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**Rethinking the Obvious: Time for New Ideas on
Medical Malpractice Tort Reform**

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Abstract

States have engaged in medical malpractice litigation reforms over the past 30 years to reduce malpractice insurance premiums, increase the supply of physicians, reduce the cost of healthcare, and increase efficiency. These reforms have included caps on non-economic damages and legal procedural changes. Despite these reforms, healthcare costs in the U.S. remain among the highest in the world, provider shortages remain, and defensive medicine practices persist. The purpose of this study was to determine how successful traditional medical malpractice reforms have been at controlling medical costs, decreasing defensive medicine practices, lowering malpractice premiums, and reducing the frequency of medical malpractice litigation. Research has shown that direct reforms and aggressive damage caps has had the most significant impact on lowering malpractice premiums and increasing physician supply. Out of the metrics which were improved by malpractice reforms, similar improvements were shown because of quality reform measures. While traditional tort reforms have shown some targeted improvement, large scale, system-wide change has not been realized, and thus it is time to consider alternative reforms.

Key Words: cost, malpractice, tort, defensive medicine, premium

Introduction

Over the past three decades, the increased prevalence of medical malpractice litigation has resulted in increased malpractice insurance premiums, higher instances of defensive medicine practices, and the relocation of physicians of various specialties to more favorable jurisdictions.¹ To avoid the possibility of a medical malpractice lawsuit, physicians have engaged in unjustifiable tests and services, otherwise known as defensive medicine practices, which have accounted for nearly 3% of healthcare spending, or roughly \$50 billion annually.² In response to this phenomenon, and in an attempt to lower malpractice insurance premiums and keep physicians in the state, over half of the United States (U.S.) have enacted state-level medical malpractice tort reforms.³

“Tort reform” within the healthcare industry has referred to several legislative measures aimed to restrict the financial liability to which a clinician was exposed, as well as to provide predictability in medical malpractice damage awards.^{4,5} There have been three distinct periods of medical malpractice tort reforms in the U.S.: first in the 1970's, then in the 1980's, and finally in the latter part of the 1990s.⁶ Of the different reforms introduced over these time frames, the two most common and impactful were: caps on non-economic damages and the dissolution of the legal concept of "joint and several liabilities" as applied to medical malpractice claims.⁷ Within these two reforms, caps on non-economic damages have been the most highly discussed and debated.^{7,8} Supporters such as physicians have argued that non-economic damage caps have discouraged unmeritorious claims, ended unrestrained damage awards, and reigned in inflated medical malpractice insurance premiums for clinicians.^{9,4} Detractors of these reforms have argued that these caps have been unproductive in achieving their stated aims and have been unjustified given the injustice in denying full legal redress to the most injured individuals.^{10,11}

The purpose of this research was to assess the effectiveness of medical malpractice tort reforms on controlling medical costs, decreasing the incentive and implementation of defensive medicine practices, lowering medical malpractice insurance premiums, and reducing the frequency of medical malpractice litigation.

Methodology

The primary hypothesis of this study was that medical malpractice tort reforms have not been effective in achieving their stated aims of reducing healthcare spending, reducing insurance premiums, and increasing the supply of physicians on a state by state basis.

This study took the form of a secondary literature review. The goal of this study was to attempt to prove the hypothesis by a thorough review of existing scholarship on the issue of the effect of medical malpractice tort reforms on the varied aims of such reforms. Any area of the hypothesis which could not be efficiently concluded from the scientific literature was identified as ripe for more extensive primary data collection in a future study.

Identified data for this study centered on peer-reviewed secondary sources, written in the English language, focused on the effect of tort reforms of the U.S. medical malpractice system, and published between the years 2005 and 2017. The academic database aggregator service "MUSummon" at Marshall University, the biomedical literature database "PubMed," EBSCOhost, Academic Search Premier, Alt-HealthWatch, LexisNexis Academic, and CQ Researcher were primarily used to identify relevant scholarship references. The primary search terms utilized to identify academic sources were, 'tort reforms' or 'malpractice tort reforms' and 'medical malpractice' and 'damage caps' and 'physician supply.'

The research focus emphasized the identification of measurable data related to the specific aims identified in the hypothesis. Relevant articles were selected following a review of abstract and conclusion sections. The review yielded 16 total articles, of which seven were chosen for inclusion in the Results section of this review. Additionally, a written semi-structured interview with an in-house legal counsel of a healthcare organization was used within the data collected. The semi-structured interview is identified as “In-House Interview, 2017” below. The literature search was conducted by JD and MF and validated by AC who also acted as a second reader and verified literature met inclusion criteria.

