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Why Are Demonstrations of Comprehensive Malpractice Reform So (At All) Controversial?*

WILLIAM M. SAGE**

I am delighted to participate in the University of Memphis’s 2007 symposium on medical liability reform. Today, you have heard interesting and important perspectives that seldom emerge in typical discussions of the subject. Alice Gosfield did a wonderful job connecting liability to quality improvement, cost control, and structural change in American health care. Peter Jacobson did an equally good job highlighting professional considerations and conflicts that often drive malpractice policy. It is significant that both previous speakers talked about liability reform not as an end in itself, but as a component of overall health policy.

We are currently coming to the end of what I have described as the first malpractice crisis of the 21st century. Malpractice crises, which are defined by shrinking liability coverage and/or rising premiums, occur periodically. The insurance crisis that now seems to be ebbing was different in certain ways from its 20th century predecessors, but will almost certainly not be the last such period to arise. As interest in “solving” this crisis wanes for various reasons, we have to ask what we have learned from the last five years. In my opinion, this crisis has produced strong arguments for testing comprehensive approaches to medical liability that connect to quality, that connect to health insurance benefits, that connect to provider payment, that connect to the big professional and social

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issues in health care. Only in this way can we break through the conventional doctors-versus-lawyers battle lines that have defined malpractice reform for generations of physicians and politicians.

Why do we have trouble taking this next step? Alice Gosfield hit the nail on the head when she commented that the trick is to change the system for the people who want and deserve change rather than for everyone at once. As Alice observed, why should the worst performing doctors get the benefit of an improved system of resolving disputes and compensating injured patients? Why not start with the best performing doctors? Why not start with people who want to change the rules and who can prove that they are likely to perform well in terms of quality, safety, and honesty under different rules?

Proposals to "demonstrate" comprehensive malpractice reform follow from this insight. Funded demonstration projects are familiar in connection with complex, publicly financed care under Medicare and Medicaid, where the entity paying the bill sponsors and monitors experimental changes to existing rules. In malpractice policy, however, demonstration projects are far more controversial than one would expect. To understand why, let us explore liability reform during the most recent crisis period.

MALPRACTICE POLICY AS HEALTH POLICY, NOT LAWYERING POLICY

One aspect of comprehensive medical liability reform that has only recently been incorporated into public debate is patient safety. Moreover, the consumer orientation of 21st century health care has framed safety not only in terms of direct regulation such as medical licensing but also around quality measurement and mandatory reporting of errors. One can apply the classic Avedis Donabedian framework for distinguishing interpersonal quality of care (meaning the provider-patient relationship) from technical quality of care, and for analyzing technical quality in terms of structure of provider organizations, processes of care, and clinical outcomes. Information about poor technical outcomes such as medical errors leading to malpractice claims and payments is increasingly seen as valuable by patients, and is being subjected to public disclosure as well as to the professional quality monitoring processes recommended by the Institute of Medicine in its 1999 report To Err Is
The next step in this incorporation of quality into liability reform is to view dispute resolution procedures that follow adverse clinical outcomes as part of interpersonal quality of care, not merely as aspects of a separate litigation track. Growing interest in error disclosure and apology, sometimes mandated or facilitated by law, moves dispute resolution techniques such as mediation closer to the point of care in exactly this fashion. Even monetary compensation for injured patients, which is very unevenly provided through malpractice litigation, is entering the quality debate as more information becomes available on the financial burden of unexpected illness or disability, such as the connection between medical expenses and individual bankruptcy filings.

Another quality-related aspect of malpractice reform is "defensive medicine," which one can define as physicians behaving differently because of the perceived threat of liability. Defensive medicine is often discussed as an aggregate social problem of wasteful spending, but also raises risks of overtreating, undertreating, or mistreating individual patients. The core challenge for policymakers with respect to defensive medicine is that physicians are demanding reform because of their own emotions rather than documented fact—that for over a generation they have been scared of lawyers and that their fear leads them to practice worse medicine. Many of these perceptions, particularly the likelihood of suit and the biases of juries, are empirically wrong. Tort law defenders therefore question why reform should cater to doctors' misperceptions. On the other hand, if those perceptions change doctors' behavior and doctors' behavior changes patient outcomes, quality does depend to some degree on the type of system that is in place to air and resolve disputes over adverse events.

