Medical Liability And Patient Safety

A silver lining in the current malpractice crisis is the opportunity to pursue shared, rather than individual, liability insurance.

by William M. Sage

PROLOGUE: Just when it appears that the persistent issue of medical error has been bumped from the national spotlight, a particularly egregious incident will surface to catapult the topic back to the front pages, reignite public outcry, and galvanize demands for change. Media coverage and public perception aside, however, the scope and pervasiveness of this problem are undeniable. More than one-fourth of U.S. adults have experienced a medical error within the past two years, despite the fact that the United States spends much more on health care than any other country.

As Bill Sage notes in this paper, the gathering movement seeking increased patient safety may be the catalyst for breaking the impasse over medical malpractice reform. The positions of both sides of the medical malpractice debate are well known and virtually calcified. Providers and hospitals insist that caps on damage awards in medical malpractice suits are necessary to stem rising malpractice insurance rates. Trial lawyers counter that spiking rates are more attributable to trends in liability insurance markets. Both camps seem to believe that patient safety matters, however, and Sage hopes that this slender thread of agreement can be woven into a new liability system that “will reduce the need for litigation by linking patient safety to risk management within health care organizations.” Perspectives by Martin Hatlie and Susan Sheridan, and George Huber follow.

Sage is a professor of law at Columbia University, where he teaches courses in health law, regulatory theory, and the professions. He serves as principal investigator for the Pew Charitable Trusts’ Project on Medical Liability in Pennsylvania and is a member of the Health Affairs editorial board. Sage holds a law degree, and also a medical degree, from Stanford University.
ABSTRACT: Political debate over medical malpractice reform seldom takes meaningful account of its policy context, including the emerging science of patient safety. Instead, stakeholders on both sides use the rhetoric of patient safety to support entrenched positions on hardened proposals such as capping damages and limiting access to information about errors. Despite its déjà vu quality, the current malpractice crisis can only be understood and addressed as the product of changes in the health care system since the last crisis nearly twenty years ago—changes that also informed the patient safety movement. Patient safety may therefore serve as a bridge between medical liability and health policy.

Another “malpractice insurance crisis” has arrived.1 Premiums are skyrocketing, insurers are exiting markets, and physicians and hospitals are warning that patients may find medical care unavailable unless “something” is done—meaning the enactment or strengthening of tort reform legislation. A new wrinkle in this long-standing debate is that both sides have embraced the rhetoric of patient safety.2 Trial lawyers point to the statistics on medical error as evidence that physicians require stricter oversight, including mandatory reporting of incidents that could form the basis for malpractice litigation. Physicians and liability insurers argue that the evident failure of punitive, adversarial approaches to error reduction demonstrates the need for tort reform, to promote admission of error and cooperative quality improvement.

Cycles of apparent crisis and purported reform have characterized medical liability since the 1970s.3 Most states have passed measures designed to reduce the number of lawsuits and their impact on defendants, such as collateral source offsets for economic damages (telling juries when insurance is available to substitute for lost wages or pay medical expenses, or deducting those amounts automatically from jury awards), shortened statutes of limitation, limits on attorneys’ contingent fees, pretrial screening panels, and periodic payment of damages.4 About half of the states have adopted caps on noneconomic damages (pain and suffering).

Changes in the health care system since the last malpractice insurance crisis in the mid-1980s—including the forces that led safety advocates to rethink medical error—suggest that something more radical than traditional tort reform is both necessary and achievable. Making health care truly “better” requires legal and medical institutions that work together not only to improve technical safety but also to communicate openly with patients and the public and to provide financial assistance if safety systems fail. Indeed, patient safety may be the trigger that finally propels ideas such as accelerated compensation for clearly avoidable events, less adversarial forms of dispute resolution, nonjudicial compensation mechanisms, encouragement of private contracting, and assumption of legal responsibility by medical institutions from the academic literature into the real world.5 This paper describes the changing landscape of medical liability and analyzes its implications for three areas: accountability, compensation, and system-based quality improvement.
Liability And Health System Change

Modern medical liability is best understood as “regulation by litigation,” not merely the private resolution of individual disputes. In areas where identifiable parties with financial resources (or insurance) cause harm, private lawsuits represent a blunt alternative to explicit regulation. Thinking about medical liability as part of an overall regulatory strategy highlights the importance of interconnections between traditional malpractice litigation and government oversight, self-regulatory mechanisms such as peer review and accreditation, and informal sources of accountability such as commercial or professional reputation.

