# MEDICAL MALPRACTICE REFORM REDUX: DÉJÀ VU ALL OVER AGAIN?

DAVID A. HYMAN*

CHARLES SILVER**

## I. OVERVIEW

The United States experienced a malpractice liability crisis in the 1970s and then again in the 1980s. During those crises, malpractice premiums spiked, with some specialties experiencing increases of 100%. Demoralized doctors were said to be "going bare," relocating, retiring, excluding risky services from their practices and hiding their assets. Doctors also organized strikes, protests, "sick-outs" and pressed for state and federal malpractice reforms. Physicians denied that there were any problems with quality or medical error, blamed plaintiffs' lawyers, the tort system and greedy patients for these problems and pressed for tort reform.[1] Plaintiffs' lawyers responded that the problem was too much medical malpractice and that the tort system was part of the solution. Both sides lobbied state and federal legislators, who struggled to figure out which side had the better argument. Many states enacted some form of tort reform.

We are currently in the midst of another malpractice crisis. At first glance, it appears to be "déjà vu all over again," as many of the same players are making many of the same moves. The American Medical Association ("AMA") has declared a malpractice "crisis" in twenty states and is pressing for tort reform at the state and federal levels.[2] The plaintiffs' bar opposes these efforts and blames both insurance companies and physicians. As in previous crises, legislators have considered (and sometimes enacted) tort reform, although the specifics have varied from state to state.

There are, however, three important differences between the current malpractice crisis and the earlier ones. The first difference is the rise of an organized quality movement. The second difference is the availability of more

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* Professor of Law and Medicine, University of Illinois.

** Co-Director, Center on Lawyers, Civil Justice, and the Media, and McDonald Endowed Chair in Civil Procedure, University of Texas School of Law.

1. 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, 895-896 (2005); William M. Sage, *Understanding the First Malpractice Crisis of the 21st Century*, *in* HEALTH LAW HANDBOOK 1 (Alice Gosfield ed., 2003); David A. Hyman, *Medical Malpractice and the Tort System: What Do We Know, and What (If Anything) Should We Do About It?*, 80 TEX. L. REV. 1639, 1639-40 (2002).

2. *See* American Medical Association, *Medical Liability Crisis Map, available at* http://www.ama-assn.org/ama1/pub/upload/mm/450/med_liab_may05.pdf. *See generally* David M. Studdert et al., *Medical Malpractice*, 350 NEW ENG. J. MED. 283 (2004).

information on health care quality and the performance of the medical malpractice system. The third difference is that some payers are starting to use their purchasing power to drive quality improvements in the delivery system. In this article, we consider whether these three differences are likely to affect the resolution of the first malpractice crisis of the 21st century, or whether it will be "déjà vu all over again," as Yogi Berra once put it.

Part II details the current status of health care quality, medical error and the medical liability system. Part III outlines the three differences between the last malpractice crisis and the current one. Part IV analyzes whether the developments outlined in Part III are likely to affect the way in which the latest medical malpractice crisis will play out. Part V offers a brief conclusion.

## II. HEALTH CARE QUALITY/MEDICAL ERROR AND MEDICAL LIABILITY

### *A. Health Care Quality*

The literature on health care quality is replete with statements that look like tabloid headlines: "[one fourth] of hospital deaths may be preventable;"[3] "180000 die annually as a result of [iatrogenic] injuries;"[4] "one-third of some hospital procedures may expose patients to risk without improving their health."[5] Health care providers in the United States routinely omit indicated procedures of known value, frequently perform unnecessary and inefficacious treatments and employ practice patterns that vary widely for no good reason. Adverse drug events are distressingly common.[6] Tens of billions of dollars are spent annually on medical services whose value is questionable or non-existent.[7]

American health care is also dogged by unacceptably high error rates. In a 1999 report, the Institute of Medicine ("IOM") concluded that medical errors kill 44,000-98,000 hospitalized Americans[8] and injure hundreds of thousands more

3. Robert H. Brook et al., *Health System Reform and Quality*, 276 JAMA 476, 477 (1996).

4. David W. Bates et al., *Incidence of Adverse Drug Events and Potential Adverse Drug Events: Implications for Prevention*, 274 JAMA 29, 29 (1995).