The second major issue is the relationship between liability climate and access to health care. Access has always been a rhetorical mainstay of tort reform advocates. During the first recognized malpractice crisis in 1975, physicians around the country engaged in high-profile work stoppages to make the point that "if you don't change the system to keep us from being sued, we will lose our malpractice coverage, and we will stop taking care of patients." But this basic argument left many questions unanswered. How many doctors would be lost? Doctors of what ages? Doctors in what specialties, and performing what sorts of procedures?
Doctors in what geographic areas? What changes to the malpractice system affect physician supply?

Both quality and access have been subjected to much more rigorous empirical investigation in this malpractice crisis than in previous ones. It has been very rewarding to watch a new generation of legal scholars, particularly scholars with expertise in economics and econometrics, develop an empirical literature on the access, cost, and quality implications of liability. Randy Bovbjerg and others have divided the "malpractice system" into three components: legal process, patient care, and liability insurance. Liability insurance has been the forgotten third among tort reformers, who have classically viewed the legal system as the cause of crisis, and also among tort defenders, who generally have focused on poor medical care. Empirical research not only evaluates the rhetorical claims and quantifies the gaps between perception and reality, but also exposes to public view the features of liability insurance markets that drive premiums and influence both physician practice patterns and compensation available to injured patients.

I want to emphasize that this is a different way of imagining the malpractice debate than what one usually reads in the papers or hears from politicians. As the current malpractice debate was building in early 2003, I attended a policy-oriented meeting in San Francisco that included selected political stakeholders, several academics, and a few legislators. A state legislator from Maine who had listened to the discussion finally raised his hand and expressed astonishment that the points of contention in the room did not match what the lobbyists were telling him back home. The essence of the political debate continues to be a battle between organized medicine and the trial bar over capping non-economic damages. This fight, rather than the underlying public policy issues, then becomes the media story, at least among reporters who have not covered malpractice reform in this way for so many years that they are sick and tired of it.

The legislator from Maine expected to find a split in the public policy and academic communities, centered on the desirability of capping damages, paralleling the political split. He learned that this division does not exist. Academics and public policy experts have reached general consensus that caps on damages standing alone do little to solve the core problems of the existing malpractice system, but would be acceptable or even desirable in conjunc-
tion with other changes intended to prevent and redress avoidable errors. (A few law professors remain uncomfortable with caps on damages because they greatly value individual rights of redress in the courts.) However, this high level of expert agreement carries little weight in the political world. As Paul Krugman wrote about economics and politics in one of his New York Times columns, politicians trot out experts only when experts disagree. When experts agree, as economists do about the ill-effects of rent control, they become useless to politicians. Malpractice reform is similar. Broad consensus among academics about the need for comprehensive malpractice reform, starting with funded demonstration projects, seldom serves the political agendas of organized interest groups, who consider the complexity of the real world "off-message," or suits the preferences of some journalists who, at least as a first approximation, tend to cover conflict instead of substance.

ACADEMIC CONSENSUS POINTS ON MALPRACTICE REFORM

What are the key conclusions among academics regarding malpractice and malpractice reform? The following imperfections of the existing system make my list, with the evidence base supporting them having been greatly strengthened by recent empirical research.

First, quality and safety in medical care could be substantially improved. Whether one believes the Institute of Medicine's figure of 98,000 avoidable deaths a year, or credits other experts' lower or higher estimates, and whether one feels the principal focus should be on reducing dramatic injury-producing events or on routine clinical practices that produce statistically better clinical outcomes, the performance of American medicine is not nearly where it should and could be.

Second, many patients (and families) suffering avoidable injury because of medical care feel uninformed and uncared for afterwards, and few are ever compensated through malpractice litigation. Even if a patient seeks legal counsel, it costs an experienced plaintiff's lawyer $50,000 or more to conduct malpractice litigation, limiting cases they will accept to those generating very high damages and leaving many patients with substantial expenses and no recourse. *Crossing the Quality Chasm*, the Institute of Medi-
cine's follow-on report to its exposé of medical error, concluded that a high-quality health system must be safe, effective, timely, efficient, equitable, and patient-centered. The protracted, adversarial, lawyer-driven, unpredictable, costly contortions of the malpractice system achieve none of these goals.

