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Malpractice Reform as a Health Policy Problem

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MALPRACTICE REFORM AS A HEALTH POLICY PROBLEM

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Calling malpractice reform a "health policy problem" means that we should analyze it in terms of the quality of health care, access to health care, and the cost of health care—the basic health policy triad with which we all are familiar. We immediately recognize patient safety as a health policy problem because it is obviously about quality. We may believe there is so much slack in the health care system that we can make major improvements in patient safety without excessive cost. But ultimately, there are going to be cost-safety tradeoffs, which are also health policy concerns. We tend not to think about patient safety as an access problem because we assume that health services have been received; but I suspect at some point we will start talking about the access-related causes of medical errors.

On the other hand, beyond the sweeping assertion that physicians will quit practice if lawsuits are not restricted, medical malpractice reform is not typically dealt with as a health policy problem. Is this not odd? Here we have two things, patient safety and medical liability, that are logically connected, but one is debated in health policy terms and the other is not. When they do appear together in the same sentence, or more likely in the same piece of legislation, one gets a strong sense that the juxtaposition is more for rhetorical effect than for substance.

BARRIERS TO COMPREHENSIVE MALPRACTICE REFORM

Why is medical malpractice not discussed as a health policy problem? My hypotheses fall under three headings: Doctors and Lawyers, Government Structure, and Politics.

Medical malpractice is the principal terrain on which the medical and legal professions have battled for well over a century. I do not think we need to revisit ancient history in what is supposed to be no more than a half-an-hour talk, but I want to mention one thing about medical traditions, and, for that matter, legal traditions. Professional norms of self-government and self-regulation are among the factors preventing medical malpractice from being dealt with in health policy terms. Malpractice cases are an imperfect way of holding experts accountable to non-experts. External accountability is never comfortable for professionals, and medical malpractice is particularly disturbing to physicians because lawyers seem to be building their fortunes and reputations at the expense of physicians' fortunes and reputations. The dynamics of professional leadership perpetuate these antagonisms. It takes many years for a doctor or lawyer to work his or her way up through the ranks of professional organizations from the county, to the

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state, to the national level. People who make these commitments are often drawn into the politics of their profession because of a crisis, and many people currently in senior positions in organized medicine became involved initially because of crises involving medical liability. Consequently, they tend to see today's malpractice crisis—which I will argue, reflects a different set of problems from those we imagined existed thirty years ago—through the same eyes as before and feel an understandable desire to complete the unfinished battles of their youth.

In terms of government structure, almost everything about medical malpractice keeps it from being a health policy problem. There is a fundamental issue of federalism. Medical malpractice has evolved at the state level. Health care regulation and health policy analysis, though certainly including a strong state component, occur increasingly at the federal level. There is separation of powers. A lot of things that have to do with medical liability involve courts and the judicial branch of government, while health policy comes more from the legislative and executive branches of government. Perhaps most importantly, as I return to in my conclusion, the federal Medicare program has an enormous influence over health policy but has had absolutely nothing to say about medical liability.

Then there is politics. There is the everyday politics of campaign contributions, which has a longstanding practice of separating money for medical liability from money for other health care lobbying. But there is also a much more fundamental and systematic problem: the politics of medical malpractice is not really the politics of health care. We tend to think about the political battle as between physicians and hospitals on one side and malpractice plaintiffs' attorneys on the other. During malpractice crises, we are bombarded with political advertising that reinforces this perception. In point of fact, these groups stand in the shadow of much more powerful interests, especially during the current crisis. This country is immersed in a vigorous debate over the social and economic effects of personal injury litigation. The general business community, largely allied with the Republican Party, stands for across-the-board tort reform. In times such as these, when health care providers are stressed by liability insurance costs, their experience becomes a useful illustration—a poster child, if you will—for general tort reformers to use to fight their larger battles. On the other side is the general trial bar, organized consumer interests, and labor unions, largely allied with the Democratic Party, who use medicine and medical liability to further their own broader objective of protecting personal injury litigation. Think back a few years to the debate over "patient protection." These pro-lawsuit constituencies actually managed to peel physicians away from their traditional tort reforming allies and got them to support expanded rights to sue managed care organizations. The larger political question is undoubtedly important, but its existence distorts malpractice reform in significant ways.

