIOUS STATE MEDICAL LIABILITY REFORM (2006), available at <http://www.heritage.org/research/healthcare/bg1908.htm>; PRICEWATERHOUSECOOPERS, THE FACTORS FUELING RISING HEALTHCARE COSTS (2006), available at <http://www.ahip.org/redirect/PwCCostOfHC2006.pdf>; OFFICE OF DISABILITY, AGING, & LONG-TERM CARE POLICY, U.S. DEP'T OF HEALTH AND HUMAN SERVS., ADDRESSING THE NEW HEALTH CARE CRISIS: REFORMING THE MEDICAL LITIGATION SYSTEM TO IMPROVE THE QUALITY OF HEALTH CARE, available at <http://aspe.hhs.gov/daltcp/reports/medliab.pdf> (July 24, 2003) [hereinafter 2003 DHHS REPORT]; Daniel P. Kessler & Mark McClellan, *Do Doctors Practice Defensive Medicine?*, 111 QUARTERLY J. ECON. 353 (1996).
- 2 PAUL B. GINSBURG, ROBERT WOOD JOHNSON FOUNDATION, HIGH AND RISING HEALTH CARE COSTS: DEMYSTIFYING U.S. HEALTH CARE SPENDING (2008); see also discussion infra notes 44–59 and accompanying text.
- 3 Adverse events are “medical interventions that cause harm or injury to a patient separate from the underlying medical condition.” See John C. Goodman, Pamela Villareal, & Biff Jones, *The Social Cost of Adverse Medical Events, and What We Can Do About It*, 30 HEALTH AFFAIRS 590, 590 (2011). Adverse events include preventable and negligent errors, while this paper calls medical errors and are properly considered malpractice due to misconduct or a failure to meet minimum standards of care. Adverse events also include preventable but non-negligent errors, such as hospital-acquired infections, and other adverse events which, because of limitations in medical knowledge, “we do not know how to prevent.” *Id.*
- 4 In 2009, the average liability premium in states without caps on damages was lower than the average premium in states with caps on damages. See AM. ASSN. FOR JUSTICE, 5 MYTHS ABOUT MEDICAL NEGLIGENCE (Nov. 2009). Meanwhile, insurer profits have continued to soar since 2000, rising 120.2 percent between 2000 and 2006. And, in states with caps on damages, insurers take in 3.5 times what they pay out compared to just twice what they pay out in states without caps. AM. ASSN. FOR JUSTICE, NO CORRELATION BETWEEN MALPRACTICE PAYOUTS AND INSURANCE PREMIUMS, available at <http://www.justice.org/cps/rde/xchg/justice/hs.xsl/8689.htm>.
- 5 TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM I (Linda T. Kohn, Janet M. Corrigan, Molla S. Donaldson, eds., National Academies Press 2000). The Institute of Medicine’s report, TO ERR IS HUMAN, has long stood as the benchmark study on medical errors. Recent work, however, suggests that the IOM report and others like it may have been missing up to 90 percent of the events they sought to measure. That is, ten times more adverse events, including medical errors, may occur than previously estimated. See David C. Classen, et al., “*Global Trigger Tool*” Shows That Adverse Events in Hospitals May Be Ten Times Greater Than Previously Measured, 30 HEALTH AFFAIRS 581, 584-86 (2011). The Department of Health and Human Services, Office of the Inspector General, also recently released a report further supporting the case for viewing *To Err is Human* as the lower estimate of adverse events and medical errors. The HHS report found that 1 in 7 hospitalized Medicare beneficiaries experienced an adverse event, 44 percent of which were preventable (i.e. medical errors). Shockingly, the HHS report found that 15,000 Medicare beneficiaries die each month, from adverse events. This means that 6,600 Medicare beneficiaries alone die every month, or 79,200 each year, from preventable medical errors. See DEPT. OF HEALTH AND HUMAN SVCS., OFFICE OF THE INSPECTOR GENERAL, ADVERSE EVENTS IN HOSPITALS: NATIONAL INCIDENCE AMONG MEDICARE BENEFICIARIES i-iv (2011). Of course, this report only investigated Medicare, which covers just 14 percent of all Americans. The HHS report, like the Institute of Medicine’s *To Err is Human* 11 years before it, also only looked at hospitals, not outpatient surgical centers, clinical visits, or in-home care, for example. There is, therefore, good reason to believe that medical errors are more prevalent than current estimates. See TO ERR IS HUMAN, *supra* at 2 (“These figures offer only a very modest estimate of the magnitude of the problem since hospital patients represent only a small proportion of the total population at risk, and direct hospital costs are only a fraction of total costs. More care and increasingly complex care is provided in ambulatory settings.”)
