Commentary: Malpractice Reform in Policy Perspective

RANDALL R. BOVBJERG

The Urban Institute

Enacted caps on malpractice awards and proposed early offer reform address the sometimes excessive verdicts of conventional liability and its very high overhead costs. However, such reforms greatly benefit medical defendants while doing too little for claimants or patients in general. Caps and early offer only affect current claims; far broader reforms are therefore needed to improve the woeful performance of liability as a general promoter of patient safety and injury compensation. Broad reforms, however desirable, seldom surmount high political and practical hurdles. A good, more evenhanded start would seek to make claims resolution faster, more accurate, more predictable, and less expensive, while separately promoting medical quality and safety as well as greater transparency for law, medicine, and insurance.

Keywords: Compensation and redress, medical liability, malpractice, patient safety, torts, health care costs, liability insurance, public policy.

MALPRACTICE REFORM AROUSES PASSIONATE partisanship about the purposes, practices, and performance of the American tort “system.”¹ Three national malpractice “crises” since 1974 and a Thirty Years War over reforms have left a trail of conflicting analyses about “the” malpractice problem, many and varied enacted or proposed reforms, along with advocacy charges and countercharges ad infinitum.

Malpractice factoids are plentiful. Clear presentations of goals, means, and performance measures are rare. Objective data are hard to come by. Analyses are uncommon. Clarifying even a fraction of the issues and

Address correspondence to: Randall R. Bovbjerg, The Urban Institute, 2100 M. St., N.W., Washington, DC 20037 (email: rbovbjer@ui.urban.org).

The Milbank Quarterly, Vol. 85, No. 2, 2007 (pp. 297–305)
© 2007 Milbank Memorial Fund. Published by Blackwell Publishing.

knowledge “in play” is complex. Commentary readily strays into trying to help readers understand the Gordian knot of entangled issues. Great complexity remains even in commenting on two specific reforms, enacted “caps” that limit awards (Nelson, Morrissey, and Kilgore 2007) and an “early offer” proposal that would limit settlements (O’Connell 2007).

Let us try instead for the big picture. The conventional medical liability system should be assessed in the same way as other public programs. Does it accomplish socially desirable goals at reasonable cost? So too for reforms or replacements for liability. How and to what extent do they achieve their intended beneficial goals and at what costs, including side effects?

There are two ways to view liability and its goals. One is to focus on what the system actually does, day in and day out. That is, it resolves disputes—happily, with courts and lawyers rather than improvised explosive devices. The other view focuses on what many pro-liability theorists claim that tort rules and process do, which is to deter negligent medical injuries, compensate those that nonetheless occur, and do both in fair ways that promote justice.

Unsurprisingly, the conventional system performs much better in achieving the narrow goal of socially legitimate dispute resolution than it does in its broader aspirations to regulate medical practice and injury compensation. From either perspective, however, improvements seem readily achievable. Through what reforms? How readily achievable? With what mix of benefits and costs?

These are the types of questions to keep in mind when considering the pros and cons of caps and early offer. Along, of course, with the solidity of evidence or estimates about each.

Improving Dispute Resolution

The legal profession may be held in low public regard in opinion polls and on Internet joke sites. But the public appreciates the tort system’s ability to resolve disputes, perhaps because many alternatives are seen as serving someone else’s interest (for instance, as specified in the fine print of many consumer contracts). Peaceful settlement of disputes is a valued aspect of the rule of law.

Significant shortcomings nonetheless abound. Standards for assessing negligence are only implicit and haphazardly applied. Compensation

standards also are vague and unquantified, especially for monetizing nonmonetary damages like pain and suffering. The case-by-case, non-systematic nature of tort process makes proportionality and consistency of results almost impossible to achieve. The filing and resolution of cases are also woefully slow, with delays averaging five years after injury (Studdert et al. 2006) and longer for higher-stakes cases with multiple defendants. And on average the overheads of legal and insurer administration cost more than the net compensation that claimants receive.

Caps are a halfway technology. They address one of the worst symptoms (occasional awards at ridiculously high levels), but they do not cure the underlying tort syndrome of vague rules and inconsistent valuation of damages (Avraham 2006; Bovbjerg 1991). As intended, caps reduce liability claims payouts and premiums for medical providers. (Astonishingly, this simple truth remains obfuscated after thirty years. Perhaps more surveys like this one by Nelson and colleagues can help, but likely not by much.) Caps also seem to calm liability markets by making payouts more predictable. It is not wrong to recognize limitations on valuation of injuries, as almost everyone routinely accepts known safety risks for personal gain and limits what they spend for greater safety (Viscusi 1998). But malpractice caps unfairly shortchange people with the worst injuries, at least as assessed by the legal system, according to the studies reviewed by Nelson and colleagues, and caps do very little to ameliorate other shortcomings in claims resolution (2007).

