

WHAT LESSONS SHOULD WE LEARN FROM THE FIRST MALPRACTICE CRISIS OF THE TWENTY-FIRST CENTURY?

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I. INTRODUCTION

We have just emerged from the first malpractice crisis of the twenty-first century, and the third malpractice crisis in the past three decades.¹ This Article highlights five lessons that scholars, policy analysts, and legislators should take away from the most recent crisis. My modest hope is that this analysis will provide a toolkit for informing the policy debate when we have our next crisis—which given the turmoil in the financial markets, may well occur sooner rather than later.

The norms of law review articles would ordinarily require me to fill two dozen pages with background on each of the most recent crises, along with citations to authority for each and every sentence that contains a proposition more controversial than “the sun rises in the morning.” Those who are interested in that sort of thing should look elsewhere.² No one reads the footnotes anyway.³ The lessons are:

1. Premiums don’t tell you much.
2. Neither do anecdotes about access (or about anything else, for that matter).
3. Defensive medicine is real. So what?
4. Diagnosis should precede treatment—even in mal-

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1. See William M. Sage, *Understanding the First Malpractice Crisis of the 21st Century*, in HEALTH LAW HANDBOOK 1-3 (Alice G. Gosfield ed., 2003).

2. If you like that sort of thing, this article is not the sort of thing you’ll like. Ok, you want a footnote? I’ll give you a footnote. Check out David A. Hyman & Charles Silver, *Medical Malpractice Litigation and Tort Reform: It’s the Incentives, Stupid*, 59 VAND. L. REV. 1085 (2006). Don’t trust me? There’s always TOM BAKER, *THE MEDICAL MALPRACTICE MYTH* (2005); FRANK A. SLOAN & LINDSEY M. CHEPKE, *MEDICAL MALPRACTICE* (2008); *MEDICAL MALPRACTICE AND THE U.S. HEALTH CARE SYSTEM* (William M. Sage & Rogan Kersh eds., 2006).

3. So why are you reading this one?

practice policy.

5. Don't ignore the real problem.

Part II provides a detailed discussion of each of these lessons. Part III considers why we have failed to learn these lessons from past crises. Part IV concludes.

II. THE LESSONS

A. *Premiums Don't Tell You Much*

What is a malpractice crisis? The choice of words suggests that a "malpractice crisis" is a sudden and salient increase in the rate of malpractice. Alternatively, a "malpractice crisis" might be the sudden recognition that the base rate of malpractice is too high, relative to some normative assessment of an "acceptable" rate. Instead, the defining characteristic of each of the past three malpractice crises is a sudden and dramatic increase in *malpractice insurance premiums*.

Unfortunately, observing that there have been sudden and dramatic increases in premiums does not tell you whether or not the increases are "real" and durable (as opposed to short-term fluctuations or random noise). More importantly, even if the increases are "real," the existence of a premium spike does not say anything useful about the cause or causes.

At the highest level of generality, a "real" premium spike can be attributable to either the tort system or the insurance system. Tort-based explanations of a premium spike include a sudden increase (or expected increase) in either the number of claims, the dollars per claim necessary to resolve the dispute, a rise in the cost of defending such claims, or some combination of all of these factors. Insurance-based explanations include a decline in projected investment income, the need to strengthen reserves, an increase in the cost of reinsurance, and the like.

Simply stated, the fact that premiums have gone up does not tell one whether tort-based or insurance-based explanations, or some combination of both, (and if both, the relative proportions of each) are responsible for the rise in premiums. In the absence of any evidence on this issue, reform is unlikely to be narrowly tailored to address the source of the problem. As such, it may not solve the underlying problem, let alone pre-

vent future recurrence. In medical terms, sudden and dramatic increases in malpractice premiums are a symptom—not a diagnosis.