MALPRACTICE AND HEALTH SYSTEM CHANGE

The United States has experienced three major malpractice crises. The first, in the mid-1970s, is often called a crisis of availability of malpractice insurance. The second, in the mid-1980s, is often called a crisis of affordability. The third, which is still ongoing, seems to mix how accessible liability insurance is for physicians or hospitals with how much it costs. Malpractice reform in the 1970s and 1980s took basically one form, which most of us know as the MICRA model after California's Medical Injury Compensation Reform Act. A $250,000 cap on non-economic damages is MICRA's most salient feature, along with allowing juries to hear evidence of collateral sources of compensation for plaintiffs, instituting sliding scale limits on lawyers' contingent fees, and shortening the statute of limitations for malpractice claims. That was 1975. This is 2004. Is the discussion different today? Not really. By and large, malpractice reform is still an up or down vote on MICRA. Why? Because MICRA honors the established battle lines between doctors and lawyers, keeps malpractice policy in the states and in the courts, and translates easily to other areas of potential tort reform.

In my opinion, the single largest gulf in the malpractice debate today is not between the physicians and the plaintiffs' lawyers, but between both those groups who think malpractice policy should be about MICRA, and law professors, other academics, and public policy experts, who think it should go well beyond MICRA. Many academic proposals, for example, involve administrative compensation regimes linked to improved patient safety. Academics also favor organizational responsibility, building on the "enterprise liability" proposals floated before and during the Clinton administration's attempt to enact universal health coverage. Academics tend to support "early offers" in settlement, though on a more sweeping basis than the very small pilot project recently announced by HHS, as well as efforts to compensate immediately an identifiable set of events that are almost always negligent, a framework called "ACEs." These types of reforms, which are all motivated by concerns about the quality of health care, access to health care, and the cost of health care, are not reflected in the standard political debate.

I am here to argue that the public should listen to the academic community rather than to the lobbyists and politicians. Why? Because there have been major changes in the health care system since 1975, and there have been major changes in our understanding and expectations of the health care system since 1975. Given those two indisputable facts, how likely is it that MICRA is going to solve the current malpractice crisis and prevent future ones? Not very, I think. This straightforward premise underlies not only the rest of my remarks today, but also the research I have been doing with many other scholars around the country and here in Pennsylvania, for the Project on Medical Liability, funded by The Pew Charitable Trusts.

MEDICAL PROGRESS, INDUSTRIALIZATION, AND COST CONTAINMENT

What changes in the health care system have occurred since 1975? I put the substantive changes into three categories: medical progress, industrialization, and cost containment. This really should not come as a surprise, but medical liability is an indication of the overall success of modern medicine, not its failure. For roughly 150 years, malpractice liability tracked the ability of health care to benefit patients. You cannot do something negligently if you cannot do it at all. Liability arising from the non-use or misuse of technology has accelerated in the last twenty or thirty years, as patients' expectations rise, as opportunities for error proliferate, as the potential for treating an injury that might occur expands, and as the costs of such remedial treatment increases.

Industrialization reflects the fact that modern medicine is a cooperative enterprise, notwithstanding professional traditions that credit individual physicians for success and assign them blame for error. When designing malpractice policy, therefore, we have to think about organizations, facilities, suppliers, and other health professions in addition to the physicians we have always placed at the center of each episode of care.

In health care, as in American society generally, industrialization has been accompanied by a steady expansion of liability, particularly at the corporate level. Gradual trends of this sort tend to go unnoticed in malpractice policy because we pay attention only when a liability insurance crisis erupts. We seldom look back at the non-crisis years and remark: "liability expanded here; liability expanded there." Think about nursing home liability. Nursing home liability was broadened in the 1980s and early 1990s when people began to worry about the enforceability of residents' rights and started enacting elder abuse laws. That was a conscious decision.

In crisis periods, industrialization places tremendous strain on the system we use to provide medical malpractice insurance, which remains, by and large, purchased by physicians. Physicians made sense as the principal source of funding for liability coverage fifty years ago, when the health care system was far less industrialized. Not so today. It is very hard for a group of small business people, which is what physicians remain, to finance reliable liability coverage for a giant industrial enterprise that generates well over a trillion dollars in annual revenue beyond what physicians collect in fees. This is particularly true when a subset of physicians, whose specialties and patient populations put them at greater risk of liability, are burdened with the highest and most volatile insurance premiums.

