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SOLUTIONS: Malpractice litigation in U.S. health care reform

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We've just finished the third malpractice crisis of the past 35 years, and the script is always the same. Physicians complain that high malpractice premiums make health care too expensive or unavailable at any price. Plaintiffs' lawyers respond that the problem is that physicians are routinely committing malpractice and getting away with it.

Lobbyists appear, campaign contributions are made, op-eds are published and hearings are held. Both sides offer tragic anecdotes supporting their respective positions. Empirical research is ignored, quoted out of context, or dismissed because it dates to previous malpractice crises. The only thing physicians and lawyers agree on is that malpractice insurers are price-gouging.

Physicians insist caps on noneconomic damages will cure the malpractice crisis. Lawyers insist caps are unfair and discriminate against women and the elderly. Some states will adopt caps, and others will not. When premiums decline, physicians in the states that adopted caps will claim that caps are responsible. Lawyers in states that didn't adopt caps will claim the same thing. As premiums decline, the debate will die down and the combatants will demobilize — only to begin the process again at the next opportunity.

What do we have to show for all this effort? Thirty-one states have a cap on noneconomic damages or total damages, or both. The rest probably won't adopt a cap voluntarily, and there is no prospect of a federal cap as long as Democrats control Congress.

A more fundamental problem is that damages caps don't do much to improve the quality of care that is being delivered. There is plenty of evidence that the quality of American health care isn't what it should be — but providers receive the benefits of a damages cap whether they have made great effort or no effort to improve the quality of services they are providing.

If we want to actually improve the quality of American health care and help ensure that we obtain value for the roughly $2.5 trillion per year we are spending, we should take five concrete steps.

First, if caps are politically inevitable, we should use them to encourage providers to improve the quality of care they provide. One obvious strategy is to reward providers for error reporting and punish them for hiding mistakes.

When a provider reports an error within a specified time of its occurrence, they should receive the protection of a limit on noneconomic damages. When a provider fails to report an error in a timely manner, noneconomic damages should be enhanced. One could use a similar strategy to reward providers who improve their performance on certain defined quality benchmarks. A second (and lower) cap on noneconomic damages would help ensure that error reports are used to improve quality, instead of being filed away.

Second, we should do more to ensure that physicians who practice high-quality, cost-effective medicine are not subjected to the tender mercies of the tort system. Although there are obvious difficulties associated with the development of consensus evidence-based standards, physicians who adhere to those standards should be absolutely immune from suit. There is no reason to devote legal resources to cases where the treatment meets professional standards.

Third, we should use financial incentives to encourage providers to practice high-quality, error-free medicine. The highest priority should be given to arrangements that enhance providers' incentives by tying their compensation to measurable improvements in outcomes and that enable patients to effectively distinguish between superior and inferior providers.

Medicare and private payers have already taken steps in this direction, and those efforts should be encouraged and expanded. If we use the payment system to reward physicians who deliver high-quality, error-free care, we will lower the incidence of malpractice.

Fourth, a relatively small fraction of all physicians appear to account for a disproportionate share of malpractice claims, settlements and judgments. Targeting reform efforts against those who are most responsible for the problem is an efficient use of limited resources.

State licensing boards and the hospitals at which repeat defendants have privileges should be required to conduct prospective quality audits, publicize the results of those audits and report them to the National Practitioner Data Bank. Even if the audits do not result in any disciplinary action or limitation of privileges, the act of publicizing the quality audits should create

considerable incentives for repeat defendant physicians to correct their deficiencies or find another line of work.

Finally, we should allow malpractice premiums to rise when the next malpractice crisis hits. Providers are rational. When injuring patients becomes more expensive than not injuring them, providers will stop injuring patients. Lowering malpractice premiums through tort reform eliminates this incentive without substituting anything. Litigation rates and premiums will fall on their own when providers improve the quality of care.

As Dr. Donald J. Palmisano, the past president of the American Medical Association, aptly observed, fewer errors "will reduce the number of lawsuits against physicians," since an uninjured patient is far less likely to become a plaintiff.

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