- 6 Henry J. Kaiser Family Foundation, State Health Facts, available at <http://statehealthfacts.org/index.jsp>.

- ⁷ George J. Annas, *The Patient's Right to Safety – Improving the Quality of Care through Litigation against Hospitals*, 354 NEW ENG. J. MED. 2063 (2006) (pointing out that “[i]n the absence of a comprehensive social insurance system, the patient’s right to safety can be enforced only by a legal claim against the hospital”). A 2004 report by Public Citizen found that just eight percent of doctors with two or more malpractice payouts and just fifteen percent of doctors with four or more payouts faced any discipline whatsoever from state medical boards. In the same report, Public Citizen identified 15 physicians who had never been disciplined by their state medical boards but were responsible for between four and twenty-seven payouts (for an average of over \$8 million per doctor). See PUBLIC CITIZEN, MEDICAL MALPRACTICE BRIEFING BOOK: CHALLENGING THE MISLEADING CLAIMS OF THE DOCTORS’ LOBBY 41-43 (2004); see also AM. ASSN. FOR JUSTICE, MEDICAL NEGLIGENCE: THE ROLE OF AMERICA’S CIVIL JUSTICE SYSTEM IN PROTECTING PATIENTS’ RIGHTS (2011).
- ⁸ STEPHANIE MENCIMER, BLOCKING THE COURTHOUSE DOORS: HOW THE REPUBLICAN PARTY AND ITS CORPORATE ALLIES ARE TAKING AWAY YOUR RIGHT TO SUE 8 (2006).
- ⁹ David A. Hyman & Charles Silver, *Medical Malpractice Litigation and Tort Reform: It’s the Incentives Stupid*, 59 VANDERBILT L. REV. 1085, 1089 (2006) (citing NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, STATISTICAL COMPILATION OF ANNUAL STATEMENT INFORMATION FOR PROPERTY/CASUALTY INSURANCE COMPANIES (2001)).
- ¹⁰ NATIONAL CENTER FOR STATE COURTS, COURT STATISTICS PROJECT, EXAMINING THE WORK OF STATE COURTS: AN ANALYSIS OF 2008 STATE COURT CASELOADS 31 (2010).
- ¹¹ *Id.* at 24, 31.
- ¹² Most doctors will see, on average, only one malpractice claim in their careers, while just 7 percent may see a claim in any given year. Anupam B. Jena et al., *Malpractice Risk According to Physician Specialty*, 365 NEW ENGLAND J. MED. 629 (2011).
- ¹³ PUBLIC CITIZEN, THE GREAT MEDICAL MALPRACTICE HOAX: NPDB DATA CONTINUE TO SHOW MEDICAL LIABILITY SYSTEM PRODUCES RATIONAL OUTCOMES 12 (2007); see also *supra* note 7 and accompanying text.
- ¹⁴ HENRY J. KAISER FAMILY FOUNDATION, MEDICAL MALPRACTICE LAW IN THE UNITED STATES 24-25 (2005).
- ¹⁵ A. Russell Localio et al., *Relation Between Malpractice Claims and Adverse Events Due to Negligence, Results of the Harvard Medical Practice Study III*, 325 NEW ENGLAND JOURNAL OF MEDICINE 245, 245 (1991).
- ¹⁶ PATRICIA DANZON, MEDICAL MALPRACTICE: THEORY, EVIDENCE, AND PUBLIC POLICY 22-24 (1985); Henry J. Aaron & Paul B. Ginsburg, *Is Health Spending Excessive? If So, What Can We Do About It? The Delicate Task of Reining in Spending Without Harming Our Welfare*, 28 HEALTH AFFAIRS 1260, 1270 (2009) (citing Patricia Danzon, *Liability for Medical Malpractice*, in HANDBOOK OF HEALTH ECONOMICS 1339-1404 (Anthony J. Culyer & Joseph P. Newhouse eds. 2000)); David M. Studdert et al., *Negligent Care and Malpractice Claiming Behavior in Utah and Colorado*, 38 MEDICAL CARE 250, 254 (2000); Localio et al., *supra* note 15, at 248; see also P.C. WEILE, ET AL., A MEASURE OF MALPRACTICE: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION (1993).
- ¹⁷ See TOM BAKER, THE MEDICAL MALPRACTICE MYTH 69 (2005).
- ¹⁸ *Id.* (citing Laurie B. Andrews, et al., *An Alternative Strategy for Studying Adverse Events in Medical Care*, 349 LANCET 309, 312 (1997)).