Third, many physicians are troubled by the malpractice system and treat patients differently as a result. However, capping damages as a response to crisis-induced run-ups in physicians' liability insurance premiums and concurrent difficulty purchasing or renewing coverage does not get to the root of the problem. Caps give physicians somewhat less of a bad system, not a better system. California's 1975 MICRA legislation has stabilized insurance premium in that state, benefiting physicians. But California physicians still feel that the malpractice litigation is a terrible method for dealing with bad medical outcomes, and when faced with an injured patient echo all of the complaints voiced by physicians in states with uncapped damages. In sum, both physicians and patients deserve a faster, fairer, more compassionate response to avoidable injury than litigation.

Fourth, liability insurance markets are defective. For physicians, insurance costs are too volatile, with the cost of insurance too high for some specialties during "hard market" swings of the insurance cycle. These problems reflect the failure of fragmented, physician-centered insurance mechanisms to keep pace with the rising cost of compensating injury in an increasingly industrialized, technologically advanced health care system from which society expects near-perfect results. Hospitals had a different insurance problem in the recent crisis period: excess layers of coverage that stop-loss carriers had previously provided at low cost suddenly became very expensive as global reinsurance markets tightened and capital flowed away from idiosyncratic, politicized sectors such as health care.

To put it differently, although malpractice claims and payments remain the primary driver of liability insurance premiums, long-term premium volatility reflects changes in the health care system and inadequacies of insurance structures much more than problems with the legal system. Think about conventional rating practices for liability insurance. We saddle physicians in individual and small-group practice with more financial responsibility for insuring the failures of the health care system than those physicians
can reasonably support. As Alice Gosfield said, the physician’s ordering pen is the greatest cost-generating device in health care, accounting for roughly two-thirds of health care expenditures. Liability largely tracks this degree of nominal control. However, only ten to fifteen percent of health care costs represent physicians’ earnings, and therefore revenue available to finance insurance purchases. Moreover, much of the financial burden falls on a small subset of specialists who diagnose and treat serious diseases in young people who are entitled to substantial damages if negligently injured.

Fifth, the effect of the current malpractice crisis on access to medical care—in many ways the key social question—is likely a moderate one. I believe that malpractice climate affects the supply of physicians to some degree and can reduce the availability of particular services through physicians’ career choices, decisions about where to practice, and willingness to perform certain procedures and treat certain patients. Those are important, but the aggregate measurable impact on statewide availability of physicians, even in high-risk fields, appears to be small. These data are not textured, however. It seems likely to me that some patients are adversely affected by instability in the malpractice system, and are probably the same patients—economically disadvantaged, minority, with multiple chronic diseases, living in poor urban or rural communities—who struggle to get access to care for other reasons as well.

**NEXT STEPS IN MEDICAL LIABILITY REFORM**

Let me turn from the “what-are-the-problems” part of my remarks to the “what-are-the-solutions” part. Here is my short list of desirable next steps for public policy coming out of the current malpractice crisis.

*Step one:* encourage communication between providers and patients when unexpected things happen. I think the single most significant movement in liability reform at the moment is to embrace error disclosure, apology, and early offers of compensation. This represents a substantial shift in medical culture, which has long resisted openness about error not only for fear of malpractice liability, but also—mainly—because it signaled individual failure and risked peer disapprobation. In my view, two things account
for the profession's recent interest in openness. One is generational change. Physicians in this generation have different expectations than their predecessors about information exchange (as do their patients), and different views about the balance between individual accountability and team or system responsibility for medical care.