5. Stephen M. Shortell et al., *Assessing the Impact of Continuous Quality Improvement on Clinical Practice: What It Will Take to Accelerate Progress*, 76 MILBANK Q. 593, 593 (1998).

6. *See* David P. Phillips et al., *Increase in U.S. Medication-Error Deaths Between 1983 and 1993*, 351 LANCET 643 (1998); David C. Classen et al., *Adverse Drug Events in Hospitalized Patients: Excess Length of Stay, Extra Costs, and Attributable Mortality*, 277 JAMA 301, 301 (1997); Bates et al., *supra* note 4, at 29.

7. *See* Milt Freudenheim, *Study Finds Inefficiency in Health Care*, N.Y. TIMES, June 11, 2002, at C14 (reporting estimate that "$390 billion a year is being wasted on outmoded and inefficient medical procedures.").

8. IOM, TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 1 (1999). These figures have been controversial. Researchers have argued that many of the patients would have died

every year.[9] The National Committee for Quality Assurance ("NCQA") and a private think-tank recently came to roughly the same conclusion.[10] These errors result in staggering social costs, most of which are borne by victims and their families. Serious quality problems afflict every aspect of the American health care system, irrespective of insurance coverage and delivery arrangements. Simply stated, "quality problems . . . abound in American medicine. The majority of these problems are not rare, unpredictable, or inevitable concomitants of the delivery of complex, modern health care. Rather, they are frighteningly common, often predictable and frequently preventable."[11]

The quality problems with American medicine include every conceivable example of overuse, underuse, misuse and out-and-out error. The IOM estimates that medical error is the eighth leading cause of death in the United States, ranking ahead of AIDS, motor vehicle accidents and breast cancer.[12] Other sources rank medical error as high as the third leading cause of death.[13] Non-mortal injuries occur even more often.[14] "[O]ver a million people are injured by medical treatments annually in the U.S."[15]

Mistakes that occur during hospitalizations are only part of the picture. Additional errors occur during home care, primary care, ambulatory care and

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anyway or that reviewer assessments are unreliable. *See* Rodney A. Hayward & Timothy P. Hofer, *Estimating Hospital Deaths Due to Medical Errors: Preventability Is in the Eye of the Reviewer*, 286 JAMA 415, 416 (2001); Clement J. McDonald et al., *Deaths Due to Medical Errors Are Exaggerated in Institute of Medicine Report*, 284 JAMA 93, 93 (2000). Those involved in the preparation of the IOM report have defended these figures. *See* Lucian L. Leape, *Institute of Medicine Medical Error Figures Are Not Exaggerated*, 284 JAMA 95, 97 (2000). *But see* Troyen A. Brennan, *The Institute of Medicine Report on Medical Errors—Could It Do Harm?*, 342 NEW ENG. J. MED. 1123, 1123 (2000).

9. Nat'l Comm. for Quality Assurance, *The State of Health Care Quality: 2004* 13 (2004), http://www.ncqa.org/communications/SOMC/SOH/2004.pdf.

10. *Id.*; HEALTH GRADES, HEALTH GRADES QUALITY STUDY: PATIENT SAFETY IN AMERICAN HOSPITALS 1 (2004),http://www.healthgrades.com/media/english/pdf/HG_Patient_Safety_Study_Final.pdf.

11. Mark R. Chassin, *Is Health Care Ready for Six Sigma Quality?*, 76 MILBANK Q. 565, 566-567 (1998) (citation omitted). *See also* Mark A. Schuster et al., *How Good Is the Quality of Health Care in the United States?*, 76 MILBANK Q. 517, 520-21 (1998); Juliette Cubanski & Janet Kline, *Improving Health Care Quality: Can Federal Efforts Lead the Way?*, THE COMMONWEALTH FUND ISSUE BRIEF #5391 (2002), http://www.cmwf.org/usr_doc/cubanski_improving.pdf.

12. IOM, *supra* note 8, at 1.

13. Barbara Starfield, *Is U.S. Health Really the Best in the World?*, 284 JAMA 483, 484 (2000) (ranking medical errors third). Although negligence-induced adverse events occur in only about one percent of hospitalizations, the mortality and morbidity figures are enormous because more than thirty million hospitalizations occur each year. *See generally* Margaret J. Hall & Jennifer R. Poprevic, Ctr. for Disease Control & Prevention, *1998 Summary: National Hospital Discharge Survey* (2000), http://www.cdc.gov/nchs/data/ad/ad316.pdf (reporting 31.8 million hospital discharges in 1998).

