

Frank Sloan: Reforming Malpractice Liability to Improve Health Care

In 1999, the Institute of Medicine (IOM) rocked the medical establishment with a report concluding that tens of thousands of hospital patients die each year as result of preventable medical errors.

Among the many issues raised in the ensuing blitz of press conferences, congressional hearings, journal articles, blue-ribbon panels, and follow-up analyses, one was conspicuously absent: the potential role for medical malpractice liability to improve health care by reducing medical errors.

The reason? In the American health care system, malpractice liability is such a toxic topic that it defies any attempt at rational discussion, according to Frank A. Sloan, a national expert on medical malpractice liability and the J. Alexander McMahon Professor of Health Policy and Management and Professor of Economics at Duke University.

“Most people who are pushing for health care quality simply don’t want the albatross of medical malpractice hanging around their neck,” says Sloan. “I think the issues go hand in hand. But the minute you bring up malpractice, you lose a large part of your audience.”

With Lindsey M. Chepke, a lawyer and research associate at Duke’s Center for Health Policy, Sloan has co-authored *Medical Malpractice*, an insightful analysis of the issues surrounding malpractice in the United States and how they can be addressed. Sloan’s work was supported by a Robert Wood Johnson Foundation Investigator Award in Health Policy Research.

Even the recent national debate on health care reform largely ignored malpractice liability. Although there may be discussions of limiting a patient’s right to sue or talk of capping damage awards, almost nowhere is there even an acknowledgement that, if properly applied, holding doctors and hospitals legally accountable for negligence *might* help to improve health care, Sloan notes.

He believes that health care professionals and policymakers are missing a major opportunity to substantially reduce the costly premiums and expensive claims settlements that have made malpractice liability reform the third rail of the health care quality discussion. “So far all we have done is try to treat some of the symptoms,” he says. “It’s time to start dealing with the disease.”

Everything We Know is Wrong

Sloan argues that hospitals and physicians should consider joining forces to embrace reforms that could simultaneously lead to meaningful reductions in medical errors, malpractice premiums, and lawsuits. But first, he says, everyone involved—physicians, lawyers, patient advocates, and policy makers—must understand: Almost everything said about malpractice in the furious debates surrounding the issue is either misleading or flat-out wrong.

“There is a lot of false advertising out there about the problems caused by malpractice liability and its influence on physician quality,” Sloan contends.

Take, for example, the virtually unquestioned assertion that malpractice liability is a major contributor to exorbitant health care expenses. According to this view, a barrage of mostly frivolous lawsuits is burdening the system with wildly inflated insurance premiums, multi-million-dollar damage awards from “runaway juries,” and billions of dollars in “defensive medicine”—unnecessary tests or treatment that physicians routinely pursue in order to avoid lawsuits.

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But Sloan notes that decades of study paint a far different picture. Research has shown that malpractice-related costs account for a very small percentage of America’s health care spending. For example, the U.S. Congressional Budget Office (CBO) issued an analysis estimating that, in 2009, the costs of malpractice liability, premiums, settlements, and awards amounted to about \$35 billion, “or about 2 percent of total health care expenditures.”

As for defensive medicine—the other major cost often assigned to malpractice liability—Sloan says that “one person’s defensive medicine is another’s quality of care.” Case in point: Cesarean sections, the most widely cited form of defensive medicine. Several studies have found that the threat of a lawsuit had little to no effect on the choice to do a C-section versus a regular vaginal birth. One study that looked at births nationwide from 1990 to 1992 found that a \$10,000 reduction in malpractice premiums had no effect on the C-section rate for women in the highest socio-economic class.

“Some groups claim that defensive medicine alone costs society \$100 billion a year,” Sloan said. “But I bet they would retreat from those claims if you offered to pass all the caps on liability claims they wanted in exchange for lowering physician reimbursements by the amount they say is spent on defensive medicine.”

But Sloan also takes issue with the argument that malpractice liability as currently applied has a positive effect by prodding health care providers to be more careful and by weeding out the bad doctors. There is no empirical evidence, he says, that the threat of a lawsuit deters medical injuries; nor is there evidence that chiefly bad doctors get sued. This lack of impact, he adds, amounts to a fairly damning indictment of a system whose key function is to deter misconduct.

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The Rise and Fall and Rise of Malpractice Crises

Yet Sloan acknowledges that physicians are not dreaming when they periodically complain of rapidly rising premiums, especially in some specialties. In the main, studies show that long-term increases are not as dramatic as suggested, although they can be sharp for specialties like obstetrics and surgery. In addition, year-to-year increases in premiums are sometimes very substantial. Historically, most of the increased premium costs generally have been passed on to patients and insurers in the form of higher fees, but with fees negotiated with payers, this is becoming much harder to do.

Premium spikes can be destabilizing, but they are not caused by comparable rises in claims and high damage awards, as many contend. Instead, the evidence points to cycles in the insurance market in which external forces often quite unrelated to health care cause sudden shifts in the cost and availability of malpractice insurance.

