The Defensive Medicine Debate:
Driven by Special Interests

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I. INTRODUCTION

Tort reform is a contentious issue within the larger U.S. debate on healthcare reform that has received surprisingly little media attention. The first medical malpractice crisis erupted in the mid-1970s, which was marked by exorbitant malpractice insurance premiums and caught the attention of Congress.¹ Since the early 2000s, however, medical malpractice rates have stabilized,² which lessened the tort reform discussion to a small piece of the healthcare reform overhaul rather than an independent issue.³ Nonetheless, the current tort reform discussion, specifically in relation to defensive medicine practices, has created a lot of tension in the current debate.⁴

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² Id.
³ Id. at 2.
In President Obama’s June 2009 address to the American Medical Association’s House of Delegates, President Obama acknowledged doctors’ concerns, not by advocating for caps on medical malpractice, but rather by advocating for solutions to curtail the use of defensive medicine by doctors.\(^5\) President Obama stated a real issue is that “some doctors may feel the need to order more tests and treatments to avoid being legally vulnerable.”\(^6\) He added, “That’s a real issue.”\(^7\)

Before this issue can be resolved, however, many questions need to be answered, including the true costs of defensive medicine, the frequency in which doctors practice defensive medicine, and the reasons why doctors practice defensive medicine. This article will provide an overview of defensive medicine practices and examine the debate from the perspectives of doctors, trial lawyers, and patients. It will conclude by briefly discussing possible interim solutions to the healthcare debate until overall tort reform is passed, which proponents argue will decrease the use of defensive medicine.

II. WHAT IS DEFENSIVE MEDICINE & WHAT ARE ITS CONSEQUENCES?

Beginning with the first medical malpractice crisis in the 1970s, defensive medicine practices have been purported as a result of malpractice legislation.\(^8\) Defensive medicine is considered “a deviation from sound medical practice,


\(^6\) Id.

\(^7\) Id.

\(^8\) Colleen Smith, Defensive Medicine: The Effects of Medical Malpractice Tort Law on Physician Behavior 1 (Jan. 28, 2009), available at http://hdl.handle.net/1961/4817 (unpublished honor’s program Capstone project, on file with American University Archives).
induced primarily by threat of liability.”9 There are two types of defensive medicine: assurance and avoidance behaviors.10 Assurance behavior is viewed as positive defensive medicine because it may not negatively affect the patient’s health, but doctors may perform extra tests or services in order to avoid medical liability suits.11 Avoidance behavior is considered negative defensive medicine because it reflects doctors’ efforts to avoid legal liability by refusing to see high-risk patients or by refusing to perform high-risk operations.12

The National Bureau of Economic Research conducted a study on the costs of defensive medicine in 1996.13 It analyzed the effects of malpractice liability reforms by using data from Medicare beneficiaries who were treated for serious heart diseases.14 Researchers Daniel Kessler and Mark McClellan contend that “defensive medicine is a potentially serious social problem: if fear of liability drives health care providers to administer treatments that do not have worthwhile medical benefits, then the current liability system may generate inefficiencies many times greater than the costs of compensating malpractice claimants.”15 In other words, it is not the cost of compensating patients through the medical malpractice system that drives up costs, but rather it is physician behavior, specifically the practice of administering treatments with minimal

10 Id.
11 Id.
12 Id.
14 Id. at 353.
15 Id.
expected medical benefit that drives up costs. McClellan and Kessler’s analysis indicates reforms which directly limit provider liability, such as caps on awards to patients, could reduce hospital expenditures by 5% to 9% within three to five years of adoption by reducing the practice of defensive medicine.

Recently, in 2008, the Massachusetts Medical Society (MMS) also conducted a study on its members’ use of defensive medicine. The study revealed that 83% of those doctors surveyed practiced defensive medicine, with an average of between 18% and 28% of tests, procedures, referrals, consultations, and 13% of hospitalizations ordered for defensive reasons. MMS estimated that these practices cost the state of Massachusetts a minimum of $1.4 billion per year. MMS contends that the consequences of defensive medicine go beyond the unnecessary toll on healthcare spending; defensive medicine practices reduce access to care for high-risk patients and, often times, the tests involving radiation can be unsafe for patients.

The MMS and the McClellan/Kessler studies are distinguishable in that they each studied different aspects of defensive medicine. MMS studied the frequency and the costs of defensive medicine, which is considered the first study of its kind, while the McClellan/Kessler report focused on the impact of defensive

16 Id. at 354.
17 Id. at 386.
19 Id. at 3.
20 Id. at 4.
21 Id. at 7.
medicine on medical malpractice costs. Medical malpractice costs are estimated at $30 billion per year, or about 1% of national healthcare spending. The estimate on the costs of defensive medicine is difficult to ascertain. The estimates are between $100 billion to $300 billion, or 3% to 10% of overall healthcare costs.

As evidence of the difficulties of putting a price tag on defensive medicine, doctors’ and lawyers’ estimates vary drastically. Doctors estimate that defensive medicine and malpractice insurance premiums cost upwards of 10% of health care spending, while lawyers estimate costs at less than 0.5%. Different specialties, geographic locations, and insurance carriers also contribute to the varying estimates of malpractice premiums. The Congressional Budget Office, while acknowledging that studies have shown evidence of defensive medicine, maintains that it is still difficult to ascertain a true measure of the costs of defensive medicine. Further, the Congressional Budget Office points out that even provider groups acknowledge that defensive medicine is difficult to measure.