14. HEALTHGRADES, *supra* note 10, at 2-3.

15. Lucian L. Leape, *Foreword: Preventing Medical Accidents: Is "Systems Analysis" The Answer?*, 27 AM. J.L. & MED. 145, 146 (2001).

nursing home care. The frequency of errors in outpatient settings has not been studied as thoroughly,[16] but the available evidence suggests that outpatient care is subject to many of the same quality problems that afflict inpatient care.[17] One study reported that errors associated with outpatient care required "116 million extra physician visits, 77 million extra prescriptions, 17 million emergency department visits, 8 million hospitalizations, 3 million long-term admissions, 199000 additional deaths, and $77 billion in extra costs (equivalent to the aggregate cost of care of patients with diabetes)."[18]

Treatment variations are enormous as well. Holding age and physical condition constant, patients who live in some areas receive far higher and far more expensive levels of care than patients who live elsewhere—with no effect on outcomes.[19] "Geography is destiny" as far as the medical treatment one receives is concerned.

Providers have made some improvements since these problems were called to their attention, but their objective performances are still far below what we expect from airlines, banks, car manufacturers, restaurants and even the post office. As a prominent patient safety advocate noted,

> If the performance of certain high-reliability industries, whose standards of excellence we take for granted, suddenly deteriorated to the level of most health care services, some astounding results would occur. At a defect rate of 20 percent, which occurs in the use of antibiotics for colds, the credit card industry would make daily mistakes on nine million transactions; banks would deposit 36 million checks in the wrong accounts every day; and deaths from airplane crashes would increase one thousandfold.[20]

Part II-B describes how the medical liability system deals with these quality problems.

### *B. Medical Liability*

The performance of the medical liability system also leaves a great deal to be desired. About three percent of hospitalized patients suffer "adverse events" and one percent of hospitalized patients are negligently injured.[21] The

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16. *See* Elizabeth M. Lapetina & Elizabeth M. Armstrong, *Preventing Errors In The Outpatient Setting: A Tale of Three States*, HEALTH AFF., July/Aug. 2002, at 26. ("little if any research has focused on errors or adverse events occurring outside of hospital settings.").

17. *See generally* Elizabeth A. McGlynn et al., *The Quality of Health Care Delivered to Adults in the United States*, 348 NEW ENG. J. MED. 2635 (2003) (studying treatments for thirty conditions, including treatments delivered in ambulatory settings, and finding significant quality problems).

18. Starfield, *supra* note 13, at 484.

19. For recent articles on treatment variations, *see* Health Affairs: Pol'y J. Health Sphere, Variations Revisited, http://content.healthaffairs.org/cgi/content/full/hlthaff.var.5/DC1.

20. Chassin, *supra* note 11, at 569-70.

21. "An adverse event is an injury caused by medical management (rather than the underlying

consequences of these adverse events "range from complete recovery in less than one month (46% of those negligently injured) to death (25% of those negligently injured)."[22] Extrapolating these figures to the nation as a whole, "adverse events account for more than 200,000 deaths every year, with medical negligence accounting for [more than half] of the total."[23]

Relatively few adverse events generate malpractice claims against health care providers. Approximately two percent of patients who are negligently injured file a claim, "although a substantially greater percentage of claims were filed in cases where the injury was more severe."[24] Many invalid claims are also asserted because valid claims and invalid claims are often difficult to distinguish using only the limited evidence available at the start of litigation.[25] Once cases are filed, the tort system does a reasonably good job of sorting the wheat from the chaff, which explains why eighty percent of claims are closed without payment.[26] However, the tort system makes a fair number of mistakes, especially by withholding payments from persons with valid claims.[27] To a degree, controversies over the system's accuracy are unavoidable, given that evidence of the effectiveness of treatments is often undeveloped and disinterested experts disagree when evaluating malpractice cases an appreciable part of the time.[28] As