Moreover, caps are takeaway reforms for which injured claimants receive no offsetting benefits. Patients are almost all uninjured; as a class, they may receive a slightly improved supply of medical care or slightly reduced costs of care, but any effects are small, and evidence is not strong. Other key conventional tort reforms are takeaways as well, like reductions in the time permitted to bring claims, the offset of any award by recoveries from health insurance and other compensatory coverages, and reductions in lawyers' fees. As Professor O'Connell (2007) notes, the best legal reforms are those that achieve social goals while balancing gains and losses for both sides.²

Enter Early Offer, Stage Right

Early offer provides pro-defendant reforms—no pain and suffering, offset of payments from other compensation, and drastically lower lawyers'

fees—but only if defendants give claimants value in return (O’Connell 2007). To qualify for this contingent form of tort reform, a defendant must promptly promise (within 120 days of a claim) to pay all of a claimant’s future out-of-pocket monetary losses as they occur. Early offers add value for claimants in three ways: First, payment is prompt and certain. This avoids the sometimes considerable psychic pain and suffering of protracted delay (Werth 1998) and encourages earlier injury rehabilitation, whereas delays in litigation encourage malingering. Second, assuming that the offers are properly implemented, payment levels will respond to changes in future needs or costs, acting much like free, noncancelable disability or health coverage. In contrast, lump-sum tort settlements can fall short of covering future costs (Sloan et al. 1993). Third, the overhead costs of litigation are slashed, and damage allotments are not reduced by one-third or more to pay lawyers’ fees and legal expenses (Bovbjerg, Sloan, and Rankin 1997).

Alas, the likely value of the new coverage benefit is curtailed because defendants will make only offers that they expect to cost less than continuing to litigate. The incentive for defendants to “game” offer making to their own advantage is hardwired into the model. Indeed, O’Connell and colleagues model this gaming in estimating likely payouts and associated legal costs (Hersch, O’Connell, and Viscusi 2006). More claims may well receive payment under early offer reform, but this outcome depends upon key assumptions. What is the distribution of claims’ likelihoods of winning at trial by size of claim? What is the distribution of the expected costs of paying future losses, including new administrative costs and resolving new types of coverage disputes? Will more claims be brought because early offers ease recovery, or fewer because payouts and legal fees are lower?

In the end, early offer also looks like a takeaway reform, albeit with more offsetting advantages to claimants than under caps.

More evenhanded reforms would try to improve legal processes rather than one side’s prospects, including such reforms as promoting more neutral expert witnesses and providing structured guidance on how to value nonmonetary losses (Bovbjerg and Berenson 2005; Bovbjerg and Shapiro 2006; Bovbjerg, Sloan, and Blumstein 1989). A personal favorite is greater transparency, which seems rather cheap to implement as well as long overdue. In Pennsylvania, for example, one can readily find out, by hospital, how many procedures are done each year by type of case, cost per procedure, and outcome statistics (PHC4 2006). One

cannot readily discover, in contrast, how many medical liability lawsuits have been brought, what jury awards have been made (much less the amounts of private settlements), which judges or lawyers are involved in the longest delays to resolution, or what premiums liability insurers have charged under varying circumstances (Bovbjerg and Bartow 2003).

Improving Injury Prevention and Resolution

The medical profession may be held in high regard, as shown in opinion polls and the public backlash against managed care constraints on its clinical discretion. But the huge variability in the quality of clinical services and the large number of medical errors and avoidable injuries nonetheless leave much to be desired (IOM 2000, 2001). The legal system purports to oversee medical care and deter substandard care, yet huge problems persist, even though both the number and the size of lawsuits have increased by an order of magnitude since modern medical liability began to emerge half a century ago. This is the key failure of liability as an injury-reduction system. Liability also fails to contribute to another aspect of the rule of law: that is, to create a predictable framework within which people can organize their affairs and enjoy productive and happy lives. Today's liability system fails to give medical practitioners timely, clear, and consistent signals about how to act. Nor does it give patients any reliable indication of what injury compensation to expect and what they need to plan for elsewhere.

Besides liability, there are many, many other influences on medical quality and safety, probably more influential influences, truth be told. The most productive of these need to be identified and given more private and public support, quite independent of what little that liability may add or detract.

Liability or some replacement policy seems most likely to become more systematic in injury prevention if it, like workers' compensation, can find more injuries, generate more information about their nature and the most reliable ways to prevent them, and fairly and promptly provide basic compensation. Non-fault-based administrative compensation similar to workers' compensation is one approach (Abraham 1988; Bovbjerg and Tancredi 2005; Ehrenzweig 1964; Havighurst and

Tancredi 1973; IOM 2003; Mello et al. 2006; Studdert and Brennan 2001). A prominent weakness is political resistance to its full-fledged implementation (Bovbjerg and Sloan 1998).