The second thing favoring physician openness about error is that it represents self-help. Although there is a role for laws that protect apology from use in subsequent litigation, disclosure can be done productively by almost any physician without modifying the current legal environment. An obvious lesson from the political iterations of liability policy over the last several decades is that legislative change is hard fought and seldom won. That sense reinforces other things about the delivery, financing, and regulation of modern medical care that make many physicians feel that they have lost control over their practice environment, its politics, its corporate organization, and its payment streams. Many physicians therefore reach for anything they can do themselves to make their professional lives better, and being honest with patients falls into that category. As Doug Wojcieszak, the founder of the Sorry Works Coalition, observes, physician don't need to depend on politicians for this type of reform. Where do public policy, professional leadership, and sometimes law come in? To help physicians and their health care teams to disclose, discuss, and resolve disputes in effective ways. The instincts that providers have about what patients want to know and how patients want to be treated are often incorrect.

**Step two: coordinate information.** To go beyond the basic insights listed above regarding the malpractice system, we need better data. I am not just expressing the self-interest of a malpractice researcher. One of the most promising areas for malpractice reform now that the acute crisis of premium increase has passed, and now that the attention of the political process has waned, is the "information policy" of patient safety and medical liability. In addition to information about medical error and injury conveyed directly from doctor to patient, what information should circulate, and to whom, about particular providers' preventive measures, safety failures, and legal outcomes? Should this information be shared with the public as consumers? Within provider organizations? With health insurers? With government? What informa-
tion should be shared about how the entire "malpractice system" works, meaning the insurance piece, the legal process piece, and the clinical care piece? Should we measure how well the system performs in terms of deterrence, or compensation, or justice, or administrative efficiency?

I believe that if we engage these informational issues constructively now, we can make progress during the less politically polarized environment we enjoy between malpractice crisis periods, and we may prevent or blunt the next crisis. This means more than just compiling information. It means understanding what you want the information to accomplish. Information tends to be an attractive political compromise. Coming out of this malpractice crisis, several states seem willing to adopt government reporting, public disclosure, and information gathering laws. Rather than do this in existing regulatory silos, such as state departments of insurance, state health departments, or state trial courts, we should bring public decision-makers together to establish coordinated information exchanges that are well designed to assist patient safety improvements, to help consumers buy safe health care, to determine whether the structure liability insurance is socially optimal, to evaluate the value received for public investment in various dispute resolution forums, and to do other things that the decision-makers think desirable.

**Step three:** fund provider-based demonstration projects. This brings me back to my title, which asks why limited tests of comprehensive malpractice reform remain controversial. Note that most demonstration projects incorporate aspects of both prior steps, which are substantially less problematic as a political matter. Demonstration proposals that have been aired generally envision mandatory disclosure and discussion of medical errors, and include careful measurement of the effects on several variables of the newly adopted system. But political, as opposed to academic, support for these proposals has thus far been lukewarm.

**GETTING DEMONSTRATION PROJECTS FUNDED**

What demonstration projects have been suggested? Most would test what I call "no trial" systems of dispute resolution and injury compensation. These are often termed "no-fault," but in my opinion no-fault language should be limited to areas, such as
automobile accidents, where society has concluded that mishaps are inevitable, that fault is subjective and unsystematic, and that conventional litigation will be slow, expensive, and inaccessible. The first two conditions do not match public or professional opinion about medical error. No patient or provider thinks that "stuff happens"—and least to the degree established in the IOM reports—and simply needs to be paid off. They want to uncover the root causes of past errors and prevent future ones. Academic proposals for demonstration projects therefore focus on determining whether a particular outcome was "avoidable" or "preventable," a more expansive category than legal negligence and one that frees the malpractice system from tort precedents and courtroom procedures. Blame is still assessed, but in a more constructive and systematic way than occurs in litigation.

Fault-based administrative substitutes for tort litigation are not new. In the late 1980s, as the second major malpractice insurance crisis of modern times receded, the American Medical Association and several medical specialty societies came out in favor of a similar approach that had been drafted by AMA staff. Although empirical understanding of the malpractice system was far less developed at that time, and the patient safety aspects of liability reform completely unknown, the AMA proposal represented a surprisingly progressive, balanced attempt to mediate between interests of plaintiffs and those of defendants, limiting exposure and enhancing predictability for physicians while reducing administrative cost and improving access to compensation for patients. Unfortunately, falling malpractice premiums sapped the reform movement of momentum in the early 1990s, and leadership changes and political shifts since then have erased nearly all memory of its administrative reform plan from the AMA's collective consciousness, despite striking similarities to many demonstration proposals today.