In theory, three independent parts of the “malpractice system” perform this regulatory role. The legal system brings complaints about quality of care to the surface and determines their accuracy. Liability insurance pays for the victim’s injuries and through risk management helps enforce standards of care set by the courts. Health care providers adjust their behavior to lessen the burden of litigation and factor the costs of both avoiding and contesting liability into their charges. In practice, however, the malpractice system fails to send clear signals for quality improvement. Few iatrogenic injuries generate claims, courts do not always demand persuasive evidence of negligence, and juries may not award damages consistent with loss. Liability insurers do not experience-rate physician premiums and engage in risk-based underwriting only in troughs of the “insurance cycle,” which further attenuates the connection between liability and quality. Consequently, physicians consider malpractice law intrusive, expensive, and arbitrary and may react by covering up errors or practicing defensively.

Drawing inspiration from “high reliability” industries such as aviation, proponents of patient safety argue that a different quasi-regulatory structure—comprising “human factors engineers” and organizational “cultures of improvement”—will minimize medical errors in a health care system that is increasingly dependent on specialized knowledge, coordinated human activity, and sophisticated clinical and information technologies. Indeed, today’s health care system differs not only from the ancien regime of solo practice that serves as standard counterpoint to the modern industrial model, but also from the system in place during the last malpractice crisis, circa 1985.

Changes in medical care. One important change is that medical care has improved. Although technology is generally seen as a boon to safety, no other factor historically has surpassed it as a stimulus for litigation. Gains in clinical competence redefine success upward and make delay actionable. Receiving “high-tech, low-touch” care in impersonal, specialized settings removed from long-term therapeutic relationships makes patients less tolerant of failure, while the higher cost of treatment forces more patients to find sources of payment if they suffer complications, especially as the ranks of the uninsured expand. Liability risks from technology affect not only physicians but also a range of service providers, suppliers, and researchers, which takes on increasing social importance because medical innovation...
is linked to future economic prosperity in many parts of the country.\textsuperscript{16}

The health care system is also more cost-constrained. Aggressive purchasing by employers and insurers, combined with Medicare cost containment, has reduced physician and hospital reimbursement, eroding physical capacity and financial reserves. Unlike past crises, providers no longer can shift the economic burden of rising malpractice premiums to public and private payers.\textsuperscript{17} Rapid increases in medical liability costs may therefore compromise access to certain physicians or services, or care for certain types of patients, something that has not been empirically demonstrable in the past. Pressures to maintain revenues by increasing throughput exert a multiplier effect on litigation, heightening the risk of medical error in both hospitals and physicians' offices while reducing the time available to avoid or defuse conflict by communicating effectively with patients.

Reflecting its expanded capabilities and its need for financial discipline, today's health care system is more industrialized as well. However, corporatization and competition alienate physicians, erode relationships by increasing patient and staff turnover, and strain trust between patients and providers—all of which predisposes to litigation. Managed care organizations themselves are widely seen as deep-pocketed defendants with suspect motives. Not surprisingly, juries who seldom ascribed malice to providers, and therefore rarely awarded punitive damages, are revisiting the possibility in cases involving managed care.\textsuperscript{18}

\textbf{Changes in law.} Legal doctrines have evolved in response to these developments, usually increasing liability exposure. The “locality rule” that judged negligence community by community has been replaced in many cases by a national standard of proficiency. Some argue that objective reasonableness, not customary practice, now governs most courts' interpretation of the standard of care.\textsuperscript{19} The merger of independent providers into “health systems” subjects defendants to suits in unfamiliar venues with less sympathetic judges and juries. Traditional malpractice claims against physicians are buttressed by other defendants and theories, such as product liability, violation of fiduciary duty, unfair business practices, elder abuse, and wrongful denial of insurance coverage.