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disease process) that results in either a prolonged hospital stay or disability at discharge. The judgment that an adverse event had occurred was based on a two-stage process using implicit standards to conduct a professional review of the medical records. The studies of New York (hospitalizations in 1984) determined that the adverse event rate was 3.7%. Subsequent studies of Utah and Colorado (hospitalizations in 1992) determined that the adverse event rate was 2.9%." Hyman, *supra* note 1, at 1642 n.8 (citing David M. Studdert et al., *Beyond Dead Reckoning: Measures of Medical Injury Burden, Malpractice Litigation, and Alternative Compensation Models from Utah and Colorado*, 33 IND. L. REV. 1643, 1650, 1658-59 (2000)) (citation omitted). *See also* Michelle M. Mello & Troyen A.E. Brennan, *Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform*, 80 TEX. L. REV. 1595, 1607-1608 (2002) (summarizing studies).

22. Hyman, *supra* note 1, at 1643.

23. *Id.*

24. *Id.*

25. *See id.*

26. For an excellent review of empirical studies of the malpractice system's accuracy, *see* Tom Baker, *Making Sense With Numbers: The Uses and Abuses of Empirical Research On the Validity of Medical Malpractice Claims*, J. L. & ETHICS (forthcoming 2005).

27. *Id.* Baker critiques the finding of the Harvard Medical Practice Study that patients with invalid claims frequently receive compensation. *See also* Catherine T. Harris et al., *Placing "Standard of Care" in Context: The Impact of Witness Potential and Attorney Reputation in Medical Malpractice Litigation* 4 (2002), http://papers.ssrn.com/abstract=333560) *See also* David A. Hyman & Charles Silver, *Medical Malpractice and Tort Reform: It's The Incentives, Stupid*, VAND. L. REV. (forthcoming 2006) ("Over the past fifteen years, there have been a number of empirical studies of the medical malpractice claims process. Virtually every one . . . has concluded that compensation paid to the plaintiff is closely related to a determination of 'negligence,' typically defined in terms of a failure by the defendant physician to meet the relevant standard of care.") (citation omitted).

28. *See*, *e.g.*, Karen L. Posner et al., *Variation in Expert Opinion in Medical Malpractice Review*, 85

Sloan observes, "[t]o the extent that there is highly incomplete knowledge about the effect of particular interventions by health care providers on outcomes, it is unrealistic to expect courts to be omniscient in this regard."[29]

The tort system is also expensive. For every dollar which reaches the injured patient, another dollar or two is spent getting it there.[30] Most of this cost is ultimately borne by patients in the form of higher medical fees, but there is a substantial public subsidy as well.[31] To summarize, the tort system does a miserable job of compensating victims of medical malpractice. This is largely due to the failure of most victims to file law suits, extremely high loading costs and a significant error rate.

Of course, compensation is not the only purpose of the tort system. Deterrence is also an important element.[32] In theory, the tort system imposes economic costs on negligent providers (and only on negligent providers), who respond by modifying their behavior to conform to professional standards. In practice, matters are considerably more complicated. As noted previously, relatively few of those who are negligently injured ever file a claim. Unless settlements and verdicts are "up-weighted" to reflect this fact, and they are not, negligent defendants will necessarily be under-deterred by the tort system. Further, although malpractice insurance gives patients some assurance of being compensated, it also undermines the deterrent signal the tort system purports to be sending, particularly when, as with most medical malpractice insurance, coverage is sold on a non-risk-rated basis.[33] The Harvard team found the tort system's deterrent signal so ambiguous that it compared it to a situation in which "the police regularly gave out more tickets to drivers who go through green lights

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J. AM. SOC'Y ANESTHESIOLOGY 1049 (1996) (noting that anesthesiologists disagreed on whether care was negligent thirty-eight percent of the time, because they used implicit standards of review, instead of explicit criteria).

29. Frank A. Sloan, *Policy Implications*, *in* SUING FOR MEDICAL MALPRACTICE 211, 219 (Frank A. Sloan et al. eds., 1993).