The earliest version of early offer was also a much more thoroughgoing reform because it called for much earlier offers. O'Connell (1982) proposed that prospective defendants act within 60 days of *injury*, not 120 days of *claim*. This difference not only would have called for a two-year faster start on paying for injury rehabilitation, but also would have made gaming the offers more difficult for medical providers, and almost certainly would have covered more injuries, with positive impacts on compensation as well as on safety incentives and information. Even so, there were vehement complaints about likely strategic, takeaway behavior by medical providers, such as making offers only for serious injuries, to people perceived as litigious, or in cases of very clear fault.

O'Connell responded (e.g., 1986) with an inventive modification: that defendants promise to make offers even *before* injury, through contracts arranging to pay injured patients' out-of-pocket losses in designated circumstances in exchange for patients' forgoing pain and suffering claims. Additional protection for patients' interests was contained in a 1990s proposal in collaboration with this commentator and other colleagues (described in Bovbjerg 2006). It specified that the preinjury contracts promise to make early offers for all *prelisted* avoidable classes of events, or ACEs. An Institute of Medicine committee (2003) further modified this proposal, adding the new protections of state oversight of ACE lists and of other contract provisions. All of these reforms would be more patient safety friendly than tort liability is.

None of these proposals has been adopted. It is very hard to make much headway with systemic reform to prevent injuries when entrenched groups of both claimants' lawyers and defense interests want to maintain a claims-based system. Lawyers want more of the same system, doctors want less of it, and the general patient-public does not appreciate the shortcomings of the status quo. Patients and patient safety would probably benefit most from a different and better system. But it seems acceptable to settle for better claims resolution and more direct public and private support for more organized promotion of medical quality and patient safety. Second best is better than none.

Endnotes

1. The terms enclosed in quotation marks are useful shorthand. But using the term “system” makes medical liability rules, process, and outcomes seem more systematic than they really are. Similarly, “crisis” is not objective, as it is meant more to encourage political action than to clarify the extent of problems. See, for example, the discussion in Bovbjerg 2005. Readers are spared further quotation marks, but in any malpractice discussion they should remain alert to rhetorical sleight of hand.
2. Balance in liability reform seems appropriate in light of the social legitimacy enjoyed by the unreformed system. It should also boost political appeal and ability to withstand judicial review. Workers’ compensation reform achieved such balance, and no-fault auto insurance promised it. Auto no fault, which O’Connell modestly omits to discuss, arose from his work with a fellow academic (Keeton and O’Connell 1965).

References

- Abraham, K.S. 1988. Medical Liability Reform: A Conceptual Framework. *Journal of the American Medical Association* 260:68–72.
- Avraham, R. 2006. Putting a Price on Pain-and-Suffering Damages: A Critique of the Current Approaches and a Preliminary Proposal for Change. *Northwestern University Law Review* 100(1):87–120.
- Bovbjerg, R.R. 1991. Lessons for Tort Reform from Indiana. *Journal of Health Politics, Policy & Law* 16(3):465–84.
- Bovbjerg, R.R. 2005. Malpractice Crisis and Reform. *Clinics in Perinatology* 32(1):203–33.
- Bovbjerg, R.R. 2006. Reform of Medical Liability and Patient Safety: Are Health Courts and Medicare the Keys to Effective Change? *Journal of Health Care Law & Policy* 9(2):252–79.
- Bovbjerg, R.R., and A. Bartow. 2003. *Understanding Pennsylvania’s Medical Malpractice Crisis: Facts about Liability Insurance, the Legal System, and Health Care in Pennsylvania*. New York: Columbia University, Project on Medical Liability in Pennsylvania, for the Pew Charitable Trusts, June. Available at http://www.pewtrusts.org/pdf/vf_medical_malpractice.0603.pdf (accessed March 11, 2007).
- Bovbjerg, R.R., and R.A. Berenson. 2005. *Surmounting Myths and Mindsets in Medical Malpractice*. Issue brief, October 27. Washington, D.C.: Urban Institute. Available at <http://www.urban.org/url.cfm?ID=411227> (accessed March 8, 2007).
- Bovbjerg, R.R., and D.W. Shapiro. 2006. A Medical Injury Prevention and Compensation System for the Twenty-first Century. Working paper. Forthcoming.

