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UNDERSTANDING THE FIRST MALPRACTICE CRISIS OF THE 21ST CENTURY

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Professional liability insurance crises in medicine have been intermittent, reaching magnitudes sufficient to generate widespread concern only in the mid-1970s, the mid-1980s, and 2002-2003. It is easy for health policymakers and the public to view each crisis as an upswing of the same pendulum. Malpractice premiums rise, doctors accuse lawyers, lawyers point back at doctors, and legislatures debate tort reform in arcane and repetitive terms (“collateral source offsets,” “non-economic damage caps,” etc.). This experience of *déjà vu*, however, is misleading. The current crisis is not simply a reprise of events in the 1970s or 1980s.

The principal difference this time around is that malpractice liability is clearly connected to overall health policy. In prior decades, any effect of malpractice on the fundamental policy problems of cost, access, and quality seemingly came from outside the health care system. According to conventional wisdom in the medical community, lawsuits reflected patient opportunism and lawyer entrepreneurship. The prevalence of medical errors was considered low, and injured patients were thought to have adequate recourse. The effect of litigation on quality was believed minimal, even paradoxical if physicians provided services with no clinical benefit in order to protect themselves from liability (“defensive medicine”). Moreover, malpractice claims were as much a personal as an economic affront to physicians -- liability insurance was not experience-rated and even steep increases in its cost could be passed through as higher medical fees to health insurers and ultimately absorbed by patients and taxpayers.¹ Consequently, as long as malpractice insurance was available in some form (to protect physicians’ personal assets), health care providers remained in business notwithstanding

¹ Patricia M. Danzon, Mark V. Pauly, and Raynard S. Kington, “The Effects of Malpractice Litigation on Physicians’ Fees and Incomes,” *AEA Papers and Proceedings* 1990; 80(2): 122-127; see also William M. Sage, Reputation, Malpractice Liability, and Medical Error, in *Promoting Patient Safety: An Ethical Basis for Policy Reform* (Virginia A. Sharpe, ed.), Washington, DC: Georgetown University Press; 2003.

premium spikes.

The terms of health care financing and delivery have changed dramatically since the 1980s, however, and many of these suppositions have been challenged and even refuted.² Therefore, it becomes necessary to articulate with precision the public policy problems posed in the current crisis before jumping to conclusions about the desirability of particular reforms. This article identifies and discusses four key areas in which changes to the health care system have altered both the “malpractice problem” and its range of potential solutions: patient safety, medical progress, industrialization, and cost-containment. From this perspective, the current liability crisis is largely a product of modern medicine’s tremendous success in treating disease, success has outstripped the structural and financial framework of medical liability. Once one appreciates the impact of health system change, moreover, the inadequacy of the political debate as it is evolving in state capitals and Washington, DC becomes apparent. Fixated as they are on re-fighting ancient battles over caps on malpractice awards, the principal stakeholders have blinded both themselves and the public to a straightforward question: Is a 30 year-old nostrum (California’s 1975 MICRA law) likely to be the best cure for what ails the health care system in

² Malpractice reform also rests on imperfect information. Malpractice is an emotional issue for health care providers, so preconceptions run deep. Empirical data about the malpractice system is relatively abundant, but not current. Because malpractice research is commissioned mainly during insurance crises, studies available today reflect the health care system and malpractice system of 15 or 25 years ago. Work currently under way will for the most part be completed only after policy makers take initial action. One must therefore extrapolate from existing information based on an understanding of how the present differs from the past.

In addition, there are few benchmarks for a properly functioning health care system. To understand whether tort liability compromises physicians’ practice choices and clinical decisions, imposes excessive costs on patients and providers, or drives doctors and hospitals out of business, one must be able to state with reasonable confidence the socially optimal numbers of doctors and hospitals, their specialty and geographic distributions, utilization rates for services, error rates, styles of practice, and forms of practice organization. Without this information, even timely, well-executed research can measure the effect of reform on various health system characteristics but cannot reach definitive conclusions about its desirability.

2003?

Patient Safety

The emerging science of patient safety is a sensible starting point for understanding how health system change influences the malpractice problem. Its central premise is that modern medicine has outgrown its traditional methods of quality control. The Institute of Medicine's landmark 1999 report, *To Err is Human*, was unsurprising to the researchers and advocates who had been studying patient safety.³ By bringing the extent and nature of medical error into general knowledge, it nonetheless changed the rhetoric and the substance of the malpractice debate. However, the connection between malpractice liability and patient safety has been interpreted very differently by the medical profession, policymakers, trial lawyers, and the public.

Patient safety passed seamlessly into the rhetoric of malpractice politics. The medical profession by and large heard a single message from the IOM: that exposed, "punitive" approaches to error detection and correction are inferior to confidential, cooperative efforts from within an expert community.⁴ Because physicians regard malpractice litigation as the epitome of punitive, they viewed the IOM report as further evidence that liability should be curtailed. Reasoning that physicians' fear of lawsuits prevented them from owning up to mistakes and working to improve quality, they ignored the historical irony that the profession's longstanding argument against tort liability had been that medical errors are few, with litigation resulting

³ Institute of Medicine, *To Err is Human: Building a Safe Health System* (eds. Linda T. Kohn, Janet M. Corrigan, and Molla S. Donaldson), Washington, DC: National Academy Press; 1999.

⁴ See Bryan A. Liang, The Adverse Event of Unaddressed Medical Error: Identifying and Filling the Holes in the Health-care and Legal Systems, *Journal of Law, Medicine & Ethics* 2001; 29(3&4): 346-368.

mainly from rabble-rousing by unscrupulous lawyers and expert witnesses.⁵ Even confronted with irrefutable evidence that errors are widespread, physicians remain convinced that malpractice liability has no legitimate role to play in quality improvement. The political voice of the profession, with the active support of liability insurers, therefore added patient safety to their list of arguments favoring MICRA-style tort reform.

In reaching these conclusions, however, physicians paid little attention to the policy context of the IOM's report. Consider MICRA's centerpiece, a flat cap on non-economic damages in malpractice cases against health care providers. It may indeed be desirable to set a ceiling on malpractice recoveries, but the level, flexibility, and scope of a cap should be designed to solve specific, clearly articulated problems. A flat cap has as its principal goal reducing the cost and volatility of class-rated physician liability insurance. A limit of \$250,000 (MICRA's cap was not indexed to inflation, and currently equals about \$75,000 in 1975 dollars) is a reasonable solution only if the problem is rapid premium growth from meritless claims and overcompensated losses. The IOM report identifies other problems: that serious, avoidable errors occur frequently but remain undetected, that most victims receive no compensation, and that health care systems rarely learn from their mistakes.⁶ Decreasing malpractice insurance premiums without reducing avoidable errors transfers money from injured patients to medical providers but does not save social resources. In fact, the IOM report explicitly recognized that systematic safety improvement is more compatible with strict liability than with no liability – a finding clearly at odds with reforms aimed at restricting lawsuits and limiting damages.