- ¹⁹ Studdert et al., *Claims, Errors, and Compensation Payments in Medical Malpractice Litigation*, 354 NEW ENGLAND J. MED. 2024 (2006). Of course, just because a case does not have a verifiable injury does not mean it was frivolous.
- ²⁰ *Id.*
- ²¹ One likely scenario is that a patient who suffers an adverse event alleges that a certain course of action was not taken, and therefore the physician was negligent. Later, in a deposition, the plaintiff may find out that the course of action was, in fact, taken, but not recorded. Alleging that such cases are frivolous simply because they are dropped ignores the design of the civil litigation system. Indeed, one study from 1991, explored the frivolous litigation claim in depth and found that cases with strong evidence on one side or the other are quickly dropped, while those cases with unclear evidence about negligence go further. Henry S. Farber & Michelle J. White, *Medical Malpractice: An Examination of the Litigation Process*, 22 RAND J. ECON. 199 (1991). This supports the common sense notion that potential litigants only know that they were injured, not whether the doctor or hospital was negligent. The civil justice system’s design is such that the initial stages of litigation help ferret out more information that leads to claims being resolved before going to trial.
- ²² Studdert et al., *supra* note 19, at 2030.
- ²³ Michelle M. Mello, Carly N. Kelly, & Troyen A. Brennan, *Fostering Rational Regulation of Patient Safety*, 30 J. HEALTH POL. POL’Y & L. 375 (2005).
- ²⁴ U.S. CONG. OFFICE OF TECH. ASSESSMENT, DEFENSIVE MEDICINE AND MEDICAL MALPRACTICE (July 1994), available at <http://biotech.law.lsu.edu/policy/9405.pdf> [hereinafter OTA DEFENSIVE MEDICINE]. Most analysis of “defensive medicine” splits it into two components: positive and negative. Positive defensive medicine is what earns the most attention, steps taken (i.e. extra tests and procedures) with liability rather than effectiveness in mind. Negative defensive medicine refers to the concept that doctors avoid certain patients or procedures because they view them as particularly susceptible to litigation.

- ²⁵ *Id.* at 56.
- ²⁶ *Id.* at 63.
- ²⁷ *Id.* at 58.
- ²⁸ Chaim Putterman & Eldad Ben-Chetrit, *Testing, Testing, Testing* . . . , 333 NEW ENGL. J. MED. 1208 (1995).
- ²⁹ CONGRESSIONAL BUDGET OFFICE, LIMITING TORT LIABILITY FOR MEDICAL MALPRACTICE 6 (2004), available at <http://www.cbo.gov/ftpdocs/49xx/doc4968/01-08-MedicalMalpractice.pdf> [hereinafter CBO, LIMITING TORT LIABILITY].
- ³⁰ Marshall Kapp, *Defensive Medicine in Geriatric Practice, in THE RATIONAL USE OF ADVANCED MEDICAL TECHNOLOGY WITH THE ELDERLY 67-74* (F. Homburger ed. 1994).
- ³¹ U.S. GENERAL ACCOUNTING OFFICE, MEDICAL MALPRACTICE: IMPLICATIONS OF RISING PREMIUMS ON ACCESS TO HEALTH CARE 27 (2003) [hereinafter GAO 2003].
- ³² Atul Gawande, *The Cost Conundrum: What a Texas Town Can Teach Us About Health Care*, THE NEW YORKER, June 1, 2009.
- ³³ *Id.*
- ³⁴ Atul Gawande, *The Cost Conundrum Redux*, THE NEW YORKER, June 23, 2009.
- ³⁵ Putterman & Ben-Chetrit, *supra* note 28, at 1211.
- ³⁶ Alvin C. Kwok et al., *The Intensity and Variation of Surgical Care at the End of Life: A Retrospective Cohort Study*, 378 LANCET 1408 (2011).
- ³⁷ MARSHALL KAPP, OUR HANDS ARE TIED: LEGAL TENSIONS AND MEDICAL ETHICS 31 (1998).
- ³⁸ Letter from Douglas W. Elmendorf, Director, Cong. Budget Office, to Sen. Orrin G. Hatch (Oct. 9, 2009) at 4 [hereinafter Elmendorf Letter].
- ³⁹ GAO 2003, *supra* note 31, at 27.
- ⁴⁰ HARVEY F. WACHSMAN, LETHAL MEDICINE: THE EPIDEMIC OF MEDICAL MALPRACTICE IN AMERICA 126 (1993).