B. Neither Do Anecdotes (About Access, or About Anything Else, for That Matter)⁴

Sudden and dramatic increases in premiums are quite distressing to those who have to pay them, but something more is required to justify public attention and a spot near the top of the legislative agenda. Accordingly, tort reformers have focused the debate on how the malpractice crisis has affected access to medical services. This might seem odd because, overall, the consumption of health care keeps going up. Because a focus on total consumption would not scare people, the subject of debate usually is the number and specialty of physicians practicing in a state or other geographical area.⁵

The framing can become extremely specific. In the debate over enacting a damages cap in Illinois (ultimately enacted in 2005, and currently under review by the Illinois Supreme Court),⁶ “the phrase ‘there are no neurosurgeons south of Springfield’ came to represent the threat of the medical liability issue.”⁷ This claim was repeated multiple times by physicians, legislators, and tort reform advocates. For example, in a 2004 article in a downstate newspaper, a family physician was quoted as follows:

We are losing all these doctors to other states where they have caps on pain and suffering . . . There will be no neurosurgeons south of Springfield in Illinois. If you have a car wreck in Southern Illinois then the odds

4. A portion of this Section first appeared on the Volokh Conspiracy. See Posting of David A. Hyman to Volokh Conspiracy Blog, http://volokh.com/archives/archive_2008_12_21-2008_12_27.shtml (Dec. 27, 2008, 00:14).

5. This is a problematic measure for all sorts of reasons, but let us just take it as a given for now.

6. *Lebron v. Gottlieb Mem'l Hosp.*, Nos. 105741, 105745 (Ill. argued Nov. 13, 2009). *Lebron* is on appeal directly from the Cook County Circuit Court following a decision by Circuit Court Judge Diane Joan Larsen that caps on all damages were unconstitutional. See *Lebron v. Gottlieb Mem'l Hosp.*, No. 2006L12109, 2007 WL 3390918 (Ill. Cir. Nov. 13, 2007).

7. See Bethany Jaeger, *Unsettled Debate*, ILL. ISSUES, Mar., 2008, available at <http://illinoisissues.uis.edu/features/2008mar/medical.html>.

aren't very good for you.⁸

In a 2005 article, another physician was quoted as follows: "This has been an uphill battle. We've lost all our neurosurgeons south of Springfield and it's even affecting those in Chicago."⁹

Legislators picked up on the claim as well. Tom Cross, the Illinois House Republican leader repeated the claim in an eight-page briefing package on the need for medical liability reform.¹⁰ U.S. Representative Mark Steven Kirk issued a press release that asserted that the problem was spreading:

South of Springfield, there are no neurosurgeons treating patients suffering from head traumas This crisis of care is now spreading to Chicago's suburbs. With only three neurosurgeons caring for patients in Lake County, we face the growing threat that our doctors will not be there when we need them most. If we do not enact reforms soon, patients will die.¹¹

Finally, a prominent magazine for hospital trustees repeated the claim and provided some geographic context: "According to the American Association of Neurological Surgeons, high malpractice premiums mean there are currently no neurosurgeons practicing south of Springfield, Ill.—an approximately 200-mile gap to the Missouri border."¹²

What are the problems with this type of anecdote-based argument? Consider a couple of questions worth asking the next time you hear a claim like this:

1. Is the claim true? Are there, in fact, no neurosurgeons in Illinois south of Springfield? Anyone who

8. Rob Stroud & Herb Meeker, *Illinois Physicians Say Insurance Rates Are Driving Them Out of State*, J. GAZETTE—TIMES COURIER ONLINE, Sept. 3, 2004, <http://www.jg-tc.com/articles/2004/09/03/news/news01.txt>.

9. Dave Whaley, *Med Mal Faces Crucial Vote in Senate*, TELEGRAPH, Mar. 15, 2005, available at <http://www.senatorcullerton.com/Press/pre 2006/Alton Telegraph - Med mal faces crucial vote.pdf>.

10. See ILL. HOUSE REPUBLICAN CAUCUS, KEEPING DOCTORS IN ILLINOIS: MEDICAL LIABILITY REFORM PLAN 6 (2005), <http://www.davidreis.org/issues/doctors.pdf> (last visited Apr. 4, 2009).