For plaintiff's lawyers, the IOM's report seemed mainly to confirm their belief in their

⁵ Louis J. Regan, *Medicine and the Law*, *New England Journal of Medicine* 1954; 250: 463.

⁶ See William M. Sage, *Medical Liability and Patient Safety*, *Health Affairs* 2003; 22(): ____ - ____.

own usefulness. Exercises in crafting public policy – the IOM’s *raison d’être* – were uninteresting to the trial bar and possibly threatening. One explanation is that the idea of a “better” liability system that offered fair compensation to more injured patients smacked uncomfortably of utilitarianism and conflicted with a deeply held belief in lawyers and juries as defenders of individual rights. (This resistance to social engineering among lawyers representing individual plaintiffs, it is interesting to note, differs strikingly from the “we-can-do-what-Congress-won’t” attitude that is the mantra of class action lawyers battling the tobacco companies and, currently, managed care). Lobbyists for the trial bar therefore countered physicians’ call for tort reform with the obvious point that patients need lawyers more rather than less if malpractice is rampant, but otherwise continued their conventional strategy of deflecting or delaying tort reform rather than seeking to make liability play a greater role in medical quality at the system level.

Where did this leave the public? Alerted, but also confused and to some extent ignored. Alerted because, compared to physicians, the public considers the safety revelations of the IOM report a serious problem.⁷ Indeed, this heightened awareness of errors may have prompted more suits by patients and probably has made jurors more receptive to allegations of malpractice. However, the public is confused by what it perceives as the IOM’s attempt to shelter physicians from individual accountability by focusing attention on improving systems. The public believes that most errors are committed by bad doctors who should not be practicing, rather than by decent doctors who practice under suboptimal conditions. The public also feels ignored for two reasons. First, the IOM’s focus on confidential reporting takes insufficient notice of injured

⁷ Robert J. Blendon et al., *Views of Practicing Physicians and the Public on Medical Error*, *New England Journal of Medicine* 2002; 347(24): 1933-1940; Andrew R. Robinson et al., *Physician and Public Opinions on Quality of Health Care and the Problem of Medical Errors*, *Archives of*

patients' thirst for information, which often leads to litigation if previously attentive physicians become uncommunicative when treatment fails.⁸ Second, many of the patient safety innovators lauded by the IOM report are professional systems engineers – in essence, expert consultants – while patients themselves value compassion as well as technical excellence.

Medical Progress

In many ways, malpractice lawsuits show medicine to be a victim of its own success. In a recent speech, President George W. Bush suggested that "frivolous and junk lawsuits" are a major primary cause of rapidly rising health care costs: "The problem of those unnecessary costs isn't in the waiting room, or the operating room -- they're in the courtroom."⁹ The President got it backwards, confusing cause with effect. Litigation costs are high because health care spending has increased. More than any single factor, malpractice expense tracks overall health care spending as technology improves, expectations rise, sources of avoidable error proliferate, and the costs of caring for those who suffer harm grow.¹⁰ In 1996 dollars, national expenditures on health care rose from \$251 billion (7% of GDP) in 1970 to \$1.3 trillion (13.2% of GDP) in 2000 – a 520% increase.¹¹ Malpractice liability premiums and self-funded reserves increased from \$1

Internal Medicine 2002; 162: 2186-2190.

⁸ See Charles Vincent et al., Why Do People Sue Doctors? A Study of Patients and Relatives Taking Legal Action, *Lancet* 1994; 343(8913): 1609-1613; Gerald V. Hickson et al., Patient Complaints and Malpractice Risk, *JAMA* 2002; 287(22): 2951-2957.

⁹ Speech in Scranton, Pennsylvania, Jan. 16, 2002, available at <http://www.whitehouse.gov/news/releases/2003/01/20030116-1.html> (accessed Jan. 27, 2003).

¹⁰ For an historical perspective, see Kenneth A. De Ville, *Medical Malpractice in Nineteenth-Century America: Origins and Legacy*, New York: NYU Press; 1990; James C. Mohr, American Medical Malpractice Litigation in Historical Perspective, *JAMA* 2000; 283: 1731-1737.

¹¹ Katharine Levit et al., Inflation Spurs Health Spending in 2000, *Health Affairs* 2002; 21(1): 172-181.

billion in 1976 to roughly \$5.2 billion in 1999 – a 505% increase.¹² The periodic nature of liability insurance crises tends to mask the inexorability of this underlying trend.

The distribution of health care spending has also changed markedly, with two effects being central to the interpretation of the medical liability crisis. First, physician fees are much a less important driver of health care expenditure growth now than thirty years ago, with pharmaceuticals, hospital care, and other services playing a proportionately larger role. It is well known that physicians account for only about 15% of health care spending, although they control roughly 70% through their “ordering” and referral decisions. Because legal fault under malpractice law is based on professional control, however, physicians’ liability insurance must protect against exposure that is a substantial multiple of professional income, and that has increased greatly in absolute dollars.

Second, the percentage of health care paid through health insurance grew rapidly between 1950 and 1980. Consequently, health insurance reimbursement determines the ability of health care providers to absorb the financial shocks of rapidly increasing liability premiums at times of crisis. Significantly, because of “insurance cycles,” crisis years tend to coincide with economic downturns, periods in which health care payers – who have also become much more cost-conscious since 1980 -- are less likely to increase reimbursement rates.

Medical progress drives liability in several ways.¹³ Foremost, improvements in the clinical

¹² U.S. Department of Health and Human Services, *Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs By Fixing Our Medical Liability System*, July 24, 2002, available at <http://aspe.hhs.gov/daltcp/reports/litrefm.pdf> (accessed Jan. 27, 2003).