\textbf{Changes in insurance markets.} Liability insurance markets have lagged behind industrial change in medicine, increasing vulnerability to economic shocks. Basing legal responsibility on professional negligence forces physicians to finance liability coverage for hundreds of billions of dollars in health care expenditures that they more or less control clinically but never capture as revenue, with the burden falling disproportionately on a few (mainly surgical) specialties. Coverage remains sharply divided between companies catering to physicians, many of them chartered during previous crises, and those serving hospitals, reducing incentives for coordinated risk management. Stopgap legislation from the 1970s establishing state malpractice funds, “joint underwriting associations,” and the like distort competitive incentives for private carriers, while insurance regulators are caught between the need to assure solvency and political pressure for low premiums. A precipitating fac-
tor in the current crisis is that marginal carriers offering cut-rate policies rushed into many states to amass premium dollars for investment during the 1990s boom, only to collapse when Wall Street retreated, leaving physicians unprotected. Excess insurance, necessary to protect against rare high-dollar judgments, went from plentiful to prohibitively expensive as a series of catastrophic losses unrelated to health care shut down reinsurance capacity worldwide.

**Legal Immunity, Information, And Accountability**

A breakthrough insight of the patient-safety movement is that creating a “safe environment” in which information is shared and analyzed without fear of individual recrimination can foster improvement in complex systems. A central question is how medical liability can be restructured to improve the production and use of information about quality and safety.

- **Refining the theory.** Because the threat of litigation can chill data generation and exchange, it is sensible to strengthen peer-review protections so that systems of voluntary reporting and expert analysis like those used in aviation can be applied to health care. Educating trial judges to follow these laws is as important as adopting them. Like physicians, judges must make decisions quickly, using limited information, and may not fully appreciate the connection between confidential peer review and medical quality improvement.

However, drawing lines that encourage reporting but maintain accountability to patients and the public may be difficult. Analogizing to aviation safety, patient-safety advocates sometimes distinguish between errors causing injury, which they recognize should be disclosed, and “near misses,” which they prefer to keep confidential. However, a difference between health care and aviation is the latter’s emphasis on preventing rare, fatal crashes. This is one reason why disclosure is necessary in the first place: One can hardly conceal a downed aircraft, whereas most iatrogenic injuries are not obvious to patients. Even fatal injuries may not be recognized as errors because of patients’ underlying diseases. By contrast, passengers’ attributes seldom compete with pilots’ conduct or mechanical characteristics of aircraft as explanations for aviation injuries.

- **Shielding providers.** The medical community sometimes takes the argument further, maintaining that lawsuits themselves are detrimental to safety because they create a “culture of blame” that impedes professional review. However, reducing liability to benefit “insiders” who might be tempted to act in their own rather than society’s interest requires a climate of public trust as well as effective internal and external controls. The public understands the Institute of Medicine’s (IOM’s) data better than its reasoning, and tort reform is not an intuitive solution to rampant medical error. Why should the medical profession, which historically criticized lawyers for inventing medical errors where none existed, receive even greater protection from lawyers now that we know errors to be widespread? Similar dissonances beset proposals to replace generalist judges and lay juries with “expert
courts” or professional review panels. Ethical lapses in research, problems with managed care, and general business misconduct contributing to the stock market crash also make the public more demanding of transparency and of maintaining avenues of self-help, including recourse to litigation.

- **Informing the public.** Focusing narrowly on technical safety also disregards other legitimate uses of information regarding errors: helping patients make better decisions about care, respecting the dignity of victims and families, and fostering public debate about the risks and benefits of medicine. Malpractice suits are often prompted by the desire to obtain explanations for unexpected tragedies or to overcome failures of empathy and communication by physicians. Indeed, the moral basis of tort law includes identifying and punishing bad actors while vindicating innocent victims (corrective justice). Although these objectives seldom enter the debate over tort reform, ignoring them risks portraying health care as something decreed by professional fiat, rather than a participatory, patient-centered process.

