

**ANNALS OF HEALTH LAW**  
***ADVANCE DIRECTIVE***

---

**VOLUME 19**

**SPRING 2010**

**PAGES 316-327**

---

***Using Medical Liability Tort Reform to  
Improve Patient Care***

*Vanessa Lu*<sup>\*</sup>

I. THE NEED FOR MEDICAL LIABILITY REFORM

Since the health care reform has passed, patient safety and access to care will continue to have issues affecting many people.<sup>1</sup> Patients are forced to wait longer and travel farther to see a doctor as physicians change their practice patterns due to the lack of affordable and available medical liability insurance.<sup>2</sup> Doctors have responded to rising liability insurance rates by giving up high-risk practices, limiting their practice to minimal litigation risk areas, or moving to states that enforces caps on liability.<sup>3</sup> Patients, in turn, are experiencing greater difficulties in seeing specialists.<sup>4</sup>

This article argues that states should continue to cap malpractice damage awards as a way of improving quality of care by managing the rising cost of

---

<sup>\*</sup> Juris Doctor Candidate, Loyola University Chicago School of Law, Class of 2011. Ms. Lu is a staff member of *Annals of Health Law*.

<sup>1</sup> Stuart L. Weinstein, *Medical Liability Reform Crisis 2008*, 467 CLINICAL RISK & JUD. REASONING 392, 392 (2009).

<sup>2</sup> *Id.*

<sup>3</sup> U.S. Dep't of Health & Human Servs., *Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs By Fixing Our Medical Liability System 1*, (2002), <http://aspe.hh.gov/daltcp/reports/litrefm.pdf> [hereinafter CONFRONTING THE HEALTH CARE CRISIS].

<sup>4</sup> *Id.*

health care. Part II discusses how our malpractice system decreases patient care when doctors practice defensive medicine. Furthermore, Part II encourages states to enact damages caps, which have demonstrably reduced the number of doctors practicing defensive medicine. Part III describes how the threat of litigation undermines efforts to improve care arguing that capping lower liability rates will assist hospitals and practice groups to divert funds to improve health care services. Finally, Part IV discusses how caps have improved access and quality of care, and how caps have ensured that each stakeholder of the healthcare system, including hospitals, physicians, nurses, and insurers, remain focused on improving patient care. Although caps are not a permanent solution, implementing caps is the best solution available under our current medical liability paradigm.

## II. THE VOLATILE MALPRACTICE ENVIRONMENT ENCOURAGES PHYSICIANS TO PRACTICE DEFENSIVE MEDICINE

Unlike other forms of insurance, such as automobile insurance, a physician's past performance does not affect how much medical liability insurance a private physician must acquire.<sup>5</sup> Generally, insurance companies charge premiums based on a physician's specialty and do not take into account the competence, skill, and quality of services provided by the physician.<sup>6</sup> To improve health care by compensating the injured, the fear of litigation has induced physicians to practice "defensive medicine." Defensive medicine is a

---

<sup>5</sup> Lee Harris, *Tort Reform as Carrot-and-Stick*, 46 HARV. J. ON LEGIS. 163, 178 (2009) ("Bad doctors are not penalized by insurance companies, which do not normally take into account previous performance when assessing medical malpractice insurance rates.").

<sup>6</sup> *Id.*

deviation from sound medical practice because doctors “alter their clinical behavior [due to] the threat of malpractice liability.”<sup>7</sup>

Defensive medicine creates important implications for the cost, access, and quality of care for patients.<sup>8</sup> When doctors practice defensive medicine, they provide substandard care to their patients.<sup>9</sup> Instead of focusing on the care the patient needs, physicians will provide care they think will help them avoid frivolous lawsuits.<sup>10</sup> Practice areas where defensive medicine is particularly prevalent include: emergency medicine, obstetrics/gynecology, neurosurgery, general surgery, orthopedic surgery, and radiology.<sup>11</sup>

One type of defensive behavior in which physicians engage in is known as “assurance behavior,” which is when a physician refers a patient to a specialist to show that the legal standard of care has been met.<sup>12</sup> Another type of assurance behavior is where a doctor supplements patient care with additional testing or treatments with little or no marginal health care value.<sup>13</sup> Doctors will also order unnecessary procedures to bolster their own confidence or create a trail of evidence that showed they had either confirmed or excluded certain diseases.<sup>14</sup> Each unnecessary test and treatment creates a potential risk to the patient, which

---

<sup>7</sup> David M. Studdert et al., *Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment*, 293 J. AM. MED. ASS'N 2609, 2609 (2005) (discussing how physicians practice “defensive medicine,” which is induced by the threat of liability).