- ⁴¹ AM. ASSN. FOR JUSTICE, THE TRUTH ABOUT “DEFENSIVE MEDICINE 2 (2009) (analyzing insurance data from *Countrywide Summary of Medical Malpractice Insurance Calendar Years 1991- 2008, National Association of Insurance Commissioners* (2009)). Of course, although routinely claimed as such, payments to victims of medical negligence are not “costs” of the civil justice system and should not be counted as such.
- ⁴² PRICEWATERHOUSECOOPERS, THE PRICE OF EXCESS (2008) (claiming that medical liability system “wastes” 1.2 trillion of the 2.2 trillion spent on healthcare every year).
- ⁴³ GREATER NEW YORK HOSPITAL ASSOCIATION, MEDICAL MALPRACTICE REFORM: THE COSTS OF DEFENSIVE MEDICINE (2010) (repeating discredited estimates of cost of defensive medicine).
- ⁴⁴ CENTERS FOR MEDICARE AND MEDICAID SERVICES, OFFICE OF THE ACTUARY, NATIONAL HEALTH STATISTICS GROUP, NATIONAL HEALTH CARE EXPENDITURES 2009 HIGHLIGHTS (2010).
- ⁴⁵ NEERAJ SOOD, ARKADIPTA GHOSH, & JOSE J. ESCARSE, DEPT. OF HEALTH AND HUMAN SERVICES, THE EFFECT OF HEALTH CARE COST GROWTH ON THE U.S. ECONOMY 3 (2007).
- ⁴⁶ Michelle M. Mello, Amitabh Chandra, Atul A. Gawande, & David M. Studdert, *National Costs of the Medical Liability System*, 29 HEALTH AFFAIRS 1569 (2010). The authors also acknowledge that they did not estimate social costs, such as reputational and emotional costs of being sued, nor several widely acknowledged social benefits, such as the deterrent effects of the liability system. As the authors point out, “[t]he economic burden of preventable medical injuries is considerable, estimated to be \$17–29 billion per year.” *Id.* at 1570 (*citing* TO ERR IS HUMAN, *supra* note 5).
- ⁴⁷ Mello et al., *supra* note 46, at 1570, 1572 (“reliable estimates [of the practice and cost of defensive medicine] are notoriously difficult to obtain.”).
- ⁴⁸ GINSBURG, *supra* note 2, at 11.
- ⁴⁹ *Id.*; CONGRESSIONAL BUDGET OFFICE, TECHNOLOGICAL CHANGE AND THE GROWTH OF HEALTH CARE SPENDING (2008).
- ⁵⁰ CENTERS FOR DISEASE CONTROL, DEPT. OF HEALTH & HUMAN SERVICES, THE POWER OF PREVENTION: CHRONIC DISEASE . . . THE PUBLIC HEALTH CHALLENGE OF THE 21ST CENTURY 1 (2009). A 12 percent increase in health care spending is five times the annual contribution of medical malpractice litigation estimated by Mello et al.
- ⁵¹ *Id.*
- ⁵² GINSBURG, *supra* note 2, at 12-14.
- ⁵³ *Id.* at 10.
- ⁵⁴ Aaron & Ginsburg, *supra* note 16, at 1269.
- ⁵⁵ *Id.* at 1270.
- ⁵⁶ Henry J. Kaiser Family Foundation, State Health Facts, available at <http://statehealthfacts.org/index.jsp>.
- ⁵⁷ Goodman, *supra* note 3, at 590.
- ⁵⁸ *Id.*
- ⁵⁹ TO ERR IS HUMAN, *supra* note 5, at 2; see also Jill Van Den Bos et al., *The \$17.1 Billion Problem: The Annual Cost of Measurable Medical Errors*, 30 HEALTH AFFAIRS 596, 596 (2011).
- ⁶⁰ See generally U.S. GOVERNMENT ACCOUNTABILITY OFFICE, MEDICAL MALPRACTICE INSURANCE: MULTIPLE FACTORS HAVE CONTRIBUTED TO INCREASED PREMIUM RATES 7, 15-17 (2003).
- ⁶¹ BAKER, *supra* note 17, at 51.
- ⁶² UNITED STATES GENERAL ACCOUNTING OFFICE, MEDICAL MALPRACTICE INSURANCE: MULTIPLE FACTORS HAVE CONTRIBUTED TO PREMIUM RATE INCREASES, Testimony Before the Subcommittee on Wellness and Human Rights, Committee on Government Reform, H. of Rep. (2003)
- ⁶³ Rachel Zimmerman & Christopher Oster, *Insurers’ Missteps Helped Provoke Malpractice ‘Crisis,’* WALL ST. J., June 24, 2002, at A1.