Results

Case Study 1: Impact of Malpractice Reforms on the Supply of Physician Services, 2005

A 2005 study by Kessler, Sage, and Becker focused on how the supply of physicians was affected, state to state, because of various medical malpractice tort reforms. These authors used the American Medical Association Physician Masterfile data for each state in the years 1985 through 2001 to identify the effect of state malpractice law changes on physician supply. The authors examined the impact of "direct" and "indirect" reforms on physician supply. Direct reforms were identified as those which directly reduced malpractice awards – damage caps, getting rid of punitive damages, removing mandatory prejudgment interest, and modifying the collateral source rule – and indirect reforms were identified as those who only indirectly reduced malpractice awards – contingency fee caps, periodic compulsory payments, reforms of joint and several liability rules, establishing a patient compensation fund, and reforming statutes of limitation.¹²

In states that enacted direct reforms, physician supply increased 8.2% more rapidly over the subject period than in states with no reforms.¹² The authors found that while this number was 9.6% when direct and indirect reforms were enacted together versus no change, states which passed only indirect reforms experienced a physician supply increase at a rate 3.4% lower than states with no reforms. As can be seen in Table 1 below, results varied by specialty as well as by years of experience. Levels of physicians with more than twenty years of experience rose 21.4% more rapidly in states with both direct and indirect reforms as compared to states with no reforms.¹²

Insert Table 1 Here

Case Study 2: Low Cost of Defensive Medicine, Small Savings From Tort Reform, 2010

A 2010 study by Thomas, Ziller, and Thayer examined the effect tort reforms have had on the overall healthcare cost associated with defensive medicine. This study utilized data from paid medical and pharmaceutical claims of CIGNA HealthCare from July 1, 2004, to June 30, 2006, measured about medical malpractice insurance data.¹³ Thomas, Ziller, and Thayer reviewed 61 risk categories in 30 states. The authors examined the cost of an episode of care and attributed any single incident to a given physician if that physician was responsible for the highest percentage of the professional charge, so long as that rate was at least 30%. Episode costs were increased because of malpractice premiums for 449 physician risk categories.¹³ However, ultimately the authors found that a 10% reduction in medical malpractice premiums would account for only 0.132% reduction in overall cost of a given episode of care. This total savings percentage would just be 0.4% if medical malpractice premiums were reduced a full 30%.¹³

Case Study 3: Does Malpractice Liability Keep the Doctor Away? Evidence from Tort Reform Damage Caps, 2007

In 2007, Matsa examined the effect of medical malpractice noneconomic damage caps on the supply of physicians. The study utilized physician population numbers from the records of the American Medical Association, as reported to the United States Department of Health and Human Services Area Resource File.¹⁴ The author concluded going into the study that any effect on physician supply because of damage caps was dependent on three factors: how much liability premiums change relative to cost and profit, how much physicians can pass along costs of medical liability to patients and the elasticity of demand for physician services. The study found that damage caps did not increase nationwide physician supply.¹⁴ However, the author found that while the number of general practitioners was unchanged in rural areas, the quantity of specialty physicians raised in rural areas by 10% to 12% as a result of damage caps, resulting in an overall physician supply increase of 3% to 5% in rural areas, which contrasted with the no change found nationwide. This disparity was attributed to the different effect of the three factors above in rural versus urban areas.¹⁴

Case Study 4: Medical Malpractice Reform: Noneconomic Damages Caps Reduced Payments 15 Percent, with Varied Effects by Specialty, 2014

A 2014 study by Seabury, Helland, and Jena examined nationwide medical malpractice claims from 1985 to 2010, compared against similar state medical malpractice liability reforms, to determine the effect damage caps had on malpractice payments. The authors examined 220,653 claims, 33.7% of which were insured claims. The study found that more restricted caps had a more significant effect than less restrictive caps, a \$250,000 cap reduced average indemnity payments 10% while a \$500,000 cap did not affect.¹⁵ Further, the authors discovered

that more restrictive damage caps had a lesser impact on riskier physician specialties. However, the ultimate finding of the study was that a \$250,000 damage cap was effective in lowering the cost of malpractice liability for the average physician in the United States, while a \$500,000 damage cap was not effective.¹⁵

