

The Culture of Defensive Medicine: Is Tort Reform Necessary?

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Introduction

This paper examines the culture of defensive medicine that has spread rapidly across the United States in response to an increase in malpractice lawsuits and staggering malpractice insurance premiums in certain high-risk medical and surgical specialties. Due to the presence of this culture, it is important to question whether tort reform (e.g. placing caps on jury awards) is necessary to curb rising malpractice insurance premiums and reduce the implicit costs of defensive medicine. Based on compelling data, placing caps on jury awards for pecuniary and non-pecuniary damages will reduce malpractice premiums, ensure fair compensation for victims of medical negligence, and encourage physicians to practice sound medicine in high-risk specialties by dismantling the culture of defensive medicine prevalent throughout the United States.

The culture of defensive medicine is defined by the Office of Technology Assessment as the practice of “order[ing] tests, procedures, or visits, or avoid[ing] high risk patients or procedures, primarily (but not necessarily solely) to reduce [doctors’] exposure to malpractice liability.”¹ Indeed, as two prominent economists, Kessler and McClellan, argue, “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.”² Even more troubling, Studdert et al. surveyed 824 physicians on the prevalence of defensive medicine in their practice: 93 percent reported that they sometimes or often engaged in defensive medicine outlined in the survey.³ Many of the respondents to the survey also reported that they had restricted the scope of their clinical practice because of liability concerns (42 percent) and/or were likely to do so further in the next two years (49 percent).³ It is critical, therefore, for policymakers and future healthcare professionals to have a sound understanding of the defensive medicine culture (and the benefits of tort reform) to understand how it contributes, along with other factors, to current “expenditures [of U.S. healthcare which are predicted to rise] from \$1.6 trillion in 2002 (14.9 percent of gross domestic product) to \$3.6 trillion by 2013 (18.4 percent of gross domestic product).”⁴

Basis for Soaring U.S. Healthcare Costs

First, this paper will discuss how the defensive medicine culture has contributed in a small (yet significant) manner

to the overwhelming cost of American health care today. Next, this essay will propose and support that a viable though contentious solution to this culture is tort reform. It will also consider opposing arguments that suggest defensive medicine is not a substantial problem, but instead that other problems (diminishing stock market returns, culture of technology, etc.) play a greater role in increasing malpractice premiums and healthcare costs. Then, it will explain why no sweeping, national tort reform measures exist in the United States. Finally, it will conclude by summarizing both sides’ arguments and discuss the broader implications of this debate for future policymakers to comprehensively attack the problem of rising healthcare costs in the United States.

The culture of defensive medicine that has taken root in the United States in recent decades has led to escalating health care costs caused by an increase in medical procedures and tests designed to prevent high-cost malpractice lawsuits. This is accurately summarized by Kessler and McClellan, who state, “Many physicians and policymakers have argued that the incentive costs of the malpractice system, due to extra tests and procedures ordered in response to the perceived threat of a medical malpractice claim, may account for...the explosive growth in healthcare costs.”² Additionally, patient care outcomes may suffer as a result of “the practice of defensive medicine...if liability induces providers either to administer harmful treatments or forego risky but beneficial ones.”

Clearly, the practice of ordering extra and unnecessary tests and procedures indirectly increases patients’ costs. Indeed, as Studdert et al. argue, “...the prevalence of assurance behavior, coupled with the unit of cost procedures typically ordered (e.g. MRIs), lends weight to arguments that the total cost of defensive medicine is substantial.”³ As patients use a larger quantity of services, insurers must reimburse physicians for more; this drives up health insurance premiums as insurers must make a profit to stay in business. Since medical resources are finite (the supply) while the medical services requested increase exponentially (the demand), the cost of each service must increase accordingly. As such, higher insurance premiums combined with higher costs for individual services contribute to an overall increase in healthcare costs for the country.

Implications for Patient Care

Physicians have a greater incentive to take precautions with certain risky procedures and medically liable patients. However, it is an incentive which has long-term, negative consequences. Regarding defensive medicine, state and national surveys have reported that 16 to 64 percent of physicians across all specialties stopped providing or limited the frequen-

cy of providing certain high-risk procedures or they simply avoided certain patients because of the malpractice environment.⁵ As more providers run more precautionary exams and tests to avoid medical liability while limiting the frequency of the high-risk procedures which may improve the patient's quality of life, more patients will suffer from chronic illnesses and may develop more serious problems due to lack of access. Studdert also supports the prevalence of the negative consequences of defensive medicine by noting that large numbers of physicians reported engaging in avoidance behavior. Indeed, some surgeons appeared to limit their practice to "bread-and-butter" cases, no longer performing difficult procedures, while avoiding sicker patients, those with prior complications, and those who had sued before.³ Jacobson and Rosenquist contest, however, that "the inability to control [the culture of technology]...is likely to put a far greater strain on the nation's health care resources than is the practice of defensive medicine", though they concede that "the existence and extent of defensive medicine comprise an important policy issue that needs to be addressed."⁶ Additionally, U.S. government institutions such as the now-defunct Office of Technology Assessment concluded in 1994 that "[defensive medicine only] accounts for approximately 5 to 8 percent of all diagnostic tests."⁷ Although the impact and extent of defensive medicine is disputed, most observers agree that it is imperative for policymakers to examine it as one of multiple contributing factors in the national dialogue on preserving the physician-patient relationship and protecting the quality of patient care.