The third important trend is cost containment. It seems odd to say this, but the 1970s and the 1980s malpractice crises came at the best of times for doctors, essentially, the financial golden era of medicine. The twenty years that have elapsed since the 1980s crisis are years in which both public and private payers focused almost single-mindedly on reducing the rate of increase of health care costs. Cost containment imposed many stresses on the health care system that

tend to be liability-enhancing. The reduction in trust in health care providers because of managed care, including the attribution of financial motivation to particular health care events, is a relatively direct effect. An indirect effect, which is perhaps more important, is that there is less uncommitted money in the health care system, and therefore, potentially less financial resilience when the liability insurance system slips into crisis. If physicians' financial cushion against rapidly rising insurance costs evaporates, there is a greater likelihood that patients will lose access to critical services or the quality of health care will be lowered.

PATIENT SAFETY AND MEDICAL QUALITY

Changes, in how we understand the health care system, are nearly as dramatic. If one had to point to research that inspired the modern patient safety movement, it would be the Harvard Medical Practice Study ("HMPS"), which reviewed hospitalizations in New York state in 1984 for evidence of medical injury, and followed those cases and others through (or not through) the courts. The HMPS was an outgrowth of the 1970s and 1980s malpractice crises. The Harvard researchers wanted to know how many errors happen in hospitals, how often those errors are negligent, how those events match up against malpractice cases that are litigated, and which situations are compensated in court or by settlement. Patient safety and malpractice policies were, in a sense, born together in the HMPS.

The HMPS revealed a significant mismatch between medical negligence and litigation. It showed that, yes, we have a lot of lawsuits that are unjustified from the perspective of our negligence-based tort system. But it also showed that there are many avoidable medical errors, most of which never give rise to legal claims, and large numbers of uncompensated medical injuries. Improving the performance of both the health care system and the malpractice system is more complicated than backers of MICRA alone care to admit.

We also learned that the process we use for resolving claims arising from medical injury is very, very poor. Litigation restricts information exchange between providers and patients and focuses entirely on monetary compensation for injury. Moreover, the malpractice system puts individual professionals, rather than organizations, in the hot seat. System-based medical error reduction initiatives that patient safety advocates favor are largely incompatible with conventional medical malpractice litigation.

Litigation is also extraordinarily slow, taking five years or more for larger cases. This delay, I believe, is the single most counterproductive element in how we deal with malpractice policy. Delay keeps much-needed funds out of the hands of injured patients and their families. Delay discourages lawyers from taking meritorious cases unless potential damages are substantial. Partly as a result of delay, litigation offers no meaningful feedback to health care providers or the health care system regarding safety and quality of care. Delay also destabilizes

liability insurance markets, because insurers setting premiums have to predict their financial exposure years after they sell a policy and also how much money they will make from investments during that time.

RESEARCHING THE MALPRACTICE CRISIS

To research the malpractice system as a health policy problem requires analyzing it along several dimensions. One set of axes describes the malpractice system's effects on cost, access, and quality. Another approach examines the three functional aspects of the malpractice system: health care delivery, the legal process, and the liability insurance system. It is also important to distinguish between the health policy implications of liability during insurance crisis years and during non-crisis years. One can divide the problem by sector and look at the impact on physicians, hospitals, health insurers, and so on. Finally, one can apply various research methods and tools. One can do formal empirical research, develop theoretical models, analyze history and context, or actually get out there and try to demonstrate how a better system might work. We took this sort of multifaceted approach in the Project on Medical Liability. The Project's work is available on our website, www.medliabilitypa.org.

DEFENSIVE MEDICINE

Let me tell you about two of our research initiatives. One involves so-called "defensive medicine." I think defensive medicine is an extraordinarily important issue. I am referring to medical care that is motivated by the avoidance of liability rather than by benefit to patients. Defensive medicine is a mainstay of tort reform rhetoric when there is *not* a malpractice crisis. During a malpractice crisis, it is pretty easy for tort reformers to argue in favor of caps on damages by suggesting that, without such measures, doctors will be unable to afford liability insurance and will be driven from practice. Defensive medicine is the argument that keeps the tort reform movement going in non-crisis years, when malpractice insurance is cheap and abundant. Tort reformers, many of whom are not particularly interested in health care, frame their argument exclusively in economic terms, and assert that Americans are wasting billions of dollars a year because rapacious lawyers are making doctors practice defensively.