30. *See* Bernard Black et al., *Stability, Not Crisis: Medical Malpractice Claim Outcomes in Texas, 1988-2002*, J. EMPIRICAL LEGAL STUD. (forthcoming 2005) (reporting on defense costs in malpractice cases); U.S. GEN. ACCOUNTING OFFICE, MEDICAL MALPRACTICE: CHARACTERISTICS OF CLAIMS CLOSED IN 1984, GAO/ HRD-87-55 (1987), *available at* http://archive.gao.gov/d2+4/132815.pdf (reporting on fees and costs incurred by plaintiffs and defendants in malpractice cases).

31. *See* Patricia M. Danzon et al., *Incentive Effects of Medical Malpractice: The Effects of Malpractice Litigation on Physicians' Fees and Incomes*, 80 AM. ECON. REV. 122, 122 (1990).

32. Corrective justice is, of course, the other goal of the tort system, but it has not figured much in the debate over the performance of the medical malpractice system. *See* PAUL C. WEILER ET AL., A MEASURE OF MALPRACTICE: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION 78 (1993).

33. *See* Gary M. Fournier, *The Case for Experience Rating in Medical Malpractice Insurance: An Empirical Evaluation*, J. RISK & INS., June 2001, at 255-276. Previous attempts to impose experience rating have been unsuccessful, as physicians have simply switched to insurers offering non-experience rated coverage.

than to those who go through red lights."[34] This appears to be an overstatement, but the evidence that the tort system does far too little to improve health care quality is clear. The high error rates documented in Part II leave little room for doubt about this.

## III. WHY IS THIS CRISIS UNLIKE PAST CRISES?

### A. The Quality Movement

The past thirty years have seen the emergence of a quality movement in health care, with the greatest changes in the past decade.[35] Historically, the issue of quality was delegated to physicians and external entities played little or no role in assessing whether the quality of care that was delivered was, in fact, adequate. A multitude of public and private organizations now monitor and measure quality of care. These organizations include the Agency for Healthcare Research and Quality ("AHRQ"),[36] the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO"),[37] the NCQA,[38] the National Quality Forum,[39] the National Patient Safety Foundation[40] and the Institute for Healthcare

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34. Weiler, *supra* note 32, at 75. To be sure, there is a substantial "base rate" problem with this metaphor. Because the vast majority of drivers don't go through red lights, even a small error rate in writing tickets will result in precisely this outcome.

35. *See* Lucian L. Leape & Donald M. Berwick, *Five Years After To Err is Human: What Have We Learned?*, 293 JAMA 2384, 2384 (2005); *See also* Thomas Bodenheimer, *The Movement for Improved Quality in Health Care*, 340 NEW ENG. J. MED. 488, 488-92 (1999).

36. *See* Agency for Healthcare Research and Quality, http://www.ahrq.gov (last visited Oct. 21, 2005).

37. *See* Joint Commission on Healthcare Organizations, http://www.jcaho.org/ (last visited Nov. 11, 2005). The JCAHO was formed in 1951 by the American Medical Association, the American Hospital Association, the American College of Physicians and the Canadian Medical Association. *See* Joint Commission on Healthcare Organizations, *A Journey Through the History of the Joint Commission*, http://www.jacho.org./about+us/history.htm (last visited Nov. 6, 2005). JCAHO has played a significant role in recent years in encouraging hospitals to adopt patient safety initiatives. Kelly J. Devers et al., *What Is Driving Hospitals' Patient-Safety Efforts?*, HEALTH AFF., Mar./Apr. 2004, at 103 (2004). JCAHO has not always had this reputation, as an excerpt from an online posting by a hospital administrator indicates:

> We never worried about JCAHO until the three months prior and the two days of the inspection. In the three months prior we backdated all the documentation that we needed to get through the inspection, and in the two days they were there we spent telling them how focused we were on quality, etc. As long as the paperwork is in order, people can be dying in the halls and there could be guppies in the IV fluid; the JCAHO wouldn't notice.

MARK A. HALL ET AL., THE LAW OF HEALTH CARE FINANCE AND REGULATION 373 (2005).

38. *See* NCQA, http://www.ncqa.org/ (last visited Oct. 21, 2005).

39. *See* National Quality Forum, http://www.qualityforum.org/ (last visited June 18, 2005).

40. *See* National Patient Safety Foundation, http://www.npsf.org/ (last visited June 11, 2005).