11. Press Release, U.S. Congressman, Mark Steven Kirk, Kirk Highlights Last Three Neurosurgeons Caring for Lake County Patients (July 27, 2004), available at http://www.house.gov/list/press/il10_kirk/pr040727.html.

12. Ron Shinkman, *The Disappearing Doctor*, TRUSTEE, Dec. 2005, at 6, available at <http://www.trustemag.com> (type "Disappearing Doctor" in the "Search Publications" box).

spends any time around political debates knows that the claims one hears routinely bear only a passing resemblance to objective reality. The fact that the Illinois Hospital Association¹³ issued an undated fact sheet that says there is one neurosurgeon south of Springfield, and President Bush gave a speech on January 5, 2005, stating that there were two neurosurgeons practicing south of Springfield¹⁴ suggests that some additional fact checking might be in order.

2. Even if the claim is true, is it framed in a way that is nonetheless misleading? Might using state borders (no neurosurgeons in Illinois south of Springfield) to define the issue be problematic, when demand for medical services does not necessarily respect those borders? Carbondale, Illinois, where Southern Illinois University School of Law is located, is 176 miles by car from Springfield, and 107 miles by car from St. Louis. If it turns out there are plenty of neurosurgeons in St. Louis, should we care (as much, or at all) that there are no neurosurgeons in Illinois south of Springfield?

3. To what extent is the in-state demand for neurosurgical services being met by other specialists? This question is not applicable to a fair chunk of what neurosurgeons do—particularly in trauma cases—but it is worth asking about access claims regarding many other specialties, where the same (or a substitute) service can be performed by others.

4. How do we know malpractice premiums are the cause of the shortage of neurosurgeons south of Springfield? Empirical studies provide little evidence that physicians decide where to practice on the basis of malpractice costs.

5. How tight is the fit between the proposed remedy (in this case, caps on non-economic damages) and the problem? If we enact a damages cap, will we get more

13. Illinois Hosp. Ass'n, Medical Liability Crisis - Fact Sheet, <http://www.ihatoday.org/issues/liability/toolkit/facts.html> (last visited Apr. 4, 2009).

14. President George W. Bush, Speech in Collinsville, Illinois (Jan. 5, 2005), available at <http://www.cnnstudentnews.cnn.com/TRANSCRIPTS/0501/05/1ol.03.html>.

neurosurgeons south of Springfield? How many more? Will they be good neurosurgeons? Could we get too many neurosurgeons south of Springfield?

6. If we are convinced we want more neurosurgeons south of Springfield, is a damages cap the best way to do that? Would a direct subsidy for neurosurgeons willing to locate south of Springfield be more cost-effective? If we have a fixed amount of money to spend on the problem, is it better spent on subsidizing relocation of neurosurgeons, or of patients needing neurosurgery (by subsidizing a system of air ambulances, for example)?

7. What are the other consequences of adopting a damages cap, apart from the effect on the supply of neurosurgeons south of Springfield? What will be the effect on other specialties, and the way in which health care is delivered? What will be the effect on patients?

Obviously, this is just a partial list of the type of questions that should be asked before giving any weight whatsoever to a proffered anecdote. But, the better course is not to give any weight to such anecdotes, absent convincing proof of truthfulness and typicality.¹⁵

To be sure, that lesson applies equally to anecdotes about plaintiffs that have suffered a medical injury, and are unable to find a lawyer because of a cap on non-economic damages.¹⁶ If you want to decide whether a non-economic cap is a good idea, you need to evaluate its costs and benefits. Doing that requires one to assess the effects of the damages cap, and compare its impact to the available alternatives – not compete to find the most heart-rending anecdote, and rely on that to make one's case.