At present, there seem to be three basic ways of bringing comprehensive reform demonstrations into the malpractice world. One is through state law, the second through private employers and private health insurers under the ERISA statute, and the third through the federal government, particularly the Medicare and Medicaid programs. Some discussion of each approach has occurred among interested sponsors and providers, with most of the traction at the state level where all branches of government are active participants in the malpractice system. But no set of actors,
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either alone or in cooperation with another, has gained political momentum.

Two important self-regulatory leaders in health care, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Institute of Medicine (IOM), have endorsed reform demonstrations during the current malpractice crisis. In 2005, JCAHO—through its public policy rather than its accreditation arm—issued a report called "Health Care at the Crossroads," offering a future vision for both patient safety and injury compensation. The JCAHO report supported funded demonstration projects to create, through various mechanisms, a liability system for hospitals and other health care institutions that makes certain core commitments: to tell patients about errors and apologize when appropriate, to make prompt offers of compensation, and to resolve disputes that arise using alternative procedures that are quick, fair, and efficient. In my opinion, this was a very progressive position for JCAHO to take. Unfortunately, the published report’s groundbreaking statements about liability reform followed instead of preceding several pages of reasonable but routine recommendations about technical safety, and did not attract attention.

Earlier, in 2002, I served on a committee convened by the IOM on an expedited basis to respond to a request by then Secretary of the U.S. Department of Health and Human Services (DHHS) Tommy Thompson to identify potential short-term improvements to the health care system that could be developed and tested through federal funding of state-based demonstration projects, similar to those DHHS supports in the Medicaid program. Largely for political reasons, liability reform became one of the study areas, alongside more significant issues in American health policy such as coverage for the uninsured, health information technology, and treatment of chronic disease. The committee’s report, titled “Fostering Rapid Advances in Health Care,” contained a chapter on liability reform that benefited from input by leading experts such as Joe Newhouse from Harvard and Bob Berenson and Randy Bovbjerg from the Urban Institute.

The IOM proposal encompassed all three aspects of the malpractice system: clinical, legal, and insurance. The IOM proposed testing two forms of “patient-centered, safety-oriented, non-judicial compensation”: a statewide program similar to workers compensation, and a provider-based program that would offer fed-
eral stop-loss insurance to hospitals and other organizations that took specific steps to identify, disclose, compensate, and prevent medical injuries. The procedural infrastructure for these projects would be developed by regulation or expert consultation within DHHS, including standards of preventability, updated lists of clinical outcomes that were likely avoidable (termed "Accelerated Compensation Events") and binding schedules (ranges) of non-economic damages based on severity and duration of injury.

Legislation authorizing the liability reform demonstrations recommended by the IOM report was introduced in Congress by Senators Michael Enzi (R-Wyoming) and Max Baucus (D-Montana) in 2004 and again in 2006, but did not reach a committee vote. The Enzi-Baucus bill also would have offered federal financial assistance to states that adopted a "health courts" alternative to traditional litigation along the lines suggested by the advocacy organization Common Good, which was founded by attorney Philip Howard. Also in 2006, Senators Hillary Clinton (D-NY) and Barack Obama (D-Illinois) introduced a bill that authorized funding to develop a National Medical Error Disclosure and Compensation Program, similar to that urged by the Sorry Works! Coalition, as well as to establish a National Patient Safety Data Base.

Of these proposed reforms, "health courts" have attracted the broadest political support, mainly though not entirely from traditional tort reform advocates. Health courts substitute specialized judicial tribunals for courts of general jurisdiction, and employ neutral rather than partisan experts as consultants on clinical issues. Common Good's formulation of the health court concept is based on the assumption that lack of expertise resolving malpractice claims creates uncertainty for physicians that is socially counterproductive. Like screening panel and certificate of merit reforms in earlier decades, health courts appeal to the self-regulatory preferences of the medical profession and their related perception that most malpractice claims are frivolous. As Jay Gold once wrote, the most difficult aspect of regulating any profession is figuring out ways to hold experts accountable to non-experts. Although physicians regard this as a "problem," it is really an inevitable part of democracy that we grapple with as best we can every day in many fields.