- ⁶⁴ Katherine Baicker & Amitabh Chandra, *The Effect of Malpractice Liability on the Delivery of Health Care*, FRONTIERS IN HEALTH POLICY RESEARCH, Vol. 8, Art. 4 at 21 (2005).
- ⁶⁵ OTA DEFENSIVE MEDICINE, *supra* note 24, at 74.
- ⁶⁶ National Conference of State Legislatures, Medical Liability/Medical Malpractice Laws, <http://www.ncsl.org/default.aspx?tabid=18516> (summarizing existing laws related to medical malpractice); *see also* Rep. Darrell Issa, *Obama Must Push Tort Reform to Lower Health Costs*, ROLL CALL Feb. 25, 2010, available at http://www.rollcall.com/issues/55_94/-43541-1.html. Rep. Issa notes that, in Florida “premiums for OB-GYNs are as high as \$214,893, whereas in California the average is \$89,953.” What Rep. Issa forgets to note is that Florida long ago passed “tort reforms,” including a cap on noneconomic damages, very similar to California’s. The missing information makes clear that tort reform has no correlation to malpractice premium rates.
- ⁶⁷ Danzon, *supra* note 16, at 1309-1404.
- ⁶⁸ HARVARD MEDICAL PRACTICE STUDY, PATIENTS, DOCTORS, AND LAWYERS: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION IN NEW YORK ch.10, at 2-3 (1990).
- ⁶⁹ Lisa Dubay, Robert Kastner, & Timothy Waidman, *The Impact of Malpractice Fears on Caesarean Section Rates*, 18 J. HEALTH ECON. 491 (1999).
- ⁷⁰ J. William Thomas, Erika C. Ziller, & Deborah A. Thayer, *Low Costs of Defensive Medicine, Small Savings from Tort Reform*, 29 HEALTH AFFAIRS 1578 (2010).
- ⁷¹ *Id.* at 1582-83.
- ⁷² Kessler & McClellan, *supra* note 1, at 387-88.
- ⁷³ *Id.* Kessler & McClellan used data from 1984, 1987, and 1990, and extrapolated from there.
- ⁷⁴ *Id.* at 386.
- ⁷⁵ *Id.* at 387-88.
- ⁷⁶ *Id.*
- ⁷⁷ Significantly, Kessler and McClellan also found that certain restrictions on civil justice actually increased the incidence of “defensive medicine,” a conclusion that is ignored in the rush to gild their paper. Kessler & McClellan, *supra* note 1, at 378. While Kessler and McClellan found that one set of tort reforms – which the authors describe as “direct” (caps on non-economic or total damages, elimination of punitive damages, ending mandatory prejudgment interest, and collateral source rule offsets) – reduced spending by 5 to 9 percent, another set of reforms – in the authors’ words “indirect” (contingent fee caps, mandatory deferment of some or all payments, joint and several liability reform, and public patient compensation funds) – actually increased spending by 2 to 3 percent. Instead of addressing this limitation, the authors simply dismiss the finding by declaring that “these reforms do not appear to have a substantial effect on expenditures.” *Id.*
- ⁷⁸ BAKER, *supra* note 17, at 129.
- ⁷⁹ Mark McClellan & Joseph P. Newhouse, *The Marginal Cost-Effectiveness of Medical Technology: A Panel Instrumental-Variables Approach*, 77 J. ECONOMETRICS 39 (1997).
- ⁸⁰ Daniel P. Kessler & Mark McClellan, *Malpractice Law and Health Care Reform: Optimal Liability Policy in an Era of Managed Care*, 84 J. PUB. ECON. 175 (2002).
- ⁸¹ U.S. GOVERNMENT ACCOUNTABILITY OFFICE, MEDICAL MALPRACTICE: EFFECTS OF VARYING LAWS IN THE DISTRICT OF COLUMBIA, MARYLAND, AND VIRGINIA 3 (1999).
- ⁸² *Id.*
- ⁸³ CBO, LIMITING TORT LIABILITY, *supra* note 29.
- ⁸⁴ *Id.* at 6–7.
- ⁸⁵ *Id.*
- ⁸⁶ Frank Sloan & John H. Shadle, *Is There Empirical Evidence for “Defensive Medicine?” A Reassessment*, 28 J. HEALTH ECON. 481 (2009).
- ⁸⁷ *Id.*
- ⁸⁸ Baicker & Chandra, *supra* note 64, at 24.
- ⁸⁹ Elmendorf Letter, *supra* note 38.