¹³ See Mark F. Grady, *Why Are People Negligent: Technology, Nondurable Precautions, and the Medical Malpractice Explosion*, *Northwestern University Law Review* 1988; 82: 293-334 (“Negligence law is fundamentally a creature of technology.

capabilities of medicine increase expectations of success, redefine success upwards, and foster the belief that failure is the result of negligence rather than misfortune. The first wave of malpractice suits in the late 19th century, involving nonunion of limb fractures, arose only because medical science had developed an alternative to amputation.¹⁴ Malpractice litigation has become as specialized as the medical care it attacks. The current edition of a leading treatise on malpractice lists over five hundred medical conditions or treatments in 34 specialties in its section on “illustrative awards.”¹⁵

In recent decades, claims based on failure to detect disease have become much more common because formerly untreatable, progressive conditions can be arrested or cured.¹⁶ In particular, dramatic advances in cancer care have made even brief delays in initiating care actionable, with more states also adopting “loss of a chance” standards for legal causation and damages.¹⁷ Even

¹⁴ E.g., *Kendall v. Brown*, 86 Ill. 387 (1877); *Holtzman v. Hoy*, 19 Ill App. 459 (1886); *Whitesell v. Hill*, 101 Iowa 629 (1897); *Jameson v. Weld*, 93 Me. 345 (1899); see also *Mohr*, *supra*, at 1733.

¹⁵ *Medical Malpractice*, New York: Matthew Bender; 1986.

¹⁶ For a dramatic comparison, consider *Langford v. Jones*, 18 Ore. 307 (1890). In *Langford*, the physician defendant had ruptured the fetal sac and caused fetal death in the course of treating a vaginal tumor because he did not realize that the plaintiff was pregnant. The appeals court reversed a jury verdict for the plaintiff and remanded with instructions to dismiss the case, observing: “In view of the character of the respondent’s sickness when she applied to the appellant for treatment, what earthly reason could he have had, after learning the history of her case, for surmising that she might be pregnant?” *Id.* at 315.

¹⁷ In *Bromme v. Pavitt*, 5 Cal. App. 4th 1487 (Cal. App. 1992), the decedent had reported symptoms of colon cancer to his physician in June 1980, but a diagnosis was not made until June 1981, and surgery was not performed until January 1982. The court held that the plaintiff could not prove that the one-year delay was a substantial factor in the causing death because the chance of survival in June 1981 was less than 50%. The court also heard testimony that the later delay in performing surgery had not affected the patient’s prognosis.

In an even earlier case, treatment of the plaintiff’s lymphosarcoma (lymphoma) was delayed for several months because her internist did not correctly diagnose neck swelling as cancerous. The jury found for the defendant based on testimony that the delay did not affect the patient’s prognosis. Even then, however, the appeals court ordered a new trial, stating: “We observe testimony ... which, if believed, would support the inference that it is a reasonable medical probability that the plaintiff would have been benefited [from prompt treatment], i.e., by possible lengthening of her life and/or her personal comfort -- even if no cure would have resulted from

when improved clinical knowledge allows patients to be rescued at advanced stages of cancer, differences in side effects between early and late treatment may give rise to claims.¹⁸ Medical progress that increases longevity, and prolongs one's ability to work, makes the elderly into viable plaintiffs who can recover substantial damages. Preserving life following iatrogenic injury also converts relatively simple wrongful death claims into composite damage calculations that add the future cost of medical care and prospective pain and suffering to amounts awarded for past injury.¹⁹ At the same time, the greater cost of undergoing treatment for complications and resulting disability, unless covered by public or private health insurance, forces injured patients to find sources of payment.²⁰ Finally, beginning with the earliest radiographs,

more prompt diagnosis and treatment.” *Cullum v. Seifer*, 1 Cal. App. 3d 20, 28 (Cal. Ct. App. 1969).

¹⁸ For example, a \$767,000 judgment for the plaintiff was reported in a case involving several months delay in diagnosing nasopharyngeal cancer. The plaintiff contended that the delay required him to be treated with chemotherapy, with severe and disabling side effects, rather than radiation. *Toarina v. Murray*, No. MON-L-5665-95 (Monmouth Co., Freehold, N.J., Super. Ct. 2001), Matthew Bender, *Medical Malpractice* 40-155.

In another case, a 39 year-old man was awarded nearly \$12 million dollars, including \$5 million for future physical pain, mental anguish, and physical impairment, in a case involving a year-long delay in diagnosing testicular cancer. The cancer spread to the lung and required chemotherapy, with toxic complications including kidney damage and neuropathy. Significantly, the patient survived the cancer and was in remission at the time of the trial. The medical expense component of the award was \$300,000. *Davidson v. Faus*, No. 99CV0256 (Galveston Co., Texas., 122nd Dist 2000), Matthew Bender, *Medical Malpractice* 40-156-57.

In *Judy v. Grant County Health Dept.*, 557 S.E.2d 340 (W.Va. 2001), the West Virginia Supreme Court upheld a jury verdict in favor of a woman who experienced a 9-month delay in diagnosing a palpable lump in her breast as cancerous. Experts for the plaintiff had testified that, had the cancer been diagnosed initially, she could have been treated by lumpectomy and radiation rather than mastectomy and chemotherapy.

¹⁹ Cf. Charles I Jones, *Why Have Health Expenditures as a Share of GDP Risen So Much?*, National Bureau of Economic Research Working Paper No. 9325, Nov. 2002 (“Medical advances allow diseases to be cured today, at a cost, that could not be cured at any price in the past”).

²⁰ In *Koehler v. Neighbors*, 751 N.E.2d 149 (Ill. Ct. App. 2001), the court upheld an award of over \$1.8 million against a pediatrician in a case involving undiagnosed bacterial meningitis in a

improvements in diagnostic technology have had dual effects on liability, not only increasing failure-to-diagnose claims, but also providing an evidentiary window on misadventures that would otherwise remain anatomically concealed. Nonunion of fractures dominated malpractice claims in the pre-invasive era of medical diagnosis largely because it was one of the few injuries that plaintiff's lawyers could demonstrate to jurors.

Consider a case involving a premature infant. Thirty years ago, many children born prematurely would not survive, rendering moot any allegation of professional negligence. Modern neonatal intensive care offers near-normal life expectancy, but creates myriad risks of technical failure potentially causing, not death, but lasting disability requiring sustained intensive treatment at extraordinary expense.²¹ This example also highlights two limitations of relying on non-economic damage caps to restore stability to liability insurance markets. First, economic damages remain extremely high – “life-care plans” for children with cerebral palsy or other serious neonatal injuries cost millions or tens of millions of dollars -- and can be unpredictable from the perspective of an insurer estimating future exposure (though less so in terms of settling disputes over injuries that have already occurred).²² Unless social insurance programs finance

9 week-old infant, resulting in mental retardation and severe disability. At trial, the plaintiff's experts estimated the present value of forgone future earning potential at \$1.1 million, and the cost of future residential care at up to \$2.1 million.