- **Balancing accountability and improvement.** If lawyers’ access to information is constrained to encourage self-reporting, other means will be needed to guarantee public accountability, such as direct government oversight (as the Federal Aviation Administration provides in aviation) or external review by reputable independent bodies. Finding ways to involve patients in safety efforts will also be critical to these efforts’ success. Technical detachment is much better suited to aviation than to medicine, because the value of health care depends greatly on the subjective experience of receiving it. In addition, there is little an airline passenger can do to contribute to aviation safety, while patients often can help protect themselves from harm. New Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards mandate disclosure to patients of errors that produce injury, and states are beginning to legislate similar requirements, but no model yet exists for implementing them successfully. Therefore, a top priority should be establishing mechanisms within hospitals that ensure effective communication with patients and their families when an error occurs, including making apology, answering questions, offering compensation if appropriate, and inviting further discussion. Proven forms of alternative dispute resolution such as mediation may be helpful in these situations. A side benefit of a less adversarial approach is to facilitate nonmonetary settlements. In litigation, money is the only medium of exchange that lawyers on both sides understand, so that plaintiffs are rarely offered other forms of satisfaction, such as assurances that similar errors will not happen again. To capture these benefits, however, alternative dispute resolution needs to be used as an anticipatory strategy, not merely a diversionary tactic for existing lawsuits.

**Tort Reform: Damage Caps And Fair Compensation**

Tort reformers focus their greatest attention on capping damages for pain and suffering, arguing that jury awards do not correlate with actual negligence and that the prospect of windfall payoffs is why lawyers and patients file lawsuits.
Caps have a single, practical objective: to reduce liability insurance premiums by limiting insurers’ financial exposure for large claims and allowing them to refuse settlement in smaller cases. Indeed, research has shown that the favorable effect of the Medical Injury Compensation Reform Act (MICRA) on malpractice premiums in California is primarily attributable to two provisions: a $250,000 cap on noneconomic damages, and the admission into evidence of collateral sources of payment for the plaintiff’s economic losses. A more visible corporate presence in health care and the diminished trust that accompanies it also suggest the need for some safeguard against excessive damages.

■ The downside of caps. Damage caps weaken the most direct purpose of malpractice litigation: compensation for injury. Reductions in malpractice premiums unaccompanied by lower rates of injury are not savings to society but, rather, transfer payments from injured patients to health care providers. It is true that malpractice law has not performed well as a system of compensation. Litigation is a customized enterprise with few economies of scale and strategic incentives for each side to impose costs on the other to pressure settlement. Accordingly, many negligent injuries never prompt lawsuits, administrative expenses consume almost half of damage awards, and final resolution of claims typically takes years. However, MICRA-style flat caps selectively penalize the neediest cases, and the strong likelihood of continued medical inflation implies that some money awarded for pain and suffering will ultimately be used to defray future health care costs. Collateral source offset provisions, by contrast, are defensible because they are invoked to prevent double recovery only when health or disability insurance is available.

■ Timely, fair compensation. An industrial model of patient safety based on reducing medical error to “acceptable” levels through systematic analysis is most compatible with an administrative system that provides timely, fair compensation for avoidable injuries. In addition to moderating the accusatory tone of malpractice claims and reducing the costs of resolving them, an administrative system linked to an effective patient-safety review mechanism would be able to identify and quickly compensate more medical errors than now occurs. Such a system would cap damages, but according to a rational schedule rather than a one-size-fits-all limit. It would also be more easily coordinated with health insurance, potentially offering malpractice insurers additional relief in cases, such as severe birth injuries, where future medical expenses and lost wages alone amount to millions of dollars.

■ Surfacing health policy. The public conversation needed to establish a “no-trial” mechanism for compensating medical errors would also open a new window on larger questions about cost and access that are obscured by the haphazard operation of current malpractice law. What constitutes a “decent minimum” of medical care, and who should pay for more? Although many safety improvements are clearly cost-justified, all human activity risks physical harm, and all risk reduction must be affordable. A difference between medical error and other sources of physical injury is that how much we value avoiding medical error is closely related to how much we
value health care in the first place. Especially if safety is equated with quality, society draws from the same pot of money for “patient safety” as for “patient care.” Should society’s large investment in health care entitle us to scrupulous protection from unnecessary harm and therefore generous payment when it occurs? Should compensation include pain and suffering because relief of pain and suffering was the purpose of the care that led to the error? Or should we be forgiving of medical error because, unlike decisions to drive to the supermarket or mow the lawn, the real possibility of injury or death is already in our minds when we submit to treatment?