<sup>8</sup> *Id.* at 2610 (“during a more volatile period in liability insurance markets, physicians’ uncertainty about the costs and availability of coverage may induce a wider array of defensive practices, affecting not only the cost of health care, but also its accessibility and quality”).

<sup>9</sup> See Michelle M. Mello et al., *Caring for Patients in a Malpractice Crisis: Physician Satisfaction and Quality of Care*, 23 HEALTH AFFS. 41, 51 (2004) (discussing how physicians’ defensive behavior may result in the form of lower quality and availability of health services).

<sup>10</sup> CONFRONTING THE HEALTH CARE CRISIS, *supra* note 3, at 4.

<sup>11</sup> *Id.*

<sup>12</sup> *Id.* at 2609.

<sup>13</sup> *Id.*

<sup>14</sup> *Id.* at 2616.

jeopardizes the patient's safety.<sup>15</sup> In addition, false-positive results associated with low-yield diagnostic testing occur more often with additional tests.<sup>16</sup> When ambiguous test results occur, the quality of care is compromised because patients undergo emotional distress when subjected to additional invasive or hazardous procedures.<sup>17</sup>

Ever increasing malpractice insurance premiums also induce physicians to practice avoidance behavior.<sup>18</sup> Physicians have attempted to limit the risk of litigation by reducing care, such as refusing to treat patients with complicated health conditions or eliminating high-risk procedures.<sup>19</sup> Physicians with high premiums avoid high-risk procedures, move to states with damage award caps, and either retire early or stop practicing medicine altogether.<sup>20</sup> All these circumstances negatively affect patient treatment because patients are required to travel farther and wait longer to be seen by a specialist.<sup>21</sup> When doctors leave a clinical practice or relocate, they disrupt the continuity of care of their patients and compromise access to health services in underserved regions.<sup>22</sup>

Studies have shown that states that have implemented damage caps have helped reduce the frequency and severity of malpractice claims, premiums, and

---

<sup>15</sup> Michael Rowe, *Medical Malpractice: What Remedy?*, 262 OECD OBSERVER 17, 18 J (2007), (calling more tests, prescribing more drugs, and sending patients to specialists are costly measures with little benefit and involve risks for patients); *see also* Studdert et al., *supra* note 7, at 2612 (prescribing more medications and suggesting invasive procedures that were unwarranted in their professional judgment).

<sup>16</sup> *See* Studdert et al., *supra* note 7, at 2616.

<sup>17</sup> *Id.*

<sup>18</sup> *Id.* at 2609.

<sup>19</sup> *Id.* at 2609, 2613.

<sup>20</sup> Mello et al., *supra* note 9, at 43-44 (discussing how physicians react to rising liability rates and practice defensive medicine).

<sup>21</sup> Donald J. Palmisano, *Health Care in Crisis: The Need for Medical Liability Reform*, 5 YALE J. HEALTH POL'Y L. & ETHICS 370, 375, 382 (2005) (discussing indirect effects on patients).

<sup>22</sup> *See* Mello et al., *supra* note 18, at 43-44.

health care expenditures because physicians engage in less defensive medicine.<sup>23</sup>

Physicians practicing in states with caps have lower perceptions of malpractice risks compared to physicians practicing in states without caps.<sup>24</sup> Damage caps help insurance carriers lower their premiums<sup>25</sup> and, as a result, more doctors can afford liability insurance.<sup>26</sup> Not only does this increase the supply of health care by increasing the number of physicians in a geographical area, but when doctors can pay their premiums, they are less likely to practice defensive medicine.<sup>27</sup>

Indeed, studies show that caps are responsible for a small but statistically significant increase in the supply of physicians.<sup>28</sup> The number of physicians in rural counties is about three percent higher in a state with caps versus states without caps.<sup>29</sup> As a result, states that enact caps can improve the quality and access to care for patients.

---

<sup>23</sup> Fred J. Hellinger, *The Impact of State Laws Limiting Malpractice Damage Awards on Health Care Expenditures*, 96 AM. J. PUB. HEALTH 1375, 1375 (2006) (discussing how tort reform directly limit payments, reduce the frequency, and severity of malpractice claims).