²¹ In *Brownsville Pediatric Ass'n v. Reyes*, 68 S.W.2d 184 (Tex. Ct. App. 2002), the court upheld an award of \$8 million in a case involving neurological impairment to a premature newborn. The allegations of negligence involve errors in mechanical ventilation, intubation, exchange transfusion, and other technologically sophisticated procedures not available for similar patients even 25 years ago. The child, who suffers from blindness and spastic paraplegia, was determined to have a life expectancy of 53 years, and was awarded \$6.5 million for future medical expenses, including cutting-edge technology such as an implantable pump to deliver drugs directly to his central nervous system.

²² In *Giventer v. Rementeria*, 705 N.Y.S.2d 863 (Sup. Ct. Richmond Co. 2000), a jury returned a verdict of over \$53 million against an obstetrician, hospital, and neonatologist in a case involving alleged neonatal injuries resulting in severe brain damage. Of this amount, the jury awarded

this cost, private liability insurance markets may still be volatile. Second, the message implicit in minimally compensating survivors for facing a lifetime of suffering is that they are lucky to be alive in the first place. This might be an acceptable attitude in a health care system that socializes its financing and guarantees universal access to a rational package of cost-effective medical care, but it seems incongruent with the U.S. model, which charges private buyers a very high price for a virtually limitless array of plausibly beneficial services.

Industrialization

Technical progress in medicine has been accompanied by equally dramatic organizational changes, although professional control over health care regulation has acted as a brake on industrialization during certain historical periods. Industrialization determines to a considerable degree who gets sued, on what legal theory, and with what kind and degree of exposure.

The most significant industrial changes predate the malpractice insurance crises of the 1970s and 1980s, but their effects continue to be felt. The concentration of medical technology within hospitals in the mid-20th century focused malpractice liability on events occurring in those institutions, while more recent technologic diffusion into outpatient settings has partially reversed the trend. Correspondingly, the geographic distribution of claims shifted as specialization moved clinical encounters into urban and suburban areas where health care providers were less protected from litigation by their social position and personal relationships. Specialist physicians also provided briefer, more goal-oriented services than their generalist counterparts, leading patients to believe that bad outcomes resulted from either inattentiveness or technical incompetence. Large plaintiff verdicts in many large cities can be seen, at least in part,

over \$36 million in economic damages, including \$1.9 million for medical care and equipment, \$2.2 million for therapies, and \$28.7 million for nursing care. The projected life expectancy of the plaintiff was 45 years.

as a product of these changes.

In the 1950s and 1960s, health insurance, particularly Medicare, funded industrial expansion, increased patients' legal and moral entitlement to high-quality services, and provided hospitals with revenues sufficient to insure against tort claims. Courts responded by withdrawing charitable immunity, modifying other tort doctrines so that physicians were no longer the sole source of compensatory damages, and introducing theories of actual authority, ostensible agency, and corporate liability that recognized hospitals' ability to influence the quality of care. Institutional tort law, more than its individual professional counterpart, subjected commercial considerations such as acquisition of specific technologies, staffing decisions, and marketing representations to close scrutiny. Direct claims against pharmaceutical companies, medical device manufacturers, and other suppliers alleging strict liability for defective products multiplied.

Recent changes include the expansion of large, for-profit hospital and nursing home chains, similar consolidation among non-profit health care providers, and the proliferation of contractual affiliations among health professionals, health facilities, and managed care organizations. Managed care itself articulated an activist model of health insurance that, subject to ERISA preemption, exposed insurers to tort theories of direct and vicarious liability that initially had been developed for hospitals. A by-product of consolidation, particularly under a for-profit umbrella, is that previously fragmented activities that lead to avoidable error either become or appear to become systematic. This greatly magnifies liability risk by exposing large corporate organizations to punitive damages in individual cases,²³ as well as to class action or other

²³ David M. Studdert and Troyen A. Brennan, The Problem of Punitive Damages in Lawsuits Against Managed-Care Organizations, *New England Journal of Medicine* 2000; 342: 280-284. For example, a Texas jury awarded \$70 million in punitive damages to the estate of an 83 year-

multiparty litigation.²⁴

The impact of these factors is heightened because the structure of liability coverage has not kept pace with industrial change. In part because of prior crises, the “risk capital” that protects health care providers and compensates injured patients is simultaneously too entrenched and too ephemeral. Primary coverage fragments the health care system into single-state, single-line carriers – mainly physician-mutuals -- each of which serves some types of providers but not others. Excess coverage depends primarily on offshore reinsurers, who have no reason to keep their money in health care whenever other industries seem more profitable. Neither source of coverage offers the health care system an acceptable combination of efficiency and stability. Insurance regulation has also proved less than ideal. In stable periods between crises, political pressure from physicians leads some regulators to approve new primary carriers offering low premiums but marginal solvency. Efforts to create publicly administered programs to offer malpractice coverage have had unintended consequences: freezing in place outdated market practices, complicating resolution of claims, and building large unfunded liabilities. An exception is federal legislation passed in the late 1980s to encourage health care providers to form risk-retention groups, but the current crisis offers the first battlefield test of these alternative insurance arrangements.

Nor has the public sent a consistent message about industrialization through legal change. Tort reforms are enacted intermittently, during insurance crises, while the tendency of both courts and legislatures in the much longer intervening periods of stability has been to expand

old woman who became severely dehydrated, developed extensive pressure ulcers, and died from cardiac arrest, while under the care of a for-profit nursing home. *Holder v. Beverly Enterprises, Inc.*, 95-437 (Rusk Co., Tex., Dist. Ct. 1997), Matthew Bender, *Medical Malpractice* 40-247-48.

²⁴ Clark C. Havighurst, *Consumers Versus Managed Care: The New Class Actions*, *Health Affairs* 2001; 20(4): 8-27; Kathy L. Cerminara, *Taking a Closer Look at the Managed Care Class*

private legal recourse in cases of medical injury.²⁵ Because of the range of corporate and professional actors involved in health care today, reforms from prior decades that limit liability exposure only for some claims or defendants tend to be offset by increases in litigation against others. Suits foreclosed or limited in recovery by laws such as MICRA may be reframed using new legal theories (e.g., elder abuse, unfair business practices, patient dumping, breach of fiduciary duty),²⁶ or directed against unprotected defendants (e.g., product liability, bad faith breach of insurance contract).²⁷ Long-term care provides an example. As more expensive,

Actions: Impact Litigation as an Assist to the Market, *Annals of Health Law* 2002; 11: 1-24.