- Bovbjerg, R.R., and F.A. Sloan. 1998. No Fault for Medical Injury: Theory and Evidence. *University of Cincinnati Law Review* 67(1):53–123.
- Bovbjerg, R.R., F.A. Sloan, and J.F. Blumstein. 1989. Valuing Life and Limb in Tort: Scheduling “Pain and Suffering.” *Northwestern University Law Review* 83(4):908–76.
- Bovbjerg, R.R., F.A. Sloan, and P.J. Rankin. 1997. Administration of Medical “No-Fault”: Goals and Achievements. *Law & Contemporary Problems* 60(2):71–115.
- Bovbjerg, R.R., and L.R. Tancredi. 2005. Liability Reform Should Make Patients Safer: “Avoidable Classes of Events” Are a Key Improvement. *Journal of Law, Medicine & Ethics* 33(3):478–500.
- Ehrenzweig, A.A. 1964. Compulsory “Hospital-Accident” Insurance: A Needed First Step toward the Displacement of Liability for “Medical Malpractice.” *University of Chicago Law Review* 31:279–91.
- Havighurst, C.C., and L.R. Tancredi. 1973. “Medical Adversity Insurance”—A No-Fault Approach to Medical Malpractice and Quality Assurance. *The Milbank Memorial Fund Quarterly* 51(2):125–68.
- Hersch, J., J. O’Connell, and W.K. Viscusi. 2006. *Evaluation of Early Offer Reform of Medical Malpractice Claims*. Washington, D.C.: ASPE Final Report from the Lewin Group, June 5. Available at <http://aspe.hhs.gov/daltcp/reports/2006/medmalcl.pdf> (accessed March 9, 2007).
- Institute of Medicine (IOM), Committee on Quality of Health Care in America. 2000. *To Err Is Human: Building a Safer Health System*, edited by L.T. Kohn, J.M. Corrigan, and M.S. Donaldson. Washington, D.C.: National Academy Press.
- Institute of Medicine (IOM), Committee on Quality of Health Care in America. 2001. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, D.C.: National Academy Press.
- Institute of Medicine (IOM), Committee on Rapid Advance Demonstration Projects. 2003. Liability: Patient-Centered and Safety-Focused, Nonjudicial Compensation. In *Fostering Rapid Advances in Health Care: Learning from Systems Demonstrations*, edited by J.M. Corrigan, A. Griener, and S.M. Erickson, 81–90. Washington, D.C.: National Academy Press.
- Keeton, R.E., and J. O’Connell. 1965. *Basic Protection for the Traffic Victim: A Blueprint for Reforming Automobile Insurance*. Boston: Little, Brown.
- Mello, M.M., D.M. Studdert, A.B. Kachalia, and T.A. Brennan. 2006. “Health Courts” and Accountability for Patient Safety. *The Milbank Quarterly* 84(3):459–92.

- Nelson, L.J., III, M.A. Morrissey, and M.L. Kilgore. 2007. Damages Caps in Medical Malpractice Cases. *The Milbank Quarterly* 85(2):259–86.
- O'Connell, J. 1982. Offers That Can't Be Refused: Foreclosure of Personal Injury Claims by Defendants' Prompt Tender of Claimants' Net Economic Losses. *Northwestern University Law Review* 77:589–632.
- O'Connell, J. 1986. Neo-No-Fault Remedies for Medical Injuries: Coordinated Statutory and Contractual Alternatives. *Law and Contemporary Problems* 49(2):125–42.
- O'Connell, J. 2007. Commentary: Binding Early Offers versus Caps for Medical Malpractice Claims? *The Milbank Quarterly* 85(2):287–96.
- Pennsylvania Health Care Cost Containment Council (PHC4). 2006. Hospital Performance Report 2005—Winter Update. Harrisburg: PHC4, downloadable Excel files available at <http://www.phc4.org/reports/hpr/05/winterupdate.htm> (accessed March 11, 2007).
- Sloan, F.A., P.B. Githens, E.W. Clayton, and G.B. Hickson. 1993. *Suing for Medical Malpractice*. Chicago: University of Chicago Press.
- Studdert, D.M., and T.A. Brennan. 2001. No-Fault Compensation for Medical Injuries: The Prospect for Error Prevention. *Journal of the American Medical Association* 286:217–23.
- Studdert, D.M., M.M. Mello, A.A. Gawande, T.K. Gandhi, A. Kachalia, C. Yoon, A.L. Puopolo, and T.A. Brennan. 2006. Claims, Errors, and Compensation Payments in Medical Malpractice Litigation. *New England Journal of Medicine* 354(19):2024–33.
- Viscusi, W.K. 1998. Valuing Life and Risks to Life. In *The New Palgrave Dictionary of Economics and the Law*, edited by P. Newman., vol. 3, 660–69. London: Macmillan.
- Werth, B. 1998. *Damages: One Family's Legal Struggles in the World of Medicine*. New York: Simon & Schuster.

Acknowledgments: My coauthors cited above and many others have all made substantial contributions to my understanding of malpractice, liability insurance, patient safety, and reform, for which help I am very grateful, personally and professionally. No funds supported the writing of this commentary, for whose content I am personally responsible.