- ⁹⁰ *Id.* at 4. There is some question as to how the CBO arrived at some of its assumptions. For example, the CBO estimates that the total direct cost of medical malpractice liability is \$35 billion, not including defensive medicine. This is at odds with the 2010 article in *Health Affairs* published by health care experts Michelle M. Mello, Amitabh Chandra, Atul A. Gawande, and David M. Studdert. Mello et al., *supra* note 46. In their article, Mello and her co-authors estimated the total national cost of the health care system at \$55 billion, of which they calculated defensive medicine accounts for \$45.6 billion, leaving less than \$10 billion for the direct cost of medical malpractice liability. It seems that the CBO may have double counted premiums in its calculation, since it states that the \$35 billion figure includes premiums, settlements and awards, and administrative costs. But as Mello and her co-authors point out, they purposely left out premiums from their estimates, because “[p]remiums represent insurers’ best estimates of their indemnity costs and defense costs, plus additional amounts to cover other operating expenses, reinsurance costs, and profits or surplus building. It would be double counting to include both malpractice premium costs and indemnity and administrative costs.” Mello et al., *supra* note 46, at 1570. Moreover, physicians only paid \$11 billion in premiums in 2010, while administrative costs and indemnity payments each were around \$5 billion. Double counting still does not lead to \$35 billion. At any rate, it is impossible to know where the CBO got this number from because it cites no sources or data to support this assumption.
- ⁹¹ CBO, LIMITING TORT LIABILITY, *supra* note 29; *see also* discussion *supra* notes 83-85 and accompanying text.
- ⁹² Elmendorf Letter, *supra* note 38, at 4.

- ⁹³ *Id.* at 2; see also *Assessing the Need to Enact Medical Liability Reform: Hearing Before the H. Subcomm. on Health of the Comm. on Energy and Commerce*, 108th Cong. (Feb. 10, 2003), at 3, 8-10 (statement of Harvey Rosenfield, President of the Foundation for Taxpayer and Consumer Rights). Using the Consumer Price Index inflation calculator from the U.S. Bureau of Labor Statistics, \$250,000 in 1975 would be equivalent to \$1,052,142.19 in 2011. CPI Inflation Calculator, <http://data.bls.gov/cgi-bin/cpicalc.pl>.
- ⁹⁴ Elmendorf Letter, *supra* note 38, at 2.
- ⁹⁵ National Center for State Legislatures, *Medical Liability/Medical Malpractice Laws*, <http://www.ncsl.org/default.aspx?tabid=18516>. For example, most states that have enacted caps have capped noneconomic damages above \$250,000. Meanwhile, 90 percent of states have statutes of limitations of at least two years.
- ⁹⁶ Letter from Sen. John D. Rockefeller IV to Douglas W. Elmendorf, Director, Cong. Budget Office (Oct. 21, 2009).
- ⁹⁷ Darius N. Lackdawalla & Seth A Seabury, *The Welfare Effects of Medical Malpractice Liability*, Working Paper w15383, National Bureau of Economic Research (2009).
- ⁹⁸ Katherine Baicker, Elliot S Fisher, & Amitabh Chandra, *Malpractice Liability Costs and the Practice of Medicine in the Medicare Program*, 26 HEALTH AFFAIRS 841 (2007).
- ⁹⁹ Sloan & Shadle, *supra* note 86.
- ¹⁰⁰ Elmendorf Letter, *supra* note 38, at 5; see Lackdawalla & Seabury, *supra* note 97. Interestingly, even as the CBO cited new studies to justify changing its view on the effectiveness of tort reform, the CBO dismissed Lackdawalla & Seabury's estimation that tort reform could increase mortality by 0.2 percent by citing Kessler & McClellan's 1996 and 2002 papers.
- ¹⁰¹ CBO, *LIMITING TORT LIABILITY*, *supra* note 29 at 1, 5.
- ¹⁰² CONGRESSIONAL BUDGET OFFICE, *THE EFFECTS OF TORT REFORM: EVIDENCE FROM THE STATES* xii (2004).
- ¹⁰³ CONGRESSIONAL BUDGET OFFICE, *BUDGET OPTIONS VOL. 1: HEALTH CARE* 21 (2008); see also CONGRESSIONAL BUDGET OFFICE, *MEDICAL MALPRACTICE TORT LIMITS AND HEALTHCARE SPENDING* (2006).
- ¹⁰⁴ GAO 2003, *supra* note 31, at 26-27.
- ¹⁰⁵ See, e.g., Tara F. Bishop, Alex D. Federman, & Salomeh Keyhani, *Physicians Views on Defensive Medicine: A National Survey*, 170 ARCH. INT. MED. 1081 (2010).
