Malpractice Litigation, Defensive Medicine Cost Less Than Thought

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September 7, 2010 — Many physicians and conservative politicians contend that to curb the rising cost of healthcare, the United States needs bold medical liability reform as opposed to the healthcare reform enacted by Congress this year. Discourage frivolous suits, eliminate jackpot judgments, and defensive medicine and all its expensive overtesting and overtreating will wane, they say.

However, the potential of tort reform to control healthcare costs comes under question in a study published in the September issue of the journal *Health Affairs*. It puts the cost of malpractice litigation and defensive medicine combined at $55.6 billion annually in 2008 dollars, or 2.4% of total healthcare spending. In contrast, a 2007 study by the conservative National Center for Policy Analysis estimated that the annual cost of defensive medicine alone was between $100 billion and $178 billion in 2005, while a 2006 study by PriceWaterhouseCoopers reported that the cost of malpractice insurance and defensive medicine topped $200 billion.

Lead author Michelle Mello, JD, PhD, a professor of law and public health at the Harvard School of Public Health in Boston, Massachusetts, and coauthors write that $55.6 billion is not a trivial amount, but "less than some imaginative estimates put forward in the health reform debate, and it represents a small fraction of total health care spending."

Of the $55.6 billion, $45.6 billion is due to defensive medicine, mostly in the form of hospital as opposed to physician services. Settlements and court judgments chalk up $5.72 billion, administrative costs such as legal fees contribute another $4.1 billion, while the value of lost clinician time is $200 million. The quality of the evidence supporting these estimates range from moderate to good, except for defensive medicine, where the quality of evidence is low.

"Reliable estimates of its cost," the authors write, "are notoriously difficult to obtain."

Fear of Malpractice Lawsuits Resembles Fear of Flying

Other studies in the September issue of *Health Affairs* also debunk conventional wisdom about malpractice. J. William Thomas, PhD, MBA, a visiting professor at the Muskie School of Public Service at the University of Southern Maine, Portland, and colleagues, for example, calculate that tort reform would have scant effect on defensive medicine regardless of specialty.

The authors looked at the relationship between malpractice insurance premiums and the cost of the care rendered or ordered by physicians. The level of malpractice premiums, which tort reform seeks to lower, served in the study as a measure of physicians' perceived liability risk. Lower premiums signified a safer liability environment that presumably called for less defensive medicine.

As it turned out, a 10% decline in malpractice insurance premiums reduced defensive-medicine costs by only 0.13% across all 35 medical specialties in the study, and by less than 1% for any given specialty. A 30% decrease in premiums led to a 0.4% decrease in defensive-medicine costs across the board.

How physicians view their chances of getting sued is the focus of a study by Emily Carrier, a senior health researcher at the Center for Studying Health System Change and colleagues, who included Dr. Mello. They measured physician concern about malpractice with a survey in which physicians could score their agreement or disagreement with statements such as, "I feel pressured in my day-to-day practice by the threat of malpractice."

Between 60% and 78% of physicians expressed agreement or strong agreement with each of the statements, translating into a composite worry score of 65.4 on a scale of 100. Among the specialties, emergency physicians topped the list at 82 while psychiatrists were the least concerned, posting a score of 51.4.
This worry score increased for physicians with higher malpractice liability risk, but only slightly, even when liability risk varied dramatically. One measure of this risk is the price of malpractice insurance premiums. Nearly a 3-fold difference in average premium costs exists between the third of states where premiums are highest and the third where premiums are lowest. Yet physicians in the top third of states scored only 5.4 percentage points higher than their counterparts in the bottom third, who scored 60.8 on the worry scale. The difference was even smaller when researchers examined other measures of risk:

- The number of paid malpractice claims per 1000 physicians
- The average payment per paid claim
- The so-called malpractice claim risk per physician, which equals the number of paid claims multiplied by the average payment
- The presence or absence of a limit on total malpractice damages a plaintiff could receive
- The presence or absence of a law abolishing joint-and-several liability, in which a plaintiff can collect the total amount of damages from any single defendant in a case involving multiple defendants, regardless of their share of liability

"The level of liability concern reported by physicians is arguably out of step with the actual risk of experiencing a malpractice claim," the authors write. They compare the fear experienced by physicians to the "statistically irrational" risk aversion of people who feel safer driving than flying, even though they are more likely to die in a car crash than a plane crash. Tort reform that replaces rancorous litigation with early, out-of-court settlement of malpractice claims may help lower anxiety levels, they write.

More Work Needed to Reduce Diagnostic Errors

Several other articles in Health Affairs point out ways to lower the incidence of malpractice in the first place.

Marcus Semel, MD, a general surgery resident at Brigham and Women's Hospital in Boston, Massachusetts, and colleagues write that hospitals can reduce their surgical complication rates — and save money in the process — by adopting the World Health Organization Surgical Safety Checklist. This checklist prompts an operating room team before induction of anesthesia, for example, to verbally establish that the patient has confirmed his or her identity, the procedure, the surgical site, and his or her consent to the operation.

But what good is a checklist if the patient undergoing the procedure had been diagnosed with the wrong disorder? Robert Watchter, MD, the associate chair of the Department of Medicine at the University of California–San Francisco, raises this question in an article that argues for a more concerted effort to lower the rate of misdiagnosis.

Missing the diagnosis accounts for almost 20% of all adverse events, yet Dr. Watchter notes that patient-safety advocates do not pay commensurate attention to the problem, partly because cognitive errors have not lent themselves to systemwide, process-oriented solutions such as checklists. Dr. Watchter recommends further research into the source of diagnostic errors along with implementation of the findings, improved training, the use of computerized decision-support systems, and more of an emphasis on diagnostic accuracy in board certification.