The cost of defensive medicine is probably significant, though difficult to measure. But defensive medicine is also a matter of hands-on patient care. Moreover, clinical effects of defensive medicine are likely to be greater during malpractice crises than between them. To test this hypothesis, the Pew Project commissioned Drs. Michelle Mello, David Studdert, and Troyen Brennan, researchers at the Harvard School of Public Health, to survey physicians in Pennsylvania in high-risk specialties in mid-2003, more or less at the peak of the

malpractice crisis.

In a study published in the *Journal of the American Medical Association* in 2005, the research team found very high levels of self-reported defensive medicine. Ninety-three percent of the doctors surveyed in obstetrics, orthopedic surgery, neurosurgery, general surgery, radiology, and emergency medicine said they sometimes or often practice defensive medicine. One might be skeptical of these findings. Physicians want tort reform, and they know that one way to get tort reform is to say they practice defensively. That criticism was anticipated. The study, therefore, asked physicians who responded that they practiced defensively to describe, in their own words, the last thing they did that constituted defensive medicine. Eighty-two percent of the physicians reporting defensive practice provided details, which is pretty reliable evidence that the incidents they described actually happened.

Physicians who felt less secure in their malpractice coverage, and who described malpractice insurance as constituting a large financial burden, reported the most defensive practice. This makes sense. In a malpractice crisis, physicians worry that the next malpractice suit that comes their way is going to be career-ending. These perceptions, rather than any objective indicator of liability risk, drove defensive medicine in our study. A lesson here is that making malpractice insurance markets less volatile would probably help reduce defensive medicine.

The largest amount of defensive practice observed was what the study calls "assurance behavior" extra things doctors do to be on the safe side. In the policy literature, it is sometimes called "positive defensive medicine," but this is a misnomer because very little about it is good. In our sample, fifty-nine percent of physicians said they often order unnecessary tests, fifty-two percent often make unnecessary referrals, and substantial numbers reported prescribing unnecessary medication or performing inappropriate invasive procedures. Costly imaging studies were the most frequently cited assurance behavior. An overwhelming motivation was to avoid missing a diagnosis of cancer (for orthopedic surgeons, neurosurgeons, and ob-gyns) or coronary artery disease (for emergency physicians) in a young or otherwise "low-risk" patient. At best, these tests and procedures increase the cost of health care with little corresponding clinical benefit. At worst, they subject patients to unnecessary risks, generate large numbers of false-positive results, and divert medical resources from more urgent needs.

A specific concern about defensive medicine during a malpractice crisis was that physicians might engage in what the study calls "avoidance behavior" eliminating certain aspects of their medical practices or refusing to care for particular patients in an attempt to protect their existing malpractice coverage by reducing the likelihood of being sued. Of the doctors surveyed, forty-two percent reported they had restricted the scope of their practices because of liability, and nearly all of them provided specific details of those changes. Patient-by-patient examples of avoidance behavior were also widespread. Of the respondents, thirty-nine percent of physicians said they avoid certain types of

patients perceived to be high-risk, thirty-three percent no longer perform certain procedures, and several no longer accept trauma or emergency call responsibility.

Below are some of the "free-text" responses received from physicians describing recent defensive acts. Some go to the cost of health care, some to quality—both technical and interpersonal—and some to access. Note that the technical quality effects of defensive medicine are ambiguous. For example, some physicians now refer patients with complex illnesses to more specialized centers. Still, none of these examples seem to be socially desirable behaviors, or responses invented to gain support for tort reform legislation:

- A radiologist—"I now often suggest CT [scans] because of a recent malpractice case. I've never practiced 'defensive medicine' except for the last 4 years. This is my 43rd year in radiology."
- An emergency physician—"I admit all young patients with atypical chest pain because if I'm wrong, even at a one in a thousand batting average, I will likely be personally bankrupted by a wrongful death verdict."
- Another emergency physician—"Almost every chest pain, even very unlikely pathology, gets a $1,000 work-up."
- An orthopedist—"A woman called saying that her son was coming from college with an injured knee and she requested an MRI before he was even seen. It was easier to order the MRI than to explain to her that a history and physical examination would diagnose more than 90 percent of knee problems. Why risk refusing and have her upset if I then decided an MRI [was] not necessary?"
- Another orthopedist—"Patient with complex infected non-union [of a limb]. Options are salvage attempt (high risk) or amputation (low risk) or defer treatment. Did not accept case due to sense of litigious nature. Not worth providing cutting-edge treatments or efforts to salvage in this environment."
- Another general surgeon—"A new patient's family expressed concern about the outlook for his ischemic leg. They looked like litiginous [sic] people to me. I refused to care for him."
- An emergency physician—"I now refer all facial lacerations to a plastic surgeon, no matter how simple."
- A general surgeon—"I routinely perform breast biopsies on obviously benign nodules because I do not win anything by being wrong."
- An ob-gyn—"I performed a pregnancy test on a patient who averred she could not be pregnant. I 'knew' she would lie if there was a bad outcome involving a diagnosis of pregnancy."
- A neurosurgeon—"I now routinely will not assume the elective care for patients that I regard as personally difficult, contentious, or perceived by me as litigious."

As some of these examples demonstrate, the women's health implications of defensive medicine are particularly worrisome. Several ob-gyns reported not

caring for high-risk pregnancies, or even giving up obstetrics entirely. Among radiologists, no longer interpreting mammograms was common. Women who were worried about breast lumps faced a different set of problems. Consulting their ob-gyns often led to referrals to radiologists for mammography, to surgeons for biopsy, and back to radiologists for additional, repetitive imaging, with all of these providers describing this care as defensively motivated and otherwise unnecessary.

It is also important to recognize that patients who are demanding or difficult—or at least who are perceived by physicians as difficult—often fall prey to defensive practice. Patients who can be pacified with an MRI scan or another expensive test typically receive it. But individuals or families who ask a lot of questions, challenge physicians' recommendations, or report problems with prior medical care may be turned away because physicians seeing them for the first time worry about getting sued. This is a useful caution to the patient safety community, which tends to rely heavily on teaching patients to "speak up"—to take charge of their care and protect themselves from medical errors. Patient assertiveness needs to be tempered with recognition of physicians' malpractice-related sensitivities.

ERROR DISCLOSURE AND MEDIATION

Defensive medicine illustrates how instability in the liability insurance system, combined with a flawed process for preventing medical errors and compensating injured patients, exerts detrimental effects on everyday patient care. Another Pew research initiative—one I'm particularly proud of—has tried to improve the dispute resolution process directly. Malpractice litigation is harshly adversarial, costly to administer, suppressive of information, extraordinarily prolonged, and ultimately, I think, quality-reducing for both patients and health care providers. For the past two and a half years, Professor Carol Liebman at Columbia Law School and her colleague Chris Stern Hyman, who are experts in health care mediation, have been working with a group of hospitals in Pennsylvania to enhance communication with patients and families following medical errors or adverse events.

You may not be aware of this, but Pennsylvania is a pioneer in promoting honesty and openness between health care providers and patients. Pennsylvania was the first state to impose an explicit disclosure requirement on health care providers; other states followed. Back in 2003, the Pennsylvania legislature passed the MCARE Act, a heavily negotiated piece of legislation that included a variety of malpractice reforms short of caps on damages, which are currently prohibited by the Commonwealth's constitution. The MCARE Act was one of the first state malpractice reform laws to be adopted after the Institute of Medicine's 1999 report on medical error brought the issue of patient safety into the political arena. In addition to instituting various changes to the legal system,

the MCARE Act restructured Pennsylvania's unusual program of publicly administered excess liability coverage, and also created a state Patient Safety Authority to help generate information that could improve medical quality.

One provision of the new law requires hospitals to disclose so-called "serious events" in writing to patients and families. Although the scope of the requirement is defined vaguely in the statute, the law's clear intent is to encourage openness following medical errors.