Improvement.[41] The comparative significance of these entities is less important than the fact that all of them exist and seek to improve quality of care.[42]

### *B. Quality Information*

The last few years have seen an explosion in the availability of information from public and private sources about quality of care. Between state and federal report cards and private sector sources, consumers have access to far more information than they once did about providers' expertise, malpractice and disciplinary records and success rates.

On the public sector side, the Center for Medicare and Medicaid Services ("CMS") has joined with hospitals and the Quality Improvement Organizations ("QIOs") in Maryland, New York and Arizona to design a group of pilot tests for publicly reporting hospital performance measures.[43] There is also a voluntary public-private program for reporting the same measures involving hospitals in every state.[44] The Medicare Prescription Drug, Improvement and Modernization Act of 2003 provides a modest incentive for hospitals to report quality data.[45] CMS also has a longstanding program for public reporting of quality information regarding dialysis providers and currently uses similar strategies to disseminate information regarding the quality of care provided by home health agencies and long term care providers.[46] Numerous states have created report cards for managed care organizations, with some providing volume information for specific conditions or quality ratings based on clinical quality measures.[47] Finally,

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41. *See* Institute for Healthcare Improvement, http://www.ihi.org/ihi (last visited June 12, 2005).

42. One set of authors believes JCAHO has been the most important of these entities. *See* Devers et al., *supra* note 37. For a different perspective, *see* Leape & Berwick, *supra* note 35, at 2386.

43. *See generally* CTRS. FOR MEDICARE & MEDICAID SERVS., HOSPITAL THREE-STATE PILOT, FACT SHEET (2005), http://www.cms.hhs.gov/quality/hospital/3StateFactSheet.pdf.

44. *See generally* CTRS. FOR MEDICARE & MEDICAID SERVS., HOSPITAL QUALITY INITIATIVE OVERVIEW (2005), http://www.cms.hhs.gov/quality/hospital/overview.pdf; *See also* AAMC, About the Hospital Quality Alliance,
http://www.aamc.org/quality/hospitalalliance/start.htm (last visited Sept. 19, 2005).

45. *See* CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 43, at 2 ("section 501(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 provided a strong incentive for eligible hospitals to submit quality data for ten quality measures known as the 'starter set.' The law stipulates that a hospital that does not submit performance data for the ten quality measures will receive a 0.4 percentage points reduction in its annual payment update from CMS for FY 2005, 2006 and 2007.")

46. *See* Ctrs. for Medicare & Medicaid Servs., End Stage Renal Disease (ESRD) Program, http://www.cms.hhs.gov/esrd/1.asp (last visited Sept. 19, 2005).

47. *See, e.g.*, The State of California, Office of The Patient Advocate, http://www.opa.ca.gov/report_card/ (last visited Sept. 19, 2005) (California report cards on HMOs and physician groups); *See also* State of New Jersey, Dep't of Health and Senior Servs., http://www.state.nj.us/health/

as noted previously, the AHRQ issues a national report on the state of the quality of care in the United States.[48]

In the private sector, the most well-known initiative is run by NCQA. NCQA developed the Health Plan Employer Data and Information Set ("HEDIS") to help assess health plans. HEDIS uses more than 50 measures of provider and plan performance in areas, such as patient satisfaction, childhood immunization and mammography screening rates, known to affect employee plan choice.[49] Other private initiatives similarly seek to make quality-related information available to employers, health plans and the general public.[50] JCAHO is also encouraging the availability of greater information by mandating that patients be told of medical errors.

Unfortunately, these information disclosure strategies have not been as effective as hoped in driving quality improvements. This ineffectiveness is due to two factors: lack of awareness of many consumers regarding quality problems in health care and the failure to provide quality information in a manner that makes it easy for consumers to make good choices and maximizes the saliency of the issue. Indeed, greater effects have been observed on the supply side (as providers discover to their dismay, that they are ranked below average or worse, and take steps to improve their performance) than on the consumer-driven demand side.