²⁵ William M. Sage, *Unfinished Business: How Litigation Relates to Health Care Regulation*, *Journal of Health Politics, Policy & Law* 2003; 28: ____-____.

²⁶ In *Delaney v. Baker*, 971 P.2d 986 (Cal. 1999), the California Supreme Court held that reckless neglect, proved by clear and convincing evidence under the state's Elder Abuse and Dependent Adult Civil Protection Act, was not subject to MICRA's limits even though the claims were brought against a nursing home that was otherwise covered by MICRA.

In *Integrated Health Care Services, Inc. v. Lang-Redway*, 2002 Fla. LEXIS 2591 (Fla. 2002), the Florida Supreme Court held that claims brought against nursing homes under Florida's nursing home liability statute were not subject to the presuit requirements of an expert opinion, notice, and a waiting period that Florida law imposes on malpractice suits against health care providers.

²⁷ In *Palmer v. Sharp Rees-Stealy Medical Group, Inc.*, 127 Cal. Rptr. 2d 252 (Cal. App. 2002), the plaintiff sought punitive damages from a medical group acting as utilization review agent for an HMO because it had denied coverage of an expensive prosthesis as not medically necessary. The court held that the medical group was shielded from excessive liability by MICRA as a "health care provider" even when performing utilization review. The HMO itself, however, could be sued without reference to MICRA's limitations.

In *Redfield v. Beverly Health and Rehabilitation Services, Inc.*, 42 S.W.3d 703 (Mo. Ct. App. 2001), the plaintiff was the mother of a ventilator-dependent quadriplegic patient who died shortly after the ventilator failed. She brought a products liability action against the manufacturer of the ventilator and a medical negligence action against nursing home. The appeals court upheld a \$2 million jury award, finding that the designer of the ventilator was not a "health care provider" protected by Missouri's statutory cap on noneconomic damages.

In *Penick v. Christensen*, 912 S.W.2d 276 (Tex. Ct. App. 1995), a patient who underwent hip replacement surgery required subsequent revisions because the prosthesis was not properly joined to the hip. He brought a medical malpractice action against the surgeon, and a products

technologically sophisticated services moved into the nursing home setting, government increased both statutory liability and regulatory oversight. Several states enacted elder abuse and neglect statutes that expanded tort liability, while the Nursing Home Reform Act (part of OBRA '87) redirected regulation toward reviewing individual cases and reinforcing patients' rights, which itself facilitated litigation.²⁸

Large awards attributed to “forum shopping” in malpractice litigation also are a consequence of industrialization. Trial lawyers typically use venue to exploit differences in judge or jury behavior. The incentive for venue shopping has increased as the gap between urban and rural juries has widened in recent years, with the latter remaining more deferential to the judgment of local physicians and hospitals and more modest in their damage calculations. At the same time, there is more opportunity for venue shopping because of the involvement of many health care providers and suppliers in the care of a single patient, the likelihood that some of these providers are corporate organizations with urban headquarters and, most importantly, the acquisition of or contractual affiliation with suburban hospitals and physician practices by large urban health systems.²⁹ In particular, non-profit health systems may not be able to insulate themselves fully

liability action against the manufacturer of cement used in the operation.

²⁸ See Nursing-Home Tort Liability Rises As Regulation, Plaintiffs Strategy Evolve, *BNA's Health Law Reporter* 1999; 8(36): 1480 (“a key development contributing to personal injury awards has been the court room use of deficiencies in the reports of state surveys”).

²⁹ In *Hoose v. Jefferson Home Health Care, Inc.*, 754 A.2d 1 (Pa. Super. Ct. 2000), the appeals court reversed a trial court order transferring venue from Philadelphia to a suburban county. The plaintiff had been treated surgically in a suburban hospital for peripheral vascular disease, but developed an infection during his rehabilitation that required more extensive and disabling surgery. The home health care company had its principal place of business in Philadelphia. The defendants in the case included a physician, a hospital, a nurse, a physical therapist, and an HMO in addition to the home health care company. The HMO had moved for venue transfer following an unsuccessful effort to transfer the case to federal court.

from the legal liabilities of their subsidiaries and affiliates.³⁰ The equities of allowing urban venue in these cases are debatable. On one hand, the behavior of an outlying hospital and a local physician is probably unaffected by their affiliation with an urban health system. On the other, that affiliation may well be a substantial factor in the patient's decision to seek care, or in the coverage made available by the patient's health insurer.

Industrialization also offers potential benefits in terms of patient safety, which counterbalances liability risk to some degree. As previously discussed, the Institute of Medicine and others emphasize that most medical errors originate in faulty systems design. Significant advances, therefore, are likely to come from larger medical organizations rather than solo practices, or from manufacturers of clinical and information technologies.³¹ Although the IOM correctly cautioned that an adversarial climate can chill voluntary disclosure and discussion of errors, innovation that improves safety often happens in the shadow of liability. For example, surgical anesthesia has made great strides through a combination of physician leadership, technical improvements in monitoring, institutional workspace redesign, and litigation risk management. As the IOM noted in a subsequent report, moreover, hospitals, large medical groups, HMOs, and similar practice settings may also be better positioned than small practitioners to weather liability insurance crises. In the current crisis, for example, physicians unable to find affordable individual insurance are increasingly seeking coverage through the hospitals in which they practice. This creates opportunities, discussed below, for policymakers

³⁰ In *Gale v. Mercy Catholic Medical Center Eastwick, Inc.*, 698 A.2d 647 (Pa. Super. Ct. 1997), the appeals court held that venue was proper in Philadelphia rather than in a suburban county. The court observed that the defendant medical center's parent hospital regularly conducts business through its Misericordia Hospital division and other offices, and that the defendant had not established that it operated independently of its parent.

³¹ Even technology designed to reduce errors will carry its own liability risk. Nicolas P. Terry, When the "Machine that goes 'Ping'" Causes Harm: Default Torts Rules and Technologically-

to establish alternative models within these organizations for identifying, compensating, and reducing avoidable errors that avoid the inefficiencies and inequities of traditional tort law.