However, there is a big difference between requiring honesty by law and achieving honesty in practice. The Project on Medical Liability was launched shortly after the passage of the MCARE Act, and inquired about the law generally, and the disclosure requirement specifically, in a series of meetings held with stakeholder groups. The comments made by the provider community were disheartening. All were deeply suspicious of the disclosure requirement, which they viewed as a potential marketing tool for plaintiffs' lawyers. At virtually every meeting, someone joked that he or she expected to see giant billboards on Pennsylvania highways asking patients if they had received an error letter from their hospital and offering to file a lawsuit. Even the well-intentioned guidance on complying with the law, provided by the Pennsylvania Medical Society ("PMS") and the Hospital and Healthcare Association of Pennsylvania ("HAP") to their members, revealed such deep-seated ambivalence about disclosure in a litigious environment that its recommendations were likely to prove counterproductive.

The Pew Project's team of experts in alternative dispute resolution and patient safety thought it could do more to help providers implement the new requirement. With the enthusiastic support of HAP and the Delaware Valley Hospital Council—for which we are very grateful—the team offered written materials, staff training, and even actual mediation services at no cost to a small group of hospitals in eastern Pennsylvania who were interested in our ideas. The goal was to improve the malpractice system from within, using approaches that, for the most part, could be instituted voluntarily by health care providers regardless of legislation or politics. A summary of the research team's experiences and recommendations was published in *Health Affairs* in 2004, and a comprehensive report on applying mediation skills to disclosing medical errors and resolving disputes was posted on the Pew Project's website in 2005.

Here are the key findings. First, all physicians, and many other health professionals, need basic training about the problem of discussing medical errors with patients. They do not need extensive training because the average physician is only going to encounter serious medical errors a few times in his or her career. A prudent use of training resources and of busy clinicians' time is to achieve a general level of awareness of the advantages of talking openly with patients and the basic skills necessary to do that.

Second, hospitals should adopt a consult service model for error communication; in other words, create and maintain a medical error "consult team," much the way most teaching hospitals maintain teams for clinical

consultations in other areas. A consult team ensures that communication is accurate and helpful, sets up a dispute resolution process (including formal mediation if appropriate), and connects these efforts to institutional patient safety mechanisms. If a medical error occurs, it will usually be the treating physician's responsibility to talk with the patient or family. However, that individual almost always needs help from experienced colleagues and institutional leadership. This is for the provider's benefit as well as the patient's. One of the main lessons of cases from the study is that the physicians and nurses are as distraught as the patient about what happened. Following a medical error, the consult team would help the health professionals involved in the care to prepare for the initial disclosure conversation, would assume directly any responsibilities the treating physician chose to delegate, and would offer emotional support to all parties.

Third, physicians and hospitals should apologize to patients who suffer medical errors, but they should apologize in the right way. There is a difference between an apology of sympathy—"I'm sorry this happened to you"—and an apology of responsibility—"I'm sorry I did this to you." The right type of apology can make a big difference; the wrong one can make matters worse. Research on apology by other scholars suggests that apologies of sympathy ring hollow when fault is clear, and make it even more difficult for patients and families to come to terms with errors.

The Project helped mediate two cases worth describing briefly. Both involved the spouses of patients who died. In one case, involving failure to diagnose a cerebral bleed in the emergency department, the breakthrough moment of the mediation occurred when everyone realized how guilt-ridden the spouse was. Underneath her anger at the hospital and doctors was her belief that, if she had managed to get her very stubborn husband to the hospital a day earlier, he would have survived, notwithstanding the medical error. When the chief of medicine stepped forward and assured her that her husband's death was entirely the hospital's fault, not hers, the tension in the room dissolved and the case settled.

The second case involved a punctured lung during the insertion of a central venous catheter by a resident physician, a known complication that probably was not negligent, as the term is defined by malpractice law. At the mediation, the spouse explained that she had been completely abandoned by the medical team after her husband's unexpected death. In particular, the spouse knew the resident was responsible for the botched procedure, watched the resident walk away without talking to her, and got the impression that the resident must not care about what happened. At the mediation, the chief of medicine explained that he had spoken with the resident, and that the resident had been tormented by the accident ever since it occurred. Once the spouse realized that her husband's death was taken seriously, and that the hospital and its physicians wanted to learn from her tragedy, she agreed to a settlement that included better training protocols for central line insertion.