Building Liability Into Patient-Safety Systems

Harmonizing medical liability with patient safety requires aligning the incentives influencing the various components of safe systems. This is the thinking behind “enterprise liability,” which should be taken seriously despite its association with the Clinton administration’s failed attempt at health reform.37

- **Benefits of group liability.** A promising approach is to unify liability wherever possible within “health care groups”—structural entities such as hospitals, group medical practices, or closed-panel health maintenance organizations (HMOs) that have both the clinical capability and the financial motivation to improve patient safety.38 Orienting liability coverage to groups could expose and address the gross illogic of current insurance rating practices, which saddle a few clinical specialties with extreme cost and volatility notwithstanding the fact that their services are indispensable to modern health care. Contractual linkages developed during the past decade also make it possible to connect provider-based patient-safety activities to nonjudicial dispute resolution and timely, fair compensation through explicit agreement among patients, providers, and insurers. A challenge for medicine is that the case for corporate liability is less intuitive than in other industries.39 In aviation, for example, the public expects airlines, not individual pilots and mechanics, to exercise strict oversight and bear ultimate legal responsibility.

- **Necessary legal change.** Legal reform is needed to foster the development of risk-bearing health care groups. For example, obstacles to shared liability should be removed—such as the risk of prosecution for Medicare fraud if hospitals provide malpractice insurance to their affiliated physicians. Especially in states whose constitutions preclude legislative abrogation of the right to sue, courts should be more receptive to voluntary modifications of liability or dispute resolution involving informed patients. Oversight mechanisms for patient safety can be adapted to monitor these arrangements, ensuring that both patients and physicians are treated fairly.40

A silver lining in the current malpractice crisis is the opportunity to head in this direction. With traditional liability insurance unavailable or unaffordable, physicians in many states are seeking coverage from the hospitals with which they are affiliated. The financial resources and management expertise of hospitals and other large institutions confer distinct advantages over individual professionals in purchasing liability insurance. Hospitals themselves are pursuing alternatives to
costly commercial coverage that potentially sharpen incentives to improve safety, such as self-insuring through captive carriers or forming risk-retention groups. A particular problem in a “hard” insurance market, however, is that reinsurers may be unwilling to participate in novel ventures on reasonable terms. Unlike hospitals’ hard assets, which are dedicated to health care and, in the case of nonprofit providers, assured of replenishment from revenues, insurance capital is “agnostic” and flows quickly from one economic sector to another. Therefore, a promising strategy would be for governments to offer financial assistance, such as subsidized excess coverage, to entities that unify liability risk and also adhere to standards of good practice regarding safety, compensation, and communication.

The IOM recently recommended that the federal government fund state-based demonstration projects along these lines. The IOM proposal is noteworthy because it integrates liability reform with other major health policy issues, including access to health insurance, chronic care, primary care, and information technology.

**The ‘Business Case’ For Safety**

Because the health care system has evolved significantly between the last malpractice crisis and the current one, the time is right to pursue a new industrial model of medical liability. This model should address changing needs and capabilities on both the supply side of medicine (the delivery of safe, cost-effective care) and the demand side (patients’ confidence in quality and accountability). True reform must consist of more than sheltering health care providers from suit and vesting exclusive oversight authority in corporate or professional bodies, however technically expert. Instead, its goals should be to reduce the need for litigation by linking patient safety to risk management within health care organizations; communicating effectively with patients and the public; and providing prompt, fair compensation should avoidable injury occur.

The principal obstacles to these reforms are political. Positions on the tort reform battlefield are deeply entrenched. One ray of hope is the business community, which may temper its general opposition to personal injury lawsuits with the recognition that medical error represents a special hazard to its employees and its productivity. Initiatives such as the Leapfrog Group’s insistence on computerized order entry, hospital outcome measurement, and intensive care unit (ICU) specialist staffing are beginning to assert the “business case” for safety. It is therefore possible that business interests could broker a compromise approach to medical malpractice, mirroring workers’ compensation, that limits liability but assures reasonable compensation and retains incentives to keep patients safe.

*The author thanks Susan Liss, Anna Bartow, Mike Nardone, and the Project on Medical Liability in Pennsylvania for help in gathering information. This work was supported by a grant from the Pew Charitable Trusts.*
NOTES