One caveat is that the fundamental premise of health courts—that lack of expertise compromises decision-making in
malpractice cases—is contestable. Empirical studies have shown that ordinary judges and juries do pretty well with medical cases notwithstanding occasionally technical subject matter, and if anything tend to excuse negligent conduct by physicians. Health courts as originally proposed were also stand-alone, reactive legal institutions that did not directly take account of the considerable failings of medicine as actually practiced, failings that have been revealed by patient safety research. To Common Good's credit, the organization has refined its original proposal to incorporate patient safety concepts, and has partnered with the Harvard School of Public Health to develop a more detailed set of recommendations.

A caution about health court proposals is that some are thinly veiled attempts to create jury pools favorable to defendants. Although juries perform reasonably well at determining liability and awarding damages, juries vary from community to community within a state in terms of sympathy and generosity. In Pennsylvania, for example, urban juries in Philadelphia tend to favor plaintiffs in malpractice cases. The rest of the state, particularly the western portion, is largely rural, elderly, conservative, and pro-physician. The first health courts bill introduced in the state legislature would have divided Pennsylvania into regional districts, with Philadelphia partitioned into several such districts and potential jurors from Philadelphia diluted by suburban and rural residents. Although the bill trumpeted the familiar health court rhetoric of expertise and reliability, restricting Philadelphia jurors was its principal objective. In my view, regional differences in jury behavior are an appropriate topic for possible reform, but the issue should be debated openly rather than being hidden in Trojan Horse legislation.

A couple of years ago, Illinois (where the Sorry Works! Coalition is based) enacted a pilot program using the Sorry Works! approach to allow one hospital selected by the state to receive public funding for a demonstration of error disclosure and apology coupled with limited immunity from traditional tort liability. If the participating hospital experienced higher malpractice-related expenses than predicted had they not informed patients about errors, the state would hold them financially harmless for the excess. I think a hold-harmless assurance is an intelligent premise for conducting demonstrations of malpractice reform, because otherwise
provider concern over cost will likely result in the demonstration being designed in ways that disadvantage injured patients. It is also a reason for the federal government to sponsor demonstrations, because it has greater financial capacity. Illinois itself has struggled to start its program because of politicking around the choice of participating hospital given the very limited amount of state money available.

But do federal demonstration projects have much chance of implementation? Although DHHS could in theory fund demonstrations under existing statutory authority, both legal and practical considerations make it necessary for Congress to act. Legally, DHHS would find it very difficult to confer immunity from state tort liability as part of a demonstration, although it might sponsor a demonstration in which patients voluntarily exchanged tort rights for more expansive access to limited compensation. Practically, DHHS is constrained in its budget and staff and in its political freedom to innovate. It seems likely that Senators Enzi and Baucus will reintroduce their legislation this congressional session, as may other legislators. However, the upcoming presidential elections will shine harsh political light on any legislative debate over demonstration funding. The unfortunate outcome may be that balanced proposals of the sort needed to make progress on such a complicated problem of health policy fail to gain support from either "tort reform" or "victims' rights" partisans.

This less-than-optimistic prediction also helps explain the failure of past Congresses to make progress on medical liability notwithstanding its national impact on health care. In tension with the need for federal financial support of innovative reform is the fact that medical malpractice has been perceived as a state issue since the 1970s crisis, a perception reinforced by the federal courts' rejection of challenges to state tort reform legislation under the U.S. Constitution. Not only tort law but also medical professional oversight and insurance regulation have been near-exclusive state domains. The legal representation and litigation aspects of medical liability have further insulated it from federal regulation by making it subject to state judicial oversight, which is even less likely than state legislative or executive action to trigger a federal response.

In the rare event that medical malpractice attracts attention in Congress, moreover, it tends to do so in the judiciary committees,
which engage the issue entirely through the lens of tort reform, and are therefore constrained by the potential spillover effects of malpractice reform on general civil litigation. It is significant that the Enzi-Baucus bill was sponsored by senior members of the Senate Finance Committee and the Health, Education, Labor, and Pensions (HELP) Committee, which are more likely to appreciate the relationship between liability reform and overall federal health policy.