Case Study 5: New Directions in Medical Liability Reform, 2011

In a 2011 study, Kachalia and Mello examined available literature on the effect of the eight most common state medical malpractice tort reforms. The study utilized all relevant published literature and government reports through 2009. The authors found that noneconomic damage caps did control the growth of liability insurance premiums. Likewise, modifications to the statute of limitations or statute of repose, also lower liability insurance premiums.¹⁶

However, other reforms such as limits on attorney fees and reforms to joint and several liabilities, have not been found to have an effect on insurance premiums or claim frequency.¹⁶

Case Study 6: Tort Reforms, 2010 do not assuage Physicians' Fears of Malpractice Lawsuits

A 2010 study by ¹⁷Carrier, Reschovsky, Mello, Mayrell, and Katz surveyed physicians found in the American Medical Association Physician Masterfile regarding practice characteristics and career satisfaction and cross-referenced it with malpractice data from the National Practitioner Data Bank. The survey had a 62% response rate and revealed that physicians with fewer than five years of practice had much higher subjective fear of malpractice litigation than did those with greater than five years of practice experience.¹⁷ This data aligned with the opinion of the In-House Interview, in which the in-house counsel stated that the more inexperienced providers in the organization had a more significant personal fear of malpractice litigation and were more likely to engage in defensive medicine practices as compared to more experienced providers.

The authors found that fear over malpractice did not significantly change in response to malpractice reforms. Overall, whether a state was a riskier malpractice environment or had higher malpractice insurance premiums did not have a significant effect on the subjective fear of malpractice experienced by that state's physicians.¹⁷ General reforms such as aggressive damage caps and the abolition of joint and several liabilities did have a modest effect on physicians' subjective malpractice fears, 0.2 and 2.9 on the study's malpractice concern scale respectively.¹⁷

Case Study 7: The Impact of Tort Reforms and Quality Improvements on Medical Liability Claims, 2015

Another study was performed by Illingworth, Shaha, Tzeng, Sinha, and Saleh and published in 2015. The authors examined the effect of traditional tort reforms on 18 Texas hospitals as compared to 9 hospitals within the same health system, located in Louisiana, which did not enact tort reforms.¹⁸ According to the authors, a medical liability claim was any legal claim brought against the hospital by a patient.

In Texas, after tort reforms were enacted in 2003, the average number of medical liability claims per quarter dropped from 7.27 to 1.4.¹⁸ However, these authors found that medical liability claims in Texas rose to the level of 7.2 from a level of 3.0 in the five quarters before tort reform was enacted in 2003. Further, according to these authors, improvements in quality measures which were passed in Louisiana also resulted in a significant reduction in medical liability claims. The patient receiving antibiotic within 4 hours of admission had the most significant impact on liability claim rates with a negative correlation coefficient of -0.445.¹⁸

Discussion

It has long been a political assumption that medical malpractice liability tort reforms would lead to decreased liability insurance premiums, higher supply of physicians, and an overall decrease in the cost of medicine. As a result, medical malpractice reforms have been a prevalent political issue for nearly 30 years. In this time, little has been written or said about the human cost or fairness of such reforms as applied to aggrieved patients. This research review has suggested that while direct tort reforms such as aggressive caps on noneconomic damages have lowered medical malpractice insurance costs, and increased physician supply in some areas and for some specialties, these reforms have not succeeded in reducing the overall cost of healthcare. As such, the hypothesis of this study has been proven to be only partly correct insofar as applied to the total cost of healthcare spending. Further, reforms have had a minimal impact on a physician's subjective fear of malpractice litigation, particularly less experienced physicians. Defensive medicine practices have been driven by the fear of malpractice litigation, and this has not been shown to respond to reforms.

The totality of research has called into question the efficacy of direct medical malpractice tort reforms. While these reforms have provided physicians with more predictability and lowered insurance premiums, it has not been significantly increased nationwide physician supply or lowered the overall cost of medicine. Further, evidence has demonstrated that quality reform measures have been just as effective at reducing instances of medical malpractice claims as tort reforms. As such, there is a strong argument to be made that the conventional thinking regarding medical malpractice reform of the past 30 years should shift to focus more on quality and less on restricting the legal rights and options of potential plaintiffs.

If noneconomic damage caps are going to be instituted, the evidence suggested that more modest caps such as \$500,000 caps have not had any effect on malpractice liability. Only more

aggressive caps at the \$250,000 level have been found to affect. Further, evidence has regularly shown that less experienced physicians had a more significant fear of malpractice, which tends to suggest that physicians education could place a significant role in decreasing defensive medicine practices by reducing the fear of malpractice claims.