PATHS TO A BETTER MALPRACTICE POLICY

Given the time allotted for this lecture, I will not attempt an extensive analysis of the three key components of comprehensive malpractice reform: liability insurance reform, legal process reform, and patient safety reform. Suffice it to say a better malpractice system would proactively identify, disclose, and work to prevent medical errors. It would offer prompt, fair, but limited compensation to a larger percentage of patients injured by avoidable error than occurs today. And it would rely primarily on institutional or administrative procedures that are quicker, cheaper, and less adversarial than conventional litigation.

The key question, of course, is how to get there from here. Let me say something about the vehicles for change that might be available to policymakers. As I described earlier, medical malpractice has been *sui generis* to the political process, making it challenging to devise approaches that integrate malpractice reform with other efforts to address the extraordinarily difficult health policy problems of quality, cost, and access.

I can imagine three possible avenues for comprehensive malpractice reform. The first involves demonstration projects at the state level. In 2002, the Institute of Medicine responded to a request by the United States Department of Health and Human Services for malpractice reform ideas by recommending federal funding of state-based demonstrations. The IOM offered two models by way of example: a statewide administrative system similar to workers compensation and a provider-based early payment system that would substitute administrative adjudication for litigation at eligible hospitals and medical groups. Both systems require participating providers to make serious commitments to patient safety, and make federal funding available as stop-loss protection for providers if total compensation to injured patients under the new system exceeded the cost of conventional malpractice litigation. Unless federal funding was extremely generous, it might be difficult to find states interested in testing this reform approach. A relatively progressive Republican state such as Colorado or Utah would be a good candidate, as would a state such as Pennsylvania with a serious malpractice crisis but constitutional constraints on comprehensive reform unless it has Federal sponsorship.

A second path is to pursue malpractice reform through employers in their roles as sponsors of private health insurance. Private employers engineered workers compensation in the early twentieth century as a compromise system to prevent injuries and help victims without litigation, and might do similarly a hundred years later for medical injuries to the employees and dependents they insure. In particular, large self-insured employers could adopt contractual standards for liability that obligate the health plans and providers with whom they do business to assume financial responsibility for promptly compensating injured patients but also preclude tort litigation in most instances. The United States Supreme Court's increasingly expansive interpretation of ERISA preemption, evident in its unanimous decision a year ago in the *Davila* case, allows employers

to innovate with respect to liability, notwithstanding more restrictive state statutes or common law. The biggest problem I foresee is that American business has two separate interests here. It has a strong interest in a healthy, productive workforce that receives safe health care and fair compensation for injury, but it also wants to use medical malpractice in the political arena as a poster child for generalized tort reform. This dynamic might temper employers' enthusiasm for malpractice reform that gives primacy to health policy goals.

I am strongly in favor of a third malpractice reform approach: to do it through Medicare. Medicare often sets the standard for the rest of the health care system. To me, having the Medicare program sidelined on medical liability for so many years has been the single biggest obstacle to getting a better system in place. In addition to demonstrations centered on particular states or employers, CMS should propose testing a better liability system for Medicare and perhaps Medicaid patients. It is well established that elderly plaintiffs fare poorly in tort litigation. They have complicated medical histories that make negligence harder to prove; they have smaller cognizable damages because of unemployment and shorter remaining life spans; they often hesitate to jeopardize therapeutic relationships by filing claims; and they are less able to withstand long procedural delays. Moreover, only the federal government acting through a major government benefit program has the financial wherewithal to place malpractice insurance on a more secure footing for the long term. CMS could test an alternative system that holds participating providers strictly accountable to the federal government for safety, offers "pay-for-performance" incentives for improvements in error prevention and compensation, and ties liability reform to other ongoing patient safety and quality initiatives within the Medicare program. Medicare also has an operational system of administrative adjudication for disputes over coverage and benefits that could be adapted to resolve medical liability claims—in essence creating a "medical court." In fact, this system is being revamped right now and brought within CMS from the Social Security Administration.

Jump-starting comprehensive reform through Medicare also has a political argument in its favor. As I stated at the outset, the politics of malpractice reform is seldom about health care, especially during "crisis" periods. Making malpractice policy through Medicare policy would substantially alter the tenor of the ongoing debate. Short of decisions that dramatically impact the overall federal budget, which this would not, the politics of Medicare—however contentious—are indeed health care politics, and what emerges from a Medicare debate is indisputably health policy.