<sup>24</sup> See John F. Dick III et al., *Predictors of Radiologists' Perceived Risk of Malpractice Lawsuits in Breast Imaging*, 192 AM. J. ROGENTOLOGY 327, 332 (2009) (radiologists from Colorado might have lower perceptions of malpractice risk compared to other U.S. radiologists because Colorado has malpractice caps).

<sup>25</sup> Hellinger, *supra* note 21, at 1377 (states with malpractice payment caps had premiums that were 17.1 % lower than states without caps).

<sup>26</sup> Weinstein, *supra* note 1, at 396 ("caps have been proven to keep premiums down").

<sup>27</sup> See Studdert et al., *supra* note 7, at 2616 (finding that physicians practiced defensive medicine to qualify for less expensive medical insurance).

<sup>28</sup> Michelle M. Mello, *Medical Malpractice: Impact of the Crisis and Effect of State Tort Reforms*, 11 (2006) (concluding that "caps are associated with a small increase in physician supply").

<sup>29</sup> Carol K. Kane et al., *The Impact of Liability Pressure and Caps on Damages on the HealthCare Market: An Update of Recent Literature*, POLICY RES. PERSP. 1, 3 (2007) (describing the positive impact of caps).

III. MALPRACTICE LITIGATION IMPAIRS THE ABILITY TO  
IMPROVE PATIENT CARE

Not only do rising liability premiums and the inability to obtain coverage influence the location of practice and what practice areas physician choose,<sup>30</sup> but they also affect the amount of time a physician can spend treating a patient.<sup>31</sup> Improving patient care requires preventing medical errors, but the fear of litigation discourages doctors and hospital staff from discussing their mistakes.<sup>32</sup> Physicians do not want their medical authority undermined; and as a result, they refrain from getting involved with another doctor's patient, even at the expense of increasing the risk of medical error.<sup>33</sup>

Fear of litigation has negatively affected the quality of care that physicians provide their patients and is detrimental to the patient-physician relationship as well.<sup>34</sup> First, fear of litigation incentivizes physicians to waste valuable and scarce hospital resources.<sup>35</sup> For example, obstetrics and breast cancer detection are high-liability fields where the quality of care is diminished when specialists order costly and wasteful imaging studies.<sup>36</sup> Second, physicians cannot provide the best quality of care and services to their patients when malpractice concerns

---

<sup>30</sup> See Kesser et al., *Impact of Malpractice Reforms on the Supply of Physician Services*, 293 J. AM. MED. ASS'N at 2618, 2618 (2005) (malpractice climate influences what specialty a physician enters into and the location).

<sup>31</sup> See Mello et al., *supra* note 9, at 50.

<sup>32</sup> See CONFRONTING THE HEALTH CARE CRISIS, *supra* note 3, at 6.

<sup>33</sup> Jonathan Todres, *Toward Healing and Restoration for All: Reframing Medical Malpractice Reform*, 39 CONN. L. REV. 668, 691 (2006) (discussing doctors' reluctance to admit and talk openly about mistakes).

<sup>34</sup> Mello et al., *supra* note 9, at 48.

<sup>35</sup> See e.g., Studdert et al., *supra* note 7, at 2613 (high-risk specialists reported performing extensive tests and ordering unnecessary tests).

<sup>36</sup> *Id.* at 2617.

preclude them from having an open and truthful patient-physician relationship.<sup>37</sup>

Because a physician views each patient as a potential lawsuit, the physician prescribes the care that he or she thinks will meet the legal standard rather than discussing the different treatment options with the patient.<sup>38</sup>

Not only does excessive litigation impede the efforts to improve care, but also forces everyone to pay higher premiums as well as increases out-of-pocket expenses.<sup>39</sup> Many practices and hospitals have taken steps, such as creating “volume” practices, to reduce overhead costs associated with liability insurance.<sup>40</sup> Practices and hospitals have reduced their clinical and administrative staff to help pay for liability insurance premiums.<sup>41</sup> Simply stated, to generate revenue doctors must either increase their fees or treat more patients. Many times, however, Medicare, Medicaid, and other managed healthcare plans prevent doctors from raising their fees.<sup>42</sup> As a result, doctors are forced to treat more patients to generate enough revenue.<sup>43</sup> Physicians who have full patient loads have a difficulty treating additional patients without compromising patient care.<sup>44</sup>

---

<sup>37</sup> See Mello et al., *supra* note 18, at 48-49 (liability pressures affect the quality of care by impinging upon the physician-patient relationship).