- ¹⁰⁶ See, e.g., *Most U.S. Physicians Practicing 'Defensive Medicine'*, U.S. NEWS & WORLD REPORT, June 28, 2010; *Vast Majority of Physicians Practice 'Defensive Medicine,' According to Physician Survey*, SCIENCE DAILY, June 1, 2010, available at <http://www.sciencedaily.com/releases/2010/06/100629094155.htm> (citing 2010 Archives of Internal Medicine survey); Christine Chinlund, *Doctors' Practice of 'Defensive Medicine' Widespread, Costly*, BOSTON GLOBE, Nov. 17, 2008, available at http://www.boston.com/news/health/blog/2008/11/doctors_practic.html (citing 2008 Massachusetts Medical Society survey).
- ¹⁰⁷ Press Release, Republican Study Committee, Gallup: 26% of Health Care Dollars Spent to Fend off Trial Bar; Medical Costs Spiral from Threat of Lawsuit Abuse (Feb. 22, 2010).
- ¹⁰⁸ Thomas et al., *supra* note 70, at 1578.
- ¹⁰⁹ Amos Tversky & Daniel Kahnemann, *Judgment Under Uncertainty: Heuristics and Biases*, 185 SCIENCE 1124, 1127 (1974).
- ¹¹⁰ See, e.g., SCOTT PLOUS, *THE PSYCHOLOGY OF JUDGMENT AND DECISION MAKING* 121-30 (1993); Sarah Lichtenstein et al., *Judged Frequency of Lethal Events*, 4 J. EXPERIMENTAL PSYCHOL. 551-78 (1978).
- ¹¹¹ Localio et al., *supra* note 15, at 245. The Harvard Medical Practice Study estimated that 27,179 cases of medical negligence occurred in New York in 1984, of which 5,396 had strong evidence that the negligence contributed to patient disability of over 6 months. Of those numbers, 415 filed claims. This equates to 1.5 percent of the larger number of total negligent events, or 7.7 percent of the major negligent events. See also HARVARD MEDICAL PRACTICE STUDY, *PATIENTS, DOCTORS, AND LAWYERS: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION IN NEW YORK* (1990).
- ¹¹² MASSACHUSETTS MEDICAL SOCIETY, *INVESTIGATION OF DEFENSIVE MEDICINE IN MASSACHUSETTS* (Nov. 2008), available at <http://www.massmed.org/defensivemedicine>.
- ¹¹³ *Medical Liability Reform: Cutting Costs, Spurring Investment, Creating Jobs: Hearing Before the H. Comm on the Judiciary*, 112th Cong. 58-59 (2011) (statement of Stuart L. Weinstein, M.D.).
- ¹¹⁴ MASSACHUSETTS MEDICAL SOCIETY, 2008 Report, *supra* note 112, at 6.
- ¹¹⁵ *Id.* at 3.
- ¹¹⁶ American Medical Association, *National Physician Survey on Professional Medical Liability* (2003), <http://old.asahq.org/news/Patients%20losing%20access%20survey%20April03.pdf>.
- ¹¹⁷ GAO 2003, *supra* note 31, at 20.
- ¹¹⁸ *Id.* at 20 n.32.

- ¹¹⁹ See, e.g., The Goldwater Institute, “Tort Reform May Mean Bringing Your Case to the Public,” (2004), available at <http://www.goldwaterinstitute.org/article/1260> (“studies have found that fear of litigation may encourage physicians to practice ‘defensive medicine,’ by ordering additional tests or unnecessarily referring patients to outside specialists.”).
- ¹²⁰ OTA DEFENSIVE MEDICINE, *supra* note 24, at 41.
- ¹²¹ David M. Studdert, *Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment*, 293 J. AM. MED. ASSN. 2609, 2617 (2005).
- ¹²² American Academy of Orthopaedic Surgeons, *Medical Malpractice Insurance Concerns – Final Report* (2002), <http://www2.aaos.org/aaos/archives/bulletin/jun02/line1.htm>.
- ¹²³ OTA DEFENSIVE MEDICINE, *supra* note 24, at 63.
- ¹²⁴ Tara F. Bishop, Alex D. Federman, & Salomeh Keyhani, *Physicians Views on Defensive Medicine: A National Survey*, 170 ARCH. INT. MED. 1081 (2010). While all three authors are doctors, two of the co-authors also hold Masters degrees in Public Health, meaning that they have had training in statistical analysis and experimental design. This may be why, in a comment to the article, the authors at least acknowledge this massive shortcoming: “we did not measure actual practice patterns to corroborate physicians’ perceptions of practicing defensive medicine, and our findings may overstate the role of defensive medicine in practice.” Of course, such limitations, tucked distantly away from the results section of the article, are easily overlooked by civil justice opponents and the news media.