A tragic story may sell newspapers and attract legislative interest—but that is not the touchstone for whether reform is required—let alone whether the proposed reform is optimal

15. See generally David A. Hyman, *Lies, Damned Lies, and Narrative*, 73 IND. L.J. 797 (1998) (evaluating the use of narrative accounts and anecdotal evidence and the consequences in the legislative arena).

16. For my own efforts in this regard, see David A. Hyman, *Not Worth The Pain and Suffering*, FORBES, Sept. 15, 2008, at 34, available at <http://www.forbes.com/opinions/forbes/2008/0915/034.html>.

when assessed across all cases. Worse still, the more compelling the anecdote, the more likely it is to be credited as truthful and typical, whether it is or not—and anecdotes are at their most compelling when they appeal to our passions and prejudices.¹⁷ The basic problem was nicely stated by Professor Michael Saks:

Even if true and accurate, anecdotes contribute little to developing a meaningful picture of the situation about which we are concerned. It makes a difference if for every ten anecdotes in which an undeserving plaintiff bankrupts an innocent defendant, one, ten, one hundred, or one thousand equal and opposite injustices are done to innocent plaintiffs. The proportion of cases that results in one or the other error, and the ratio of one kind of error to the other, ought to be of greater interest to serious policy-makers than a handful of anecdotes on either side of the issue. Reforms are intended to change that ratio and the tens of thousands of anecdotes the ratio summarizes.¹⁸

Argument by anecdote also worsens the tendency in policy debates to privilege identifiable lives over statistical lives—hardly a recipe for sensible and cost-effective policies.¹⁹ Indeed, even if an anecdote is highly representative, other considerations may dictate a policy diametrically opposed to the one suggested by the anecdote.²⁰

17. See David A. Hyman, *Regulating Managed Care: What's Wrong With A Patient Bill of Rights*, 73 S. CAL. L. REV. 221, 241 (2000) ("[T]he more compelling the anecdote, the less likely we are to consider issues of typicality and frequency – meaning the risk of being led astray is a direct function of the persuasiveness of the anecdote.").

18. See Michael J. Saks, *Do We Really Know Anything About the Behavior of the Tort Litigation System - And Why Not?*, 140 U. PA. L. REV. 1147, 1161 (1992).

19. See Clark C. Havighurst, James F. Blumstein & Randall Bovbjerg, *Strategies in Underwriting the Cost of Catastrophic Disease*, 40 LAW & CONTEMP. PROBS. 122, 140-41 (1976) (contrasting society's willingness to sacrifice identifiable lives v. statistical lives) ("It is difficult to improve significantly on the commonplace observations that human beings cannot empathize with faceless abstractions and that 'squeaking wheels' - the complaints of known victims, such as the very vigorous lobbying of kidney-disease patients - not the silence of statistical unknowns will get the governmental grease. Spending 'millions of dollars to save a fool who has chosen to row across the Atlantic has external benefits' lacking from highway safety spending.").

20. See David A. Hyman, *Do Good Stories Make For Good Policy?*, 25 J. HEALTH POL. POL'Y & L. 1149, 1153 (2000).

C. *Defensive Medicine Is Real. So What?*

Each of the past three malpractice crises has involved a bitter debate over the magnitude and significance of defensive medicine. To most physicians and tort reform advocates, the existence of defensive medicine is incontestable, and offers a decisive argument for comprehensive tort reform. Tort reform opponents contest the seriousness of the problem of defensive medicine, arguing that it is such small (financial) potatoes as to constitute rounding error when compared to total spending on health care.

Defensive medicine is real, and it comes in two varieties: avoidance behavior and assurance behavior.²¹ Avoidance behavior is when physicians restrict the scope of their practice or relocate to avoid malpractice risk. Assurance behavior is when physicians run additional tests/imaging studies, or invest in equipment to prevent errors. "Defensive medicine" thus describes both good things (e.g., running additional cost-justified tests, limiting one's practice to services one performs well) and bad things (e.g., non-cost worthy tests to "paper the file," access problems for patients).