<sup>38</sup> *Id.* at 44 (the physician-patient relationship suffers because the physician does not trust the patient and does not speak freely due to the fear of malpractice); see also Studdert et al., *supra* note 7, at 2609.

<sup>39</sup> David A. Hyman et al., *Speak Not of Error*, HEALTH & MED. 52, 54 (2005) (discussing how the tort system does not adequately compensate patients, increases costs and error rate).

<sup>40</sup> See Mello et al., *supra* note 18, at 50.

<sup>41</sup> *Id.* at 50-51.

<sup>42</sup> James A. Comodeca et al., *Killing the Golden Goose By Evaluating Medical Care Through the Retroscope: Tort Reform From the Defense Perspective*, 31 U. DAYTON L. REV. 207, 220 (2006).

<sup>43</sup> Mello et al., *supra* note 18, at 50 (discussing how liability pressures affect the quality of care by impinging upon the physician-patient relationship).

<sup>44</sup> *Id.* (“The first victim is going to be quality of care, in terms of how many patients you seen an hour, the amount of time you give them.”).

Finally, practices and hospitals must sacrifice improving patient safety and modernizing treatment facilities to pay high liability costs.<sup>45</sup>

Indeed, health services have been reduced in response to the rising medical malpractice costs. Even trauma centers are not immune from the downward spiral of quality of care caused by the threat of litigation and increased malpractice insurance premiums.<sup>46</sup> In 2003, two neurosurgeons from Joliet, Illinois were forced to stop practicing brain surgery.<sup>47</sup> As a result, the only two hospitals in Joliet could no longer treat head trauma cases.<sup>48</sup> The hospitals were forced, therefore, to stabilize and transport their patients with serious head injuries to the nearest trauma center, which was forty-five minutes away.<sup>49</sup> Forcing a patient with serious head injuries to wait forty-five minutes to receive medical treatment is not only unreasonable, but clearly shows that tort reform is necessary. Our current malpractice system creates barriers that not only limits a patient's access, but also diminishes the quality of care.<sup>50</sup>

High malpractice costs have forced free clinics to shut down; thus, leaving many Americans vulnerable without access to quality care.<sup>51</sup> Because many doctors cannot afford their high liability insurance, they are unable to volunteer their time in free clinics.<sup>52</sup> Clinics are forced to spend the little funding they have to obtain malpractice insurance and, thus, less money is left to provide services

---

<sup>45</sup> *Id.* at 51

<sup>46</sup> Comodeca et al., *supra* note 40, at 220-21 (almost half of the American hospitals have reported reduced coverage in their emergency department).

<sup>47</sup> *Id.* at 221.

<sup>48</sup> *Id.*

<sup>49</sup> *Id.*

<sup>50</sup> See CONFRONTING THE HEALTH CARE CRISIS, *supra* note 3, at 2.

<sup>51</sup> *Id.* at 4.

<sup>52</sup> *Id.*

for low-income patients.<sup>53</sup> Free clinics have a difficult time providing health care services due to the lack of volunteer physicians.<sup>54</sup>

Hospitals, doctors, and nurses are reluctant to report errors and problems and to participate in joint efforts to improve patient care.<sup>55</sup> Our adversarial legal system discourages open and honest communications because doctors fear that any admission of fault will be used against them in court.<sup>56</sup> To reduce litigation, physicians must be assured that any admissions of error will not be used against them and thus, future mistakes can be prevented.<sup>57</sup> Unless our healthcare paradigm provides doctors protection from liability, mistakes will continue to occur and injure patients.

#### IV. DAMAGE CAPS ARE THE MOST EFFECTIVE TORT REFORM AVAILABLE

In comparison to other tort reform measures, legislation that limits damage awards has proven to be effective in controlling liability costs, reducing medical costs to consumers, and increasing access to health care.<sup>58</sup> Statute of limitations is a law that “establish[es] a time limit for [a plaintiff to sue] in a [medical-malpractice] case, based on the date when the [plaintiff’s] claimed accrued (as when the injury occurred or was discovered).”<sup>59</sup> Many states have shortened their statute of limitations to encourage plaintiffs to take prompt legal action and

---

<sup>53</sup> *Id.*

<sup>54</sup> *See id.*

<sup>55</sup> *Id.* at 1.