III. COMPETING SPECIAL INTERESTS

A closer look at obstetricians will lend insight into the prevalence of the practice of defensive medicine. Some researchers and doctors have been able to

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23 See generally MMS, supra note 18; see also Kessler & McClellan, supra note 13.
24 Kaissi, supra note 5.
25 Id.
27 Id.
28 Fernandez et al., supra note 1, at 4.
connect cesarean sections with defensive medicine. For example, according to Dr. Elizabeth A. Platz, from the Medical University of South Carolina in Charleston, “states classified as having a medical liability crisis or crisis brewing by ACOG (American College of Obstetricians and Gynecologists) have significantly higher rates of cesarean delivery, and this may reflect a pattern of defensive medicine in response to the liability climate.”29 Currently, cesarean rates are as high as 30% of total births in the United States compared to only 4.5% of births in 1965.30 Obstetricians may be quicker today to perform cesarean sections at any sign of complications from a fear of litigation and the high price of malpractice awards in these types of suits.31 Other doctors concur with the obstetricians’ position that it is the fear of litigation driving the practice of defensive medicine.32 Doctors, however, also say that it is difficult to ascertain which decisions are driven solely by fear of litigation because doctors also want to provide patients with comprehensive exams and treatments.33

Another group with a special interest in the defensive medicine argument is trial lawyers. Considering that trial lawyers represent patients in medical malpractice suits, it is not surprising that the trial lawyers’ position on tort reform has historically been in stark contrast to that of doctors; their stance on defensive medicine is no exception. Trial lawyers point to medical errors, contending that

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30 Id.
31 Id.
“one way to slash the exorbitant cost of health care would be to cut down on errors doctors make so that fewer cases wind up in the legal system.”34 In other words, “bad medicine, not lawsuits is to blame.”35 The organization Americans for Insurance Reform believes that “only a very small portion of health care costs result from defensive medicine.”36

Finally, the most important perspective of all is the patient’s perspective. Kevin Pho, a primary care doctor based in Nashua, New Hampshire, who also manages a medical blog, 37 discusses the risks associated with more tests and posits that a doctor must have a willing patient.38 A patient must “know that more tests might not always be better medicine.”39 Further, “before undergoing a scan or procedure, [the patient should] understand why it is being ordered.”40 Interestingly, it is not always the doctor who is practicing defensive medicine, but it is the patient who is asking for a certain test, and doctors comply by practicing assurance medicine.41 It is this very assurance behavior that may change the standard of care that patients expect, as well as accessibility to medical

37 Searcey & Goldstein, supra note 33.
39 Id.
40 Id.
41 Marloes A. van Bokhoven et al., Influence of Watchful Waiting on Satisfaction and Anxiety Among Patients Seeking Care for Unexplained Complaints, 7 ANNALS FAM. MED. 112, 113 (2009).
information through the internet or other forms of media that may also change their expectations of care.\textsuperscript{42}

IV. POSSIBLE SOLUTIONS

Historically, Democrats generally side with the trial lawyers, who oppose tort reform, while Republicans advocate for tort reform.\textsuperscript{43} Placing this debate in the current political context is important to understand why tort reform is only a small component of the healthcare overhaul. Additionally, with an overview of the defensive medicine debate, it is clear that no one solution will appease all groups. But, the White House has included in the current bill a $25 million allocation for states to implement patient safety and medical liability programs.\textsuperscript{44} The extent of these programs is yet to be determined.

The special interest groups have their own ideas of what could be the best interim solution until the political stars align and tort reform is passed. For instance, the American Medical Association advocates for safe harbor legislation, which would protect doctors from being sued for failing to order a test if the doctor has followed established guidelines that indicate a test is unnecessary.\textsuperscript{45} Yet, another solution approved this summer by the House Committee on Energy and Commerce requires malpractice attorneys representing patients to get a certificate of merit.\textsuperscript{46} This certificate of merit would be issued by a medical

\textsuperscript{43} Kaiser, supra note 26.
\textsuperscript{45} Jones, supra note 34.
\textsuperscript{46} Searcey & Goldstein, supra note 33.
professional certifying that procedures in a case failed to meet certain minimum standards.\textsuperscript{47} Another solution, supported by the MMS, is the creation of a task force to investigate issues related to the practice of defensive medicine.\textsuperscript{48} This task force could investigate the frequency of defensive medicine and the cost of defensive medicine in each state. Any of these solutions would be a step forward to better understanding the effects of defensive medicine on patient quality of care.

V. CONCLUSION

President Obama’s call to the American Medical Association House of Delegates to acknowledge and address the use of defensive medicine is not only an important call to doctors, but also to lawyers, patients, and Congress. It is clear that each of the groups have a special interest in either accepting or rejecting the prevalence of defensive medicine practice. Congress should bear these biases in mind when considering the different arguments on the true costs of defensive medicine, the frequency in which doctors practice defensive medicine, and the reasons why doctors practice defensive medicine.

\textsuperscript{47} Id.

\textsuperscript{48} Massachusetts Medical Society, \textit{supra} note 18.