Defensive medicine is one of the factors that should be weighed in assessing the costs and benefits of reform. That said, even if everyone agrees that defensive medicine is a serious problem (and not everyone does), it is hard to believe that a cap on non-economic damages is the optimal strategy for doing something about it. Instead, treating compliance with authoritative treatment guidelines as an absolute bar to liability is one obvious strategy to address non-cost-worthy assurance behavior.²² Access problems are trickier, but direct subsidies are an obvious possibility. Regardless, the basic point is that the observation that defensive medicine is real is only the start of the discussion/analysis. "So what" (or less pejoratively, "now what") is the obvious rejoinder.

21. David M. Studdert et al., *Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment*, 293 J. AM. MED. ASS'N 2609 (2005).

22. Hyman & Silver, *supra* note 2, at 1132-33 (suggesting this approach to deal with overclaiming as well).

D. Diagnosis Should Precede Treatment – Even in Malpractice Policy

It is a cliché in medicine that diagnosis should precede treatment. During each of the three past malpractice crises, this fundamental precept of medicine has been ignored. Policymakers have simply assumed the tort system is responsible for the premium spikes—a fact that largely explains why tort reform (specifically, caps on non-economic damages) has been the dominant response. Yet, as noted previously, the simple fact that premiums have increased dramatically provides no compelling reason for thinking that tort-based explanations are applicable. Insurance economists have offered other explanations for premium crises, such as herd behavior by insurers and shocks to insurers' equity that can only be met in the short-run by price hikes. The evidence that insurance crises are driven by underlying litigation crises is also exceptionally flimsy. Although premiums certainly respond to changes in tort costs over the long run, in the short term premiums fluctuate more widely than tort costs do. Even when policymakers understand that it is an open question whether the tort system is responsible for the premium spikes, the political dynamics are such that they often feel compelled to move forward with tort-focused remedies.

Consider Pennsylvania, which in 2001 was ground-zero for the debate over malpractice reform. In the midst of this firestorm, the Pew Trusts funded the "Project on Medical Liability in Pennsylvania" with a grant of \$3.2 million to "elevate public awareness and discussion of the medical liability crisis in Pennsylvania, to conduct research on the causes and consequences of the crisis, and to identify potential reforms to alleviate the crisis."²³ The larger goal of the Project was to "provide decision-makers with objective information about the ways in which medical, legal, and insurance-related issues affect the medical liability system . . . and focus attention on the relationship between medical liability and overall health and economic prosperity."²⁴ With Professor William Sage (then of

23. Pew Charitable Trusts, Project on Medical Liability in Pennsylvania, http://www.pewtrusts.org/program_investments_grant_details.aspx?id=16906 (last visited Jan. 31, 2009)

24. MEDICAL MALPRACTICE AND THE U.S. HEALTH CARE SYSTEM 1 (William M. Sage & Rogan Kersh eds., 2006).

Columbia Law School) as the Principal Investigator, the Project funded research papers by various experts on medical malpractice—published periodically beginning in 2003, and culminating in a book in 2006.²⁵

One would have hoped that Pennsylvania would have waited for the results of the Project before doing anything. In fact, Pennsylvania enacted substantial malpractice reform in 2002, and there have been aggressive tort reform efforts in the intervening years—even though the 2003 report made it clear that the premium spikes had multiple interacting causes.²⁶ Every time the issue was considered by the legislature, the outcome turned not on the empirical findings generated by the Project, but on the raw political power of supporters and opponents of tort reform.²⁷

Such behavior is not unique to Pennsylvania or to the latest malpractice crisis. During the previous malpractice crisis, researchers at the Harvard School of Public Health proposed to do a study on the causes of the crisis using Massachusetts data. Physicians and hospitals in Massachusetts were worried that the study would derail pending legislation to cap non-economic damages. Although the researchers were located in Massachusetts, they were unable to obtain the necessary access to data and research support—so the study was ultimately performed using data from New York.²⁸

If we want reform to actually improve the status quo, it is important that we improve the ratio between evidence and advocacy in our policy-making.²⁹ Requiring diagnosis to precede treatment is an excellent place to start.