Indeed, there is evidence that the implicit, mutual trust of the physician-patient relationship is eroding as physicians see patients as adversaries and potential plaintiffs. In fact, "certain types of patients commonly prompt specialist physicians to behave defensively, especially those who are seen as demanding, emotional, or unpredictable...patients with prior complications...noncompliant patients, workers' compensation cases, and obese persons...[This reflects] a level of suspicion that itself is arguably detrimental to quality [and leads to dissatisfaction among physicians]."³ If unhappy physicians cannot reciprocate the trust placed in them by their patients, they cannot provide quality care; likewise, if the patient cannot trust the physician, he is less likely to adhere to medical advice and more likely to have a poor outcome. Kaiser Permanente researcher Donald Freeborn agrees, stating, "Low levels of job satisfaction among physicians may affect doctor-patient relationships and compromise quality of care."⁸ Consequently, it is clear that the culture of defensive medicine in the U.S. has multiple negative consequences: higher health-care costs through unnecessary tests and procedures, limited access to high-risk procedures or for high-risk patients, lower quality patient care/outcomes, and a more hostile, adversarial physician-patient relationship.

Solution: Tort Reform?

In response to these harmful consequences of defensive medicine, many groups (American Medical Association,

American Tort Reform Association, and the U.S. Chamber of Commerce) have proposed tort reform through caps on jury awards to rein in the escalating costs of malpractice insurance and encourage physicians to practice sound medicine. Indeed, many physicians "maintain that escalating, multimillion-dollar awards are driving premium increases and that restricting malpractice payments will lower health care expenditures by reducing the practice of defensive medicine."⁹

To be clear, it is not merely speculation that malpractice insurance premiums are increasing for many physicians in high-risk specialties. According to Emory University public health expert Kenneth Thorpe, "Depending on the specialty

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and state, the median increase in malpractice premiums ranged from 15 to 30 percent. Rate increases in other states, such as Pennsylvania, ranged from 26 to 73 percent in 2003."¹⁰ Linking malpractice premiums to defensive medicine, several studies have found evidence "supporting...that the scope and extent of defensive medicine is greater in areas with high malpractice claim rates and high premiums." For additional evidence, the Hellinger study noted that "rates of growth in malpractice premiums and claims payments have been slower on average in states that enacted certain caps on damages for pain and suffering—referred to as non-economic damage caps—than in states with more limited reforms... from 2001 through 2002, average premium rates rose approximately 10 [percent] in states with non-economic damage caps of \$250,000 compared with approximately 29 [percent] in states with more limited tort reforms."⁹ Therefore, setting caps on jury awards has a positive impact on reducing defensive medicine and malpractice premiums.

The Thorpe article "The Medical Malpractice 'Crisis'" supplies additional data to support the passage of caps on jury awards: "premiums in states with a cap on awards were 17.1 percent lower than in states without such caps."¹⁰ To further bolster this argument, the authors from Indiana University, Gronfein and Kinney, discuss the effects of tort reform in Indiana of caps on both economic and non-economic damages. In 1975, Indiana adopted a comprehensive set of malpractice insurance and tort reforms, including a cap on all damages, a state-operated insurance fund for claims over \$100,000 and mandated pre-trial medical review before trial. Compared with similar sized, neighboring states Michigan and Ohio, which do not have these reforms, Indiana has enjoyed one of the lowest rates of malpractice insurance in the United States. In fact, Gronfein and Kinney go on to argue that "under Indiana's system, all major parties are better off in the aggregate. Malpractice insurers...[are better off because] claim severity is controlled and therefore more predictable. Providers are better off because they are assured the availability of coverage and comparatively low malpractice insurance costs. Most importantly, most claimants with large claims are better off

because they receive more (30 to 40 percent higher than in Michigan or Ohio) for their injuries and their attorneys' fees are capped."¹¹

However, there is an important tradeoff to consider with the reduced compensation of elderly and unemployed plaintiffs under a tort system capped for non-economic damages. As Hyman et al. report in the case of Texas, "Payouts...varied across groups; for example aggregate (per claim mean) payouts declined by 38% (19%) for elderly plaintiffs, compared to 22% (10%) for babies...there is a striking gap [as well] between the 53% aggregate reduction payout for unemployed deceased plaintiffs, versus 17% decline for employed deceased plaintiffs."¹² Tort reform through caps on jury awards clearly decreases malpractice premium rates and helps reduce defensive medicine, but proponents must carefully design and implement plans to minimize disparities in fair compensation for victims of medical negligence based on age, employment status, or other factors.

Criticism of Tort Reform

As seen in parts of this article, opponents of tort reform argue that defensive medicine is not the problem (or only contributes negligibly to total health care costs), but rather that insurance companies' declining stock market returns are to blame for the current medical liability crisis. They argue that tort reform through caps on jury awards reduces fair compensation to injured plaintiffs, allows physicians to escape punishment, makes no guarantee that insurance companies will reduce malpractice premiums, and results in unsafe medical practices. They contend that defensive medicine is not a substantial problem contributing to the rising costs of health care in the United States.