Finally, the industrialization of medicine and of malpractice liability helps explain a critical aspect of the current liability insurance crisis: its tie to economic development. Health care is an economic engine. It is the largest employer in many communities, with a generally skilled, well-compensated workforce. According to a recent news report, health care accounted for 9.6% of employment in the Northeast and 8.2% nationally in 2002, 1.5% percent higher in each case than in 1987.³² The service side of health care depends in turn on allied technologies – pharmaceuticals, medical devices, biotechnology, genomics -- with continued innovation promising further economic growth. For this reason, cities or states with prominent academic medical centers often seek to build high-technology “corridors” around a critical mass of clinician-innovators. Spikes in physician and hospital liability costs therefore ripple through the “medical-industrial complex,” unsettling economic prospects for states and even entire regions. For example, medical device companies are concerned about the current malpractice crisis only in small part because of their own legal exposure. Mainly, they fear the evaporation of their customer base. Indeed, there is anecdotal evidence that spine surgery has decreased in high liability states as orthopedists and neurosurgeons limit their practices, with accompanying reductions in sales of related surgical hardware. This creates familiar pressure within state legislatures to compete with other states for business goodwill, potentially triggering a “race to the bottom” – excessively strict limits on suits or damages designed primarily to keep economic activity within one state.

Mediated Health Care Injuries, Saint Louis University Law Journal 2002; 46: 37-59.

³² David Leonhardt, Growing Health Care Economy Gives Northeast a Needed Boost, N.Y. Times, Dec. 30, 2002, at A1, A14.

Cost Containment

The two decades that have elapsed since the last nationwide malpractice insurance crisis have been characterized by an almost single-minded focus by both public and private payers on restraining growth in health care expenditures. Insurers and employers no longer pay passively on an indemnity basis but aggressively negotiate discounts, structure services, and question expenses. As a result, price competition, which was alien to medical services in 1975, is cutthroat today. Excess capacity, mainly in hospital beds but extending as well to specialized physician services, has been squeezed out of many markets, while cutbacks in Medicare and Medicaid payment have slashed margins and depleted cash reserves for many medical institutions and physician practices.

This implies a health care system that is less resilient to external financial shocks. When the economic incidence of liability costs was studied in the 1980s, researchers concluded that premium increases were quickly passed through to consumers.³³ In other words, physicians took umbrage at previous premium spikes not so much because the financial impact was unsustainable, but because they interpreted the increases as a sign of rampant litigation, which was an affront to their professional pride and sense of justice. Today, however, volatility in medical liability premiums is no longer cushioned by “blank check” reimbursement. Private managed care and restrictive government payment policies mean that sudden, sharp increases in malpractice premiums hit physicians in their wallets and hospitals on their bottom line.

The potential result: loss of access to physician and hospital services. In prior liability crises, hospital closures and physician walkouts were often political theater. Today, by contrast, the payment environment is inconsistent – at least in the short term – with the rising cost of

³³ Danzon et al., *supra*.

doing business. This can render customary practice patterns financially impractical, particularly in states with high malpractice premiums but low Medicare and private insurance reimbursement rates. Because premiums are determined mainly according to specialty, types of procedures performed, and geographic location, physicians may respond (short of retirement) by altering their mix of patients and services, or by relocating. Shifts in behavior potentially causing serious access problems may be subtle. For example, many obstetrical patients are covered by Medicaid, which has chronically low reimbursement rates, while adult gynecologic surgery is typically performed on patients with more generous payment from Medicare or private insurance. Consequently, ob-gyn physicians who are considering eliminating obstetrics from their practices to save on liability premiums may be able to do so without simultaneously suffering a loss of practice income.

Surgical specialties – orthopedics, neurosurgery, obstetrics-gynecology, and general surgery -- are at highest risk for these effects – with clear implications for access in already underserved communities and the possibility of service disruptions elsewhere. Non-surgical fields are also vulnerable to access effects despite their relatively lower liability costs, in part because they tend to be less well-compensated to begin with. By unhappy coincidence, women’s health may suffer a double setback, as ob-gyns cut back on obstetrical care and radiologists decline to interpret mammograms – those services being the primary drivers of liability cost within their respective specialties.

Two decades of cost containment have affected malpractice risk directly as well as physicians’ financial ability to absorb premium increases.³⁴ As physician fees have come under tighter

³⁴ This phenomenon is not limited to the United States. See Timothy A. Caulfield, *Malpractice in the Age of Health Care Reform*, in *Health Care Reform and the Law in Canada* (eds. Timothy A. Caulfield & Barbara von Tigerstrom), Edmonton: University of Alberta Press; 2002.

control, physicians understandably respond by increasing throughput, which potentially heightens the risk of litigation and of medical error. For example, prescriptions written under pressure to placate patients and expedite office visits may expose patients unnecessarily to adverse drug reactions. Because physicians must spend precious minutes accomplishing a larger, more complex set of tasks now than twenty years ago, they may also forgo discussion that could both improve care and increase patient satisfaction. Similarly, more medical care is being delegated to non-physician office staff. Patients may notice these changes in the physician's demeanor and routine, and may attribute any subsequent problem to negligence.

A major effect of cost-containment, particularly managed care, has been to make individual physicians feel more acutely the gap between what they are held legally accountable for and what they actually control. As noted, health care becomes a far more complex and expensive endeavor with each passing decade. The "primary" physician's skill and judgment, while still central, increasingly depends on coordination with other physician and non-physician actors, including institutions, in order to translate into successful health care. "Defensive medicine" becomes a somewhat different consideration for malpractice policy under these circumstances. It is always hard to disentangle the motives for additional tests and procedures: fear of litigation, legitimate risk reduction, patient demand, fee-for-service payment, habit, or something else. "Defensive" practice by physicians under greater time and cost pressure may indicate that they consider the current practice environment truly unsafe for patients, irrespective of litigation risk. Unfortunately, reacting to cost pressures by increasing high-cost testing and referral only induces payers to impose even more Draconian cost-control measures. Getting physicians and payers "on the same page" with respect to both cost and accountability for error is therefore a priority for malpractice reform (and was in fact the main motivation for the Clinton administrations

much-maligned proposal for “enterprise liability”).³⁵

Because of cost-containment, hospitals are very different entities now than in the early 1980s. Hospitals used to service the entire life cycle of both moderate and serious illness -- initial presentation, diagnosis, treatment and recovery. They now perform a much more focused role, providing high-intensity, technologically sophisticated services to very sick people for brief periods of time. Higher severity of illness and shorter lengths of stay themselves predispose to error and therefore to litigation.³⁶ Hospitals are also labor-intensive businesses, and a generally tight labor market in the 1990s has combined with specific budget cuts affecting health care to decrease staffing and increase staff turnover. These effects were if anything magnified for nursing facilities because their employees are poorly compensated compared to hospitals, and because both the perception and the reality of quality in long-term care depends on lasting relationships between staff and patients.