25. *Id.*

26. RANDALL R. BOVBERG & ANNA BARTOW, PROJECT ON MED. LIAB. IN PENN., UNDERSTANDING PENNSYLVANIA'S MEDICAL MALPRACTICE CRISIS: FACTS ABOUT LIABILITY INSURANCE, THE LEGAL SYSTEM AND HEALTH CARE IN PENNSYLVANIA 61 (2003), available at http://www.pewtrusts.org/uploadedFiles/wwwpewtrustsorg/Reports/Medical_liability/vf_medical_malpractice_0603.pdf.

27. David A. Hyman, *Improving the Evidence/Advocacy Ratio in Medical Malpractice Reform*, 26 HEALTH AFF. 289, 290 (2007).

28. See HARVARD MEDICAL PRACTICE STUDY, PATIENTS, DOCTORS, AND LAWYERS: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION IN NEW YORK (1990).

29. Hyman, *supra* note 26.

E. Don't Ignore the Real Problem

Because the identification of each of the past three malpractice crises has been framed around premium spikes, the entire focus has been on that problem. But, it is quite clear that the “real” problem with American health care and the medical malpractice system is far broader. The quality of health care services delivered in the United States is highly variable—and the medical malpractice system doesn’t do nearly enough to create the necessary incentives to ensure that only high-quality care is provided.³⁰ The mismatch is profound:

At a recent conference on medical malpractice policy, a state legislator remarked with some astonishment that the malpractice reform debate indeed seemed highly polarized, but that the most profound disagreement was not between health care providers and the plaintiff’s bar. The principal conflict he observed was between the major political stakeholders on one side, and the academic community on the other. The former group understood the central question to be the desirability of enacting MICRA-style measures to discourage lawsuits and limit recoveries, with a \$250,000 cap on non-economic damages as its centerpiece. The latter group was essentially unanimous in its opinion that traditional “tort reform” offers incomplete solutions to only a subset of critical problems.³¹

Reforms aimed at the wrong problem are unlikely to fix the real problem. Stated differently, it’s hard to hit something if you’re not aiming at it.

30. Hyman & Silver, *supra* note 2, at 1130; see generally David A. Hyman & Charles Silver, *The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution?*, 90 CORNELL L. REV. 893 (2005). A vast literature explores the quality inadequacies of the American health system. See generally INSTITUTE OF MEDICINE, *TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM* (1999); Mark R. Chassin & R.W. Galvin, *The Urgent Need to Improve Health Care Quality: Institute of Medicine National Roundtable on Health Care Quality*, 280 J. AM. MED. ASS’N 1000 (1998).

31. Sage, *supra* note 1, at 31.

III. WHY DO WE KEEP MAKING THE SAME MISTAKES OVER AND OVER AGAIN?

Because we're human beings, and that's what we do.³² Or, as a former colleague nicely put it: "The problem with life is the personnel."³³

IV. CONCLUSION

Oliver Wendell Holmes famously observed: "Ignorance is the best of law reformers."³⁴ That observation clearly applies to the last three malpractice crises. If we want to do better the next go-round, it might make sense to think hard about the lessons outlined above—and structure the reform process accordingly. Otherwise, in the immortal words of Yogi Berra, it will be "déjà vu all over again."³⁵

32. At least, that seems to be the point of behavioral economics.

33. Personal communication with Robert Condlin, Professor of Law, The University of Maryland School of Law.

34. OLIVER WENDELL HOLMES, *THE COMMON LAW* 64 (Mark DeWolfe Howe ed., Harvard Univ. Press 1963) (1881).

35. A point I have made previously in an article that uses those words in the title. David A. Hyman & Charles Silver, *Medical Malpractice Reform Redux: Déjà vu All Over Again?*, 12 WIDENER L. REV. 121 (2005). How's that for déjà vu?