First, according to many of the studies cited in this paper, both defensive medicine and insurance company losses play a role in the current malpractice crisis. While Thorpe states that "higher investment returns offset the need to raise premiums", indicating that insurance company losses in the stock market may contribute to rising premiums, Jacobson et al. admit that "liability fears have no doubt influenced the climate of medical practice...[though] isolating the use of specific tests or procedures to avoid liability remains a difficult task." Second, tort reform actually increases fair compensation for injured plaintiffs. For instance, Indiana actually pays out "nearly 40 percent [more]...than the mean claim payment in Michigan [and] 33 percent [more] than the mean claim payment in Ohio." Under their reformed civil law system, Indiana physicians are assured "availability of [malpractice] coverage and comparatively low malpractice insurance costs." Third, victims of real medical negligence, as determined by a pre-trial medical review board, can still sue physicians for generous awards commensurate with their injuries. Fourth, as the tort reform in Indiana shows, malpractice premiums dropped relative to the rates in the rest of the country as "claim severity [was] more controlled and predictable." Last, with lower malpractice premiums, physicians would be encouraged to treat high-risk patients and perform high-risk procedures more often; the financial and emotional costs of defensive medicine

would decrease as doctors limited tests and procedures to only those that were necessary.⁸

Current Obstacles

Despite the benefits of tort reform and legislation to place caps on jury awards in 28 states, no federal legislation has passed to provide sweeping damage caps in the entire nation due to the efforts of various lobbying forces. According to a 2001 article by Scott Tarry, the American Association of Justice (AAJ) lobby, formerly known as the Association of Trial Lawyers of America, is "one of the nation's most well-connected and biggest spending interest groups."¹³ In fact, the Center for Responsive Politics reported recently that the AAJ lobby contributed over \$1.4 million to various political campaigns in the 2008 election cycle. In comparison, the American Medical Association lobby has spent a meager \$300,000 in campaign contributions thus far.¹⁴

Unfortunately, politicians respond to campaign contributions through the legislation they push through Congress, which often serves the interests of their richest supporters. As such, the AAJ and others lobby aggressively to block legislation that would threaten hefty fees in malpractice lawsuits (i.e. tort reform through caps on jury awards). Ironically, as mentioned above, plaintiffs would actually obtain larger jury awards ("40 percent more than in Michigan, 33 percent more than in Ohio") with tort reform as seen in Indiana. Trial lawyers would still draw generous fees from their clients' lawsuits, but perhaps not the exorbitant sums they often receive. "During 1990, 1.5 percent of all paid claims exceeded a million dollars. By 2001 the percentage had risen to 8 percent," cites Thorpe, underscoring the rising rate of large jury awards. Additionally, even though juries award large sums to plaintiffs, much of it is swallowed up by "standard contingency fees charged by plaintiffs' attorneys (35 percent of the indemnity payment),"¹⁵ which affirms Studdert's prior convictions. As such, as long as there are lobbyists in Washington, it is clear that legislation will favor the most generous lobbyists; to combat this problem and push tort reform through, like-minded organizations must band together to spend more money explaining its merits to key members of Congress who can then effect change to pass bipartisan, nuanced legislation with the cooperation of opposing parties.

Conclusion

The culture of defensive medicine that has taken root across the United States calls for greater discussion of change in the tort law system among all parties involved (physicians, insurers, lawyers, patients). The presented data from a wide variety of studies and reports suggest that setting caps on jury awards through tort reform will appreciably decrease malpractice premiums, encourage physicians to practice sound medicine, and decrease the number of malpractice lawsuits through the elimination of the pervasive defensive medicine culture. Indeed, as Kessler and McClellan conclude in their study, "We find that malpractice reforms that directly reduce provider liability pressure lead to reductions of 5 to 9 percent

in medical expenditures without substantial effects on mortality or medical complications...liability reforms can reduce defensive medical practices.”² Keeping in mind the Hyman et al. article, wise reformers will take a nuanced approach to tort reform, particularly with setting caps on jury awards, to ensure fair, equitable compensation for all plaintiffs regardless of age, employment status, or other variable¹².

Nevertheless, the passage of meaningful tort reform similar to that of Indiana will require a significant majority of supporters, especially among those who staunchly oppose any caps on jury awards. While tort reform opponents make their case articulately against caps on jury awards, which they claim would protect physicians and insurers over patients, the data for the benefits of tort reform is more compelling. In particular, explaining the current, stabilized malpractice situation in Indiana (an example of effective tort reform) to the AAJ is a wise move in building a task force across aisles to best serve the economic interests of lawyers, physicians, insurers, and the economic interests of and quality of care for patients. Future policy makers and politicians interested in progress on this clearly divisive issue should focus on generating healthy debate on the various factors contributing to the costliness of American healthcare (defensive medicine, diminishing stock market returns, culture of technology) and negotiating comprehensive, bipartisan legislation “[chiefly] to promote patient safety [and] not merely to provide safe harbors for potential defendants.”⁵

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