Medicare reimbursement changes probably account for these effects to a larger degree than managed care, but managed care did more to reduce patient trust in the health care system. Among other things, managed care led patients to change physicians relatively frequently as employers switched health plans to obtain lower premiums or physicians resigned from or were “deselected” by plan networks. This increased the potential for error and reduced the likelihood of forgiveness. Although health plans can claim ERISA preemption of claims against them in some instances, their affiliated physicians and hospitals face a variety of legal risks arising from

³⁵ William M. Sage, *Enterprise Liability and the Emerging Managed Health Care System*, *Law & Contemporary Problems* 1997; 60(1&2):159-210.

³⁶ In *Mazzarino v. Kushner*, 36 Pa. D. & C. 4th 517 (Pa. Ct. Common Pleas 1996), the plaintiff sued for injuries suffered as the result of post-operative complications from hysterectomy. She alleged, among other things, that York Hospital had discharged her prematurely because her medical assistance benefits were about to expire. The court dismissed this theory of direct liability for lack of evidence, but allowed claims to proceed against the hospital as vicariously responsible for the negligence of the plaintiff’s physician.

cost management practices. Examples include treatment delays resulting from utilization review, failure to refer under gatekeeping arrangements, and care by unqualified practitioners in restricted provider networks. The notion of physicians receiving financial incentives to limit services, whatever its true clinical significance, was also uncomfortable for many patients because it suggested disloyalty – and certainly troubled jurors in malpractice cases if the judge allowed the fact into evidence.³⁷ Not surprisingly, the prospect of punitive damages, not only against health plans but against hospitals and even physicians, is greater now than in previous decades.

Long-term care offers the clearest illustration of both medical progress and cost-containment influencing tort liability. Average liability insurance costs in long-term care facilities increased nearly ten-fold nationally from \$240/bed in 1995 to \$2,360/bed in 2001.³⁸ These numbers are frequently cited as evidence of a generalized “litigation explosion.” A more sophisticated, and more likely, explanation principally invokes health system change. In 1995, long-term care facilities still paid what are called “hospitality rates” for their liability coverage. In other words, they were rated as hotels. By 2001 they were rated as true health care providers, mirroring the shift in terminology from “nursing home” to “skilled nursing facility” over the past two decades.³⁹ The watershed event in this transformation was the adoption of Medicare’s

³⁷ In *Sweed v. CIGNA Healthplan of Delaware, Inc.*, 1989 Del. Super. LEXIS 51 (1989), treatment of the plaintiff’s cancer was delayed for nine months because her primary care physician did not refer her to a surgeon after detecting a lump in her breast. The plaintiff sought punitive damages from the physician, alleging that he was influenced by financial motives in delaying referral. The court granted summary judgment to the physician on the punitive damage claim.

³⁸ U.S. Department of Health and Human Services, *supra*.

³⁹ State malpractice law has evolved accordingly. In *Henderson v. Franklin Nursing Inns, Inc.*, 1981 WL 2530, ___ (Ohio Ct. App. 1981), the court cited an earlier decision, *Morris v. Monterey Yorkshire Nursing Inn, Inc.*, 29 Ohio App. 2d 98 (Ohio Ct. App. 1971) for the proposition that “a nursing home which does not perform the functions of a hospital cannot be

prospective payment system for acute-care hospitals in the early 1980s. Under financial pressure to discharge patients sooner, hospitals increasingly turned to long-term care facilities (who were still paid on a cost-basis by Medicare) for post-acute care and rehabilitation. Over the next decade, the demographics of long-term care shifted away from purely residential services for the oldest old, and toward shorter stays for somewhat younger but substantially sicker patients admitted from hospitals.⁴⁰ Many of these patients still required intensive medical care, and properly regarded the nursing facility as an extension of the hospital.⁴¹ Moreover, the nature of hospital discharge planning gave few patients or their families a meaningful choice among facilities, further increasing the likelihood of subsequent litigation.⁴² Similar forces are beginning to increase liability risks for the home health care industry as medical technology moves into the home and workers seem more like health professionals and less like friends or neighbors.

guilty of malpractice,” and dismissed a suit for failure to diagnose and treat an infected toe that led to gangrene of the foot and leg. By contrast, in *Catanzaro v. Tri-County Extended Care Center, Inc.*, 1989 Ohio App. LEXIS 1442 (Ohio Ct. App. 1989), the court permitted a malpractice claim to be brought against a nursing home for negligence in caring for a stroke victim, which allegedly resulted in pneumonia and death.

⁴⁰ The time needed for these changes to permeate the long-term care industry, coupled with the lengthy period required to litigate and resolve high-dollar malpractice claims, likely accounts for most of the delay in re-rating skilled nursing facilities for liability insurance purposes. State elder abuse laws, most of relatively recent vintage, no doubt also played an important temporal role.

⁴¹ Patients who 20 years ago would have been hospitalized are now receiving all or most of their inpatient treatment at nursing facilities. A nursing home in Texas paid \$3.5 million to settle a claim involving a 72 year-old admitted for a short stay to recover from a fractured fibula. The patient had died three months later from malnutrition, dehydration, pressure ulcers, and renal failure. *Arledge v. Oak Grove Nursing Home, Inc.*, No. A162668 (Jefferson Co., Groves, Tex. 58th Jud. Dist. Ct. 2001), Matthew Bender, *Medical Malpractice* 40-255.

⁴² In *Palmer v. Beverly Health and Rehabilitation Services, Inc.* (No. CV-00-2775, Ala. Cir. Ct. Mobile Cty. Dec. 14, 2001), a jury awarded \$7 million in damages, including \$5 million in punitive damages, to the son of an elderly woman who sustained head injuries at the defendant’s facility and died. The woman had been admitted for rehabilitation after being diagnosed with a brain tumor, but fell out of bed six times during her first night at the facility. Medical

Conclusion: Refining the Problems and Solutions

Some commentators describe the malpractice insurance crisis of 2002-2003 as a “perfect storm”: rising malpractice claims and awards, falling investment income for liability insurers, failures and pullouts of primary carriers, and global shortages of reinsurance capital.⁴³ As significant as malpractice insurance markets and the legal system are to the overall problem of medical liability, their impact reflects the changes in the health care system described in this article. Treating the current malpractice crisis as identical to preceding ones therefore both mischaracterizes the problem and shortchanges the range of potential solutions.