This topic continues to have enormous practical applications for the entire U.S. healthcare industry. As healthcare costs continue to rise, the issue of lowering the costs of medicine has continued to be a political topic. Despite past tort reforms, the problem of reducing healthcare costs persists. Defensive medicine practices have been detrimental to efficiency and best practice, and thus if previous reforms have not changed these practices, new improvements should be considered. Per the In-House Interview, defensive medicine practices have led to an over-reliance on outside referral, which has made it difficult to provide quality care in rural areas with fewer specialists. Further, less experienced providers have been more susceptible to malpractice fears, and this has led to overutilization among less experienced providers. It is enormously important that the healthcare industry institute effective reforms based on evidence. The stated goals of tort reforms have been to increase physician supply, lower malpractice insurance premiums, and lower the cost of healthcare. However, all malpractice reforms naturally come at the expense of the legal rights and options of potential plaintiffs. As such, like with all of healthcare, it is time to begin re-imagining what is efficient with liability reforms. Given the modest effect that tort reforms have had through the years, medical liability likely needs to continue the trend present in all of healthcare and begin examining increased quality measures as a means of lowering the costs associated with malpractice claims.

This study was limited in that the only included primary research into the effect of medical malpractice liability tort reforms was a single survey interview with an in-house counsel

of a healthcare organization. Further, this topic continues to be timely, which means that new data has been produced all the time. Also, this study was limited by the bias of the researchers, bias of the available publications, limitations of the chosen research strategy, and the number of databases utilized for the secondary research.

Conclusion

Medical malpractice tort reforms have been a prominent political topic for over 30 years. Reforms have focused mainly on non-economic damage caps and procedural changes. However, despite these reforms, defensive medicine practices persist. Healthcare costs continue to be alarmingly high due to overutilization and inefficiency. Given the inability of successful improvements to solve the problems partly attributed to malpractice litigation, it is the time that the U.S. consider new and innovative medical malpractice tort reforms to provide predictability to providers and rein in costs and inefficiencies.

Table 1 – Changes in Physician Supply in Response to Reforms by Specialty/Experience

Physician Groups	Direct Reforms vs. No Reforms	Direct Reforms vs. No Reforms >20 Years of Experience	Indirect Reforms vs. No Reforms	Indirect Reforms vs. No Reforms >20 Years of Experience	Direct and Indirect Reforms vs. No Reforms	Direct and Indirect Reforms vs. No Reforms >20 Years of Experience
All	8.2	18.7	-3.4	13.6	9.6	21.4
Emergency	7.3	46.7	-19.7	110.7	-2	70.6
OB/GYN	1.6	9.7	-6.9	6.5	2.3	7.7
Anesthesiology	5.9	14.7	-7.4	14.3	12.3	21
Radiology	6.5	11.3	-1.6	10.1	11.1	20
Surgery	0	5.9	-0.7	4.3	2.2	6.9

Adapted from: Kessler et al, 2005 Kessler, D. P., Sage, W. M., & Becker, D. J. (2005)¹².

APPENDIX A

Questions asked in a Semi-Structured interview of an In-House Legal Counsel of a Healthcare Organization.

1. Is your office concerned about the practice of defensive medicine?
2. If yes, why?
3. What is your sense of how many extra medical services, on average, physicians are providing to ensure that patients will not later seek legal action for damages as a result of care rendered at your facility?
4. What physician practice groups or departments are particularly concerned with the threat of medical malpractice litigation if any? Why those departments?
5. Does your organization hold or offer any sort of training or education regarding medical malpractice issues and avoidance? Why or why not?
6. How many physicians does your organization employ? Out of these physicians, what percentage have had a claim brought against them for medical malpractice in the past five years?
7. What is your opinion of the 2003 changes to the West Virginia Medical Professional Liability Act which lowered the cap on noneconomic damages for most medical malpractice claims to \$250,000?
8. What is your opinion of the 2003 changes to the West Virginia Medical Professional Liability Act which eliminated joint and several liabilities as applied to medical malpractice cases in this state?

9. Has your organization experienced difficulty recruiting any class of physician due to the medical liability climate in West Virginia? Why or why not?

10 If so, which specialties? Why those particular specialties?

Medical malpractice insurance Had premiums risen or fallen over the last ten years? Five years?

Why or why not?

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