### *C. Just Paying v. Paying for Performance*

In most sectors of the economy, self-interest encourages vendors to continuously improve their quality and satisfy consumers' preferences. The simple fact that producers profit by meeting customers' needs creates enormous pressure to treat customers well. The problems outlined in Part II-A force one to ask why health care lags behind other sectors of the economy in providing high quality services. One answer is that, in health care, providers are "paid for what [they] do, not for what [they] accomplish."[51] This failure to pay for

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hcsa/hmomenu.htm (last visited Sept. 19, 2005) (New Jersey report cards on HMOs); *See also* Health Care Choices, http://www.healthcarechoices.org (last visited Sept. 19, 2005) (collecting several state report cards on cancer and cardiac surgery).

48. *See* AHRQ, 2004 National Healthcare Quality Report (2001), http://www.qualitytools .ahrq.gov/qualityreport/documents/nhqr2004.pdf.

49. *See* NCQA, The Health Plan Employer Data and Information Set (HEDIS®), http://www.ncqa.org/Programs/HEDIS/ (last visited Sept. 19, 2005).

50. *See*, *e.g.*, Consumer Reports, Hospital Report Cards (2003), http://www.consumerreports.org/main/content/display_report.jsp?FOLDER%3C%3E_folder_id=342103bmUID=11130099172108.

51. David A. Kindig, *Public Policy and Managerial Impact Section: Purchasing Population Health: Aligning Financial Incentives to Improve Health Outcomes*, 33 HEALTH SERVS. RES. 223, 223 (1998) (quoting former Assistant Secretary of Health and Human Services. Philip Lee).

performance ("P4P")[52] means that providers have little or no economic incentive to invest in quality-improvement. Indeed, when providers are compensated based on the number of their encounters with patients, they can readily profit by skimping on quality.[53] As former Speaker of the House Newt Gingrich cuttingly noted, "healthcare is the only industry in America that can give you a disease and then charge you to cure the disease it gave you."[54]

By forcing providers to internalize the costs of low quality care and enabling them to capture the benefits of high quality care, P4P can directly spur improvements in the quality of health care. P4P also has an important information-forcing aspect. Many health care organizations have hostile internal cultures that discourage health care workers from reporting and dealing with mistakes. P4P can encourage these organizations to transform themselves by making their dysfunctional culture more expensive.

P4P arrangements have become more common in recent years. The Medicare program recently introduced a demonstration project that pays modest financial incentives for hospitals that score in the top twenty percent and modest financial disincentives for hospitals that score in the bottom twenty percent on specified measures of quality for five conditions.[55] Medicare has a similar bonus program for managed care plans regarding the treatment received by individuals with congestive heart failure. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 also established a Care Management Performance pilot that will pay bonuses to physicians that adopt and use information technology to improve quality and reduce avoidable hospitalizations for chronically ill patients.[56]

Employers and private plans are also experimenting with P4P and other strategies to reward providers that adopt processes believed to improve quality. The Pacific Business Group on Health has been using incentive-based

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52. In two prior articles, we called for increased used of result-based compensation arrangements ("RBCA's") that would tie providers' compensation to measurable improvements in patients' health or other objective targets. *See generally* David A. Hyman & Charles Silver, *You Get What You Pay For: Result-Based Compensation for Health Care*, 58 WASH. & LEE L. REV. 1427 (2001); *See also* David A. Hyman & Charles Silver, *Just What the Patient Ordered: The Case For Result-Based Compensation Arrangements*, 29 J. L. MED. & ETHICS 170 (2001). Although we appear to have won the war over the propriety and desirability of these arrangements, we lost the battle over acronyms. P4P has swept RBCA from the field.

53. *See* Leape & Berwick, *supra* note 35, at 2388.

54. NEWT GINGRICH, SAVING LIVES & SAVING MONEY: TRANSFORMING HEALTH AND HEALTHCARE 18 (2003).

55. *See* CTRS. FOR MEDICARE & MEDICAID SERVS., REWARDING SUPERIOR QUALITY CARE: THE PREMIER HOSPITAL QUALITY INCENTIVE DEMONSTRATION (2005), http://www.cms.hhs.gov/quality/hospital/PremierFactSheet.pdf.