<sup>56</sup> Bryan A. Liang et al., *Medical Liability Insurance and Damage Caps: Getting Beyond Band Aids to Substantive Systems Treatment to Improve Quality and Safety in Healthcare*, 30 AM. J.L. & MED. 501, 503 (2004) (discussing how reducing medical errors will reduce medical malpractice).

<sup>57</sup> *Id.*

<sup>58</sup> *See id.* at 502.

<sup>59</sup> BLACK’S LAW DICTIONARY 1450-51 (8<sup>th</sup> ed. 1999).

discourage frivolous lawsuits; however, this measure fails to improve patient compensation.<sup>60</sup> In fact, statute of limitations does not ensure that only meritorious cases proceed and the tolling period varies from state to state.<sup>61</sup> Limiting contingency fees may reduce the number of frivolous lawsuits; but this remedy does not efficiently compensate the injured patient, does not facilitate harm reduction, and does not address the emotional needs of the patient.<sup>62</sup>

Alternative dispute resolution (ADR) is another remedy used to permit parties to “control” how they want to resolve the malpractice conflict by allowing parties to select the arbitrator as well as reduce the trauma of litigation, reduce costs, and provide an efficient resolution.<sup>63</sup> Nevertheless, ADR presents a less restrictive forum compared to the traditional legal system.<sup>64</sup> Furthermore, ADR alleviates the procedural restraints and procedural rules that would be enforced in court.<sup>65</sup> Critics of ADR question whether patients really fully understand all the terms of the mandatory arbitration contract.<sup>66</sup> Similar to ADR, mediation is a more informal environment for parties to resolve their dispute; however, the threat of litigation exists if a resolution cannot be reached.<sup>67</sup>

Although damage caps are not a permanent solution, this type of reform has proven to be effective and is the best solution available under our current

---

<sup>60</sup> Todres, *supra* note 33, at 695.

<sup>61</sup> *Id.*

<sup>62</sup> *Id.* at 696.

<sup>63</sup> *Id.* at 697.

<sup>64</sup> *Id.*

<sup>65</sup> *Id.*

<sup>66</sup> *Id.* at 699.

<sup>67</sup> *Id.*

healthcare system.<sup>68</sup> To help alleviate costs for practice groups, hospitals and clinics, states should further implement damage caps. Studies show that states with caps have per capita health expenditure costs three percent lower than states without caps.<sup>69</sup> States without caps should enact laws to cap the total damage awarded or limit the noneconomic component to deter frivolous lawsuits, but still permits meritorious claims to proceed.<sup>70</sup> Consequently, insurance companies would be able to lower their liability rates because caps make it possible for insurers to more accurately predict exposure to malpractice damages.<sup>71</sup> In some states, damage caps have helped insurance companies to reduce their rates and, thus, allowing physicians to continue to practice and provide continuous care to patients in that particular state.<sup>72</sup>

## V. CONCLUSION

Legislation that limits damage awards has proven to be effective in controlling liability costs, reducing medical costs to consumers, and increasing access to health care for individuals.<sup>73</sup> Research studies show that these laws have a successful track record to help lower losses or indemnity amounts, lower premiums, and increase the supply of physicians.<sup>74</sup> As such, states should implement damage caps to help improve the quality of care and medical services

---

<sup>68</sup> Liang et al., *supra* note 56, at 502.

<sup>69</sup> Hellinger, *supra* note 23, at 1379.

<sup>70</sup> See Troyen A. Brennan et al., *Medical Malpractice*, 350 NEW ENG. J. MED. 283, 288 (2004) (discussing how caps on damages make the most lucrative lawsuits worth less, indirectly limit the contingency fee, and ensure that fewer cases hold the promise of a favorable return on investment for a plaintiff's attorney).

<sup>71</sup> *See id.*

<sup>72</sup> Liang et al., *supra* note 56, at 502.

<sup>73</sup> Hellinger, *supra* note 23, at 1375.

<sup>74</sup> *Id.*; see also MELLO, *supra* note 28, at 11.

to its citizens. Although damage caps are not the perfect solution, this is a tort reform that has proven to be effective to helping several states reduce their health care costs and stabilize access to care by providing incentives for physicians to continue practicing within the state.<sup>75</sup>

---

<sup>75</sup> Liang et al., *supra* note 56, at 502.