For example, rising interest rates or natural disasters that rock the entire insurance industry can prompt companies to raise premiums for many forms of liability insurance, not just medical malpractice. There also have been periods in which industry competition has provoked price wars that under-price malpractice insurance. These periods are then followed by malpractice insurance “crises” as some companies that failed to charge enough for their policies drop out of the market and others try to recoup their losses.

Most politicians respond to such crises by seeking to enact caps on damage awards. Although these actions may seem effective, in fact “they do nothing to affect cycles in the insurance market, nor do they offer anything to patients or taxpayers,” Sloan says. “But they are becoming increasingly popular as constraints on health spending make it harder for doctors to pass on the rising cost of malpractice premiums in the form of higher fees.”

Particularly troubling to Sloan is that what currently passes as malpractice reform—capping damage awards—measures success almost exclusively in terms of reduced lawsuits and lower pay-outs to patients. Little thought is given, he says, to considering that some claims might actually merit a lawsuit and that some forms of negligence might warrant a high award. Instead, the implication is that almost nothing good can be expected from subjecting physicians to liability.

“It’s really hard to convince physicians, and, increasingly, politicians as well, that medical malpractice might have a constructive role to play in health care,” he notes.

Hospitalizing Physicians: The Benefits of Enterprise Insurance

Sloan believes there is a way for malpractice liability to be a force for good in health care: Embrace a system in which hospitals cover physicians for any claims that result from care delivered in their facilities. In exchange, physicians agree to work with hospitals to implement patient safety measures that are known to improve patient care and reduce medical errors.

Many large medical centers, including Duke University Health System (DUHS), where Sloan teaches, have adopted this approach, known as “enterprise insurance,” in which the hospital essentially creates its own insurance company. For example, DUHS established an insurance subsidiary, the Durham Casualty Company, that provides malpractice liability insurance to DUHS hospitals and to many physicians who practice in its facilities. It also implemented a number of patient safety initiatives whose many objectives included reducing the hospital’s risk of incurring malpractice lawsuits. By acting as the insurance provider, the hospital is not only directly responsible for malpractice costs, it also reaps the financial rewards that come from reducing its risk of being sued.

Even if the hospital ends up paying for a medical malpractice claim, it is in a better position than a conventional insurance provider to assess whether the situation warrants a broad increase in premiums, he adds. In addition, with hospitals as the insurer, health care providers are no longer exposed to the price cycles in the insurance industry that are unrelated to quality of care or risk of lawsuit.

Sloan acknowledges that physicians may balk at accepting enterprise insurance because it requires closer relationships with hospitals. But the choice, he says, is pretty straightforward: “Do you want to continue to pay higher premiums or do you want to lower premiums and, in exchange, agree to work with hospitals to avoid bad outcomes for patients?”

There are some barriers to widespread adoption of enterprise insurance. Some hospitals may not be large enough to operate their own insurance plans, but Sloan notes that they could solve that problem by forming regional partnerships or creating their own subsidiaries.

Then there are the costs of implementing patient safety measures that don’t always have an immediate or obvious financial payoff. In addition, it is possible that the costs frequently associated with medical malpractice liability are so over-inflated that measures to reduce real risk will appear to have a low pay-back.

“If there was a clear and strong financial case to be made beyond reducing premiums for physicians, then you would see a lot more of this,” he says. Nonetheless, as Sloan and Chepke assert in their book, “just because enterprise insurance is not likely to be the silver bullet does not imply that it is a B.B. gun.”

There are other positive changes that can be implemented. For example, no-fault insurance has several attractive features relative to tort, in particular low administrative expense and speedier payment. However, rather than replace tort with universal no-fault, Sloan and Chepke propose that states enact legislation enabling hospitals to offer no-fault as a substitute

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About the Investigator

Frank Sloan is the J. Alexander McMahon Professor of Health Policy and Management and Professor of Economics at Duke University, a position he has held since 1993. He is also the director of Duke's Center for Health Policy, Law and Management.



Professor Sloan did his undergraduate work at Oberlin College and received his Ph.D. in economics from Harvard University. Before joining the faculty at Duke in July 1993, he was a research economist at the RAND Corporation and served on the faculties of the University of Florida and Vanderbilt University. He was chair of the Department of Economics at Vanderbilt from 1986 to 1989.

Professor Sloan's current research interests include alcohol use prevention, long-term care, medical malpractice, and cost-effectiveness analyses of medical technologies. He also has a long-standing interest in hospitals, health care financing, and health manpower.

He has served on several national advisory public and private groups. He is a member of the Institute of Medicine of the National Academy of Sciences and president elect of the American Society of Health Economists. He was recently a member of the Physician Payment Review Commission.

for tort on a voluntary basis. Patients would be offered the option of a no-fault policy at the time of admission. If they selected no-fault, this would be the compensation mechanism in the event of an adverse outcome.

Sloan believes that the myths surrounding malpractice liability eventually will be revealed for what they are. Meanwhile, he says, "it is important that we start looking at malpractice liability not just as something that should be limited, but something that should be reformed in ways that improve health care quality and patient safety, and start considering how liability can become a positive force for what it was originally intended to do, which is to improve the quality of health care in the U.S."

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