- ¹²⁵ Henry J. Kaiser Family Foundation, State Health Facts, <http://statehealthfacts.org/index.jsp> (data from U.S. Census Bureau, American Community Survey (2008)).
- ¹²⁶ U.S. Central Intelligence Agency, The World Factbook, Country Comparison – Infant Mortality Rate, <https://www.cia.gov/library/publications/the-world-factbook/rankorder/2091rank.html>.
- ¹²⁷ U.S. Central Intelligence Agency, The World Factbook, Country Comparison – Life Expectancy at Birth, <https://www.cia.gov/library/publications/the-world-factbook/rankorder/2102rank.html>.
- ¹²⁸ U.S. DEPT. OF HEALTH AND HUMAN SERVICES, OFFICE OF INSPECTOR GENERAL, ADVERSE EVENTS IN HOSPITALS, NATIONAL INCIDENCE AMONG MEDICARE BENEFICIARIES (Nov. 2010).
- ¹²⁹ TO ERR IS HUMAN, *supra* note 5, at 1; see also *supra* note 5 and accompanying text. It should be noted that Medicare treats just 14% of U.S. citizens.
- ¹³⁰ MICHAEL D. GREENBERG, AMEILA M. HAVILAND, J. SCOTT ASHWOOD, & REGAN MAIN, RAND INSTITUTE FOR CIVIL JUSTICE, IS BETTER PATIENT SAFETY ASSOCIATED WITH LESS MALPRACTICE ACTIVITY: EVIDENCE FROM CALIFORNIA (2010).
- ¹³¹ Suzanne Bachelor, *Baby, I Lied. Rural Texas is Still Waiting for the Doctors Tort Reform Was Supposed to Deliver*, TEXAS OBSERVER, Oct. 18, 2007, available at <http://www.texasobserver.org/archives/item/15207-2607-baby-i-lied-rural-texas-is-still-waiting-for-the-doctors-tort-reform-was-supposed-to-deliver>.
- ¹³² *Id.*
- ¹³³ *Id.*; Texas Medical Association, Proposition 12 Produces Healthy Benefits (Nov. 29, 2011), <http://www.texmed.org/template.aspx?id=5238>.
- ¹³⁴ Rick Perry Says Texas Added 21,000 Doctors Because of Tort Reform, TAMPA BAY TIMES, Aug. 25, 2011, available at <http://www.politifact.com/truth-o-meter/statements/2011/aug/25/rick-perry/rick-perry-says-texas-added-21000-doctors-because-/>; see also TEXAS STATEWIDE HEALTH COORDINATING COUNCIL, 2011-2016 TEXAS STATE HEALTH PLAN 53 (2010).
- ¹³⁵ TAMPA BAY TIMES, *supra* note 134.
- ¹³⁶ See PUBLIC CITIZEN, LIABILITY LIMITS IN TEXAS FAIL TO CURB MEDICAL COSTS (Dec. 2009), available at http://www.citizen.org/documents/Texas_Liability_Limits.pdf. Some accounts suggest that tort reform has worked “too well,” barring so many plaintiffs from their day in court that judges are now taking cases that would have otherwise been settled “just to keep busy.” Stephanie K. Jones, *Has Tort Reform Worked Too Well in Texas?*, INSURANCE JOURNAL, Dec. 7 2007.
- ¹³⁷ Henry J. Kaiser Family Foundation, State Health Facts, <http://statehealthfacts.org/index.jsp>.

About the Authors



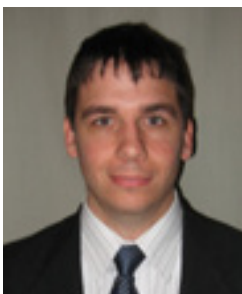
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[Climate Change and the Puget Sound: Building the Legal Framework for Adaptation](#), CPR White Paper 1108, by CPR Member Scholars Robert L. Glicksman and Catherine O'Neill, and CPR Policy Analyst Yee Huang; and CPR Member Scholars William L. Andreen, Robin Kundis Craig, Victor Flatt, William Funk, Dale Goble, Alice Kaswan, and Robert R.M. Verchick, June 2011. Read the [news release](#).

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[The BP Catastrophe: When Hobbled Law and Hollow Regulation Leave Americans Unprotected](#), CPR White Paper 1101, by CPR Member Scholars Alyson Flournoy (University of Florida Levin College of Law), William Andreen (University of Alabama School of Law), Thomas McGarity (University of Texas at Austin School of Law), Sidney Shapiro (Wake Forest University School of Law) and CPR Policy Analyst James Goodwin, January 2011.

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