The importance of developing a liability regime that is compatible with overall health policy goals should be obvious. Nonetheless, the political process is mired in what one might call “malpractice exceptionalism” – regarding malpractice liability as categorically different from and unrelated to other issues of health system design. Several factors account for this, including the long history of professional conflict over malpractice, the presence of articulate and well-funded lobbyists on both sides, and – at the federal level – lack of experience with a state law issue that does not map cleanly onto Medicare and Medicaid policy.

Most important, perhaps, is politics. Despite the health care system’s acute need -- indeed because of it – broad coalitions across the political spectrum are tempted to co-opt medicine to advance larger agendas about the effect of lawsuits on social stability and economic prosperity. Indeed, “Are you for malpractice caps?” is becoming a litmus test of loyalty for partisans on both sides. In other words, the political fight in Washington over malpractice is about lawyers, not about health care. Five years ago, the trial bar used fears of managed care to drive a wedge

Malpractice Law & Strategy, Feb. 2002, at 13.

⁴³ E.g., Randall R. Bovbjerg, Malpractice Insurance Crises in Perspective, World Medical Leaders Presentation, Oct. 25, 2002 (on file with author).

between physicians and general business interests – both core Republican constituencies – over the desirability of litigation. This year, anti-lawsuit forces have turned the tide, peeling patients away from general consumer groups and organized labor, which have typically been allied with the plaintiffs’ bar on the Democratic side. The trends identified in this article suggest that, no matter which camp claims victory in the overall battle, the outcome will not address serious deficiencies in how American law deals with medical errors.

The key message for patients, physicians, hospitals, health insurers, and other industry stakeholders, therefore, is to advocate for reforms that improve the health care system, rather than being distracted by broader ideological battles.⁴⁴ This is particularly important to emphasize in periods of crisis, when medicine’s need for reform is acute, but addressing that need competes with exploiting it for general political advantage.

What are the problems that malpractice reformers should take into account? Six can be readily identified. First, liability coverage is expensive and sometimes unavailable, with volatility as important an issue as absolute cost. This problem is somewhat different for physicians, who are concerned mainly about primary layers of coverage, than for hospitals, which face greater cost and availability constraints for excess layers. Second, liability crises potentially impair access to medical services because the health care system is less resilient financially now than in the past. Third, compensation for injured plaintiffs is inadequate: most avoidable injuries are not compensated at all, and even successful claimants keep only a portion of what they are receive through the tort system. Fourth, too many avoidable medical errors

⁴⁴ See, e.g., Philip K. Howard, *The Collapse of the Common Good: How America’s Lawsuit Culture Undermines Our Freedom*, New York: Ballantine Books; 2000; Theodore B. Olson, The Parasitic Destruction of America’s Civil Justice System, *Southern Methodist University Law Review* 1994; 47: 359-368. For a more detached view, see Frank B. Cross, Lawyers, the Economy, and Society, *American Business Law Journal* 1998; 35: 477-514.

occur. Fifth, the process of resolving disputes through tort law is too slow, too costly, too uncertain, and too unpleasant. Sixth, the liability climate threatens the economic success of the health care industry by discouraging providers and reducing incentives to innovate. No reform can solve all these problems, but the desirability of any proposal must be measured by its likely effect on each of them.

Unfortunately, most malpractice proposals under active debate focus only on one or two problems, and potentially worsen the rest. An exception is the Institute of Medicine's recent report urging state-based demonstration projects.⁴⁵ The IOM proposal, which draws on established though largely untested reform ideas, integrates liability policy with other key areas of health system performance: primary care, chronic care, information technology, and access to health insurance.

The IOM recommends replacing much of current malpractice law with an administrative system of strict liability for clearly avoidable injuries. The IOM offers two options: provider-based early payment and statewide administrative resolution. Under the first option, certain provider organizations (e.g., hospitals, large medical groups, closed-panel HMOs) would receive financial assistance in exchange for electing to participate in a modified liability system. Participating providers would build the safety systems necessary to identify and reduce medical errors, and would promptly pay economic loss and pre-defined non-economic damages for identifiable classes of avoidable injuries. Hospitals would be encouraged to cover affiliated physicians under the hospital's program and work with them to improve safety. Under the

⁴⁵ Institute of Medicine, *Fostering Rapid Advances in Health Care: Learning from System Demonstrations* (eds. Janet M. Corrigan, Ann Greiner, and Shari Erickson), Washington DC: National Academy Press; 2002; see also David M. Studdert and Troyen A. Brennan, Toward a Workable Model of "No-Fault" Compensation for Medical Injury in the United States, *American Journal of Law and Medicine* 2001; 27(2-3):225-52. The author was a member of the IOM

second option, all health care providers would pay amounts determined by an administrative adjudication system in cases of avoidable injury. Both options are intended to be “no-trial” rather than “no-fault” systems, capping non-economic damages in accordance with a predetermined schedule based on severity and duration of injury, but preserving financial incentives for safety at the provider level.

After a recent conference on medical malpractice policy, a state legislator remarked with some astonishment that the malpractice reform debate indeed seemed highly polarized, but that the most profound disagreement was not between health care providers and the plaintiff’s bar. The principal conflict he observed was between the major political stakeholders on one side, and the academic community on the other. The former group understood the central question to be the desirability of enacting MICRA-style measures to discourage lawsuits and limit recoveries, with a \$250,000 cap on non-economic damages as its centerpiece. The latter group was essentially unanimous in its opinion that traditional “tort reform” offers incomplete solutions to only a subset of critical problems.

If Congress enacts MICRA-style caps on damages, no national tragedy will follow. But neither will any lasting benefit to health care be achieved. The same will be true if Congress fails to do anything after prolonged political debate, as was the case with rights to sue managed care plans. Government will simply have missed a significant opportunity for truly productive change. The real malpractice debate is between those who view medical liability as an external drag on the health care system and those who see a properly functioning liability system as integral to its future success. Politics favors the former camp, but history is on the side of the latter.

committee that issued the report.