Are there other possible sources of federal action on malpractice demonstration projects? The U.S. Department of Labor might build liability reform into its oversight of employer-sponsored health insurance under the ERISA statute, perhaps with authorizing legislation shepherded through Congress by the labor committees. Even without new laws, current interpretations of ERISA’s preemptive scope probably allow large employers to offer health insurance options that channel beneficiaries into alternative dispute resolution systems with limited remedies in the event of medical injury. Ideally, these systems would be connected to other quality improvement innovations such as pay for performance and standardized outcome reporting. As yet, however, there has been no movement in this direction. Employers are caught between their interest as health insurance purchasers in having efficient, effective patient safety systems and their interest as potential defendants in having as little personal injury litigation as possible. Thus far, the latter position has prevailed, placing most business groups firmly in the camp of conventional tort reformers and reducing the appeal of liability innovations that are designed to achieve specific health policy goals.

Considering these constraints, Professor Eleanor Kinney and I have urged that demonstrations be conducted expressly for Medicare beneficiaries. Federal law engages most actively with health care through payment policy under Medicare and Medicaid, and both these programs are frequent sponsors of state-based demonstration projects. Medicare’s hands-off policy toward medical liability is a striking aspect of the program’s forty-year history, and may partly explain the failure of the malpractice system to keep pace with changes to the health care system during that time. Lack of Medicare oversight may also contribute to the prevalence during crisis periods of knee-jerk malpractice reform legislation driven
mainly by antipathy between state medical societies and their trial lawyer counterparts.

Although a detailed presentation on Medicare as a forum for liability reform would exceed the time I have today, it is worth observing that Medicare beneficiaries are poorly served by the existing malpractice system. Even if they realize that they have suffered negligent injury and are willing to file a claim despite their continuing dependence on medical care, elderly patients seldom recover damages of sufficient magnitude to make their cases worth litigating from a lawyer’s perspective. The protracted nature of malpractice litigation is an additional deterrent for the elderly. Empirical studies confirm that the elderly file fewer malpractice claims and receive lesser damages. Of the 100 largest amounts paid in malpractice cases in Texas from 1990 to 2003, for example, only one case involved a claimant over age sixty-five.

Medicare is also a promising source of malpractice innovation because it is a “first-party” insurer of its beneficiaries. The insurance side of the malpractice system is “third-party” liability coverage, meaning that the insurer’s customer is the physician, not the person who sues the physician. Third-party insurance risk management will never be fully committed to patient safety because, from the insurer’s perspective, a patient who sues an insured physician is no different from someone who slips on the sidewalk outside that physician’s office door. All claimants, regardless of prior affiliation or obligation on the part of physicians, are strangers to the insurer, and, moreover, are strangers who are presumed to be adversaries. By contrast, Medicare exists to serve the interests of its beneficiaries. Medicare also has in place an extensive system of administrative review that is used to resolve disputes over insurance benefits. With appropriate modification, this system could become the catalyst for functioning “health courts” within Medicare that are truly connected to major national initiatives involving patient information, medical error reduction, and overall quality improvement.

CONCLUSION

Federally funded demonstration projects of comprehensive liability reform should be uncontroversial. How else can we assure participants who are interested in trying something new that it is
not too risky financially? And how else can we measure the results of any new system we try?

Yet controversy remains—a product of deeply ingrained professional rivalries, extreme partisanship around tort reform for both ideological and economic reasons, and the failure of health care purchasers and regulators to sustain interest in liability reform outside of "crisis" periods. I often refer to medical malpractice as the Rip Van Winkle of health policy. It rouses itself every twenty years or so, largely oblivious to major changes in the health care system since its previous awakening. The challenge for academics and other public policy entrepreneurs is to get the public, like Rip Van Winkle’s townspeople, to notice that today’s malpractice reformers are wearing tattered clothing and brandishing rusty weapons. If advocates of malpractice demonstration projects can expose the inadequacies of the conventional debate and offer feasible alternatives, progress is possible. But it remains an uphill battle.