56. Ctrs. for Medicare & Medicaid Servs., *CMS Urges States to Adopt Disease Management Programs, Agency Will Match State Costs* (2004), http://www.cms.hhs.gov/media/press/release.asp?Counter=967.

performance targets for eight years in its contracts with HMOs. HMOs that fail to meet targets for patient satisfaction and various clinical benchmarks (including prenatal care, mammography, pap smears, childhood immunizations and cesarean section) forfeit two percent of their fees.[57] The Leapfrog Group, a coalition of 145 private and public organizations, is using its purchasing power to encourage hospitals to adopt computerized physician order entry ("CPOE"), referrals to high volume hospitals for certain procedures and staffing intensive care units ("ICUs") with intensivists.[58] Finally, one prominent health insurer, HeathPartners, has decided it will no longer pay for medical treatments that should not have been provided.[59]

Payers share some responsibility for the comparative rarity of P4P in health care. Historically, they have cared more about price than quality, and have negotiated terms that delegated responsibility for quality to providers. However, some payers seem to have stepped up to the plate and sought to use their purchasing power to drive quality improvements throughout the health care delivery system.

## IV. LOOKING FORWARD

The "first malpractice crisis of the 21st century" thus differs from the preceding malpractice crises on three grounds: (1) the rise of an organized quality movement; (2) the availability of more information on health care quality and the performance of the tort system; and (3) the use of purchasing power to drive quality improvements. How are these differences likely to affect the handling of the current malpractice crisis and the prospects of long-term durable improvements in health care quality and patient safety?

We think it unlikely that any of these developments will affect the resolution of the current crisis. Legislative reform depends on a host of imponderable factors, many of which are not under the control of those proposing (and opposing) legislative initiatives. A timely tragedy can derail a reform initiative or make it unstoppable. That said, the legislative debate over medical malpractice liability has focused on access and the desirability of caps. The quality movement, information on quality and malpractice and P4P don't seem to figure on the legislative agenda and there is no obvious mechanism to reframe the

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57. Helen Halpin Schauffler et al., *Raising The Bar: The Use Of Performance Guarantees By The Pacific Business Group On Health*, HEALTH AFF., Mar./Apr. 1999, at 134, *available at* http://content.healthaffairs.org/cgi/reprint/18/2/134.pdf (outlining use of performance contracts by Pacific Business Group on Health).

58. Kelly J. Devers & Gigi Liu, *Leapfrog Patient-Safety Standards Are a Stretch for Most Hospitals*, CENTER FOR STUDYING HEALTH SYSTEM CHANGE, *available at* http://www.hschange.org/CONTENT/647/?words=Leapfrog+Patient-safety (last visited Sept. 19, 2005).

59. Chen May Yee, *HealthPartners to Withhold Payment for Errors*, STAR TRIBUNE, Oct. 6, 2004, at 1A.

debate to consider them. To be sure, the plaintiffs' bar has sought to use the results generated by the quality movement to forestall tort reform legislation—but that strategy is complicated by the fact that many in the quality movement have no use for the tort system in handling the problems they have identified.

The quality movement has played an important role in sensitizing policy makers and the public to the problems of low quality care and encouraging the reporting of information about quality. Yet, these efforts have had limited success in actually improving the quality of care that is delivered. To pick one obvious example, the IOM's report on medical errors received front-page coverage throughout the nation approximately five years ago—but the leaders of the quality movement recognize that there have been, at best, relatively modest improvements in the interim.[60]

Similar problems beset consumer information strategies. Absent a clear demand-side effect, which is difficult to ensure, consumer information strategies must rely on the voluntary supply-side responses of providers who do not like being ranked below average, let alone dead last. This mechanism is better than no mechanism, but it is an unreliable basis on which to expect public investment in consumer information, let alone private investment. Finally, empirical studies of the malpractice system in action have played essentially no role in debates over tort reform.

We are more optimistic, at least in the long run, about P4P arrangements. P4P harnesses the economic self-interest of providers and can create a business case for quality. A world in which health care providers profit by making mistakes is a world in which they will find reasons for allowing high error rates to persist. Of course, P4P is only as good as the incentives it creates. If the incentives are inadequate, or the incentives are tied to the "wrong" factors, then the results will be sub-optimal.

## V. CONCLUSION

In the long run, we expect P4P to have a greater effect on the performance of the health care system than the quality movement and consumer information. In the short run, we think it unlikely that any of these factors will affect the way in which the current malpractice crisis is handled.

Finally, having swiped the title for this article from Yogi Berra, we think it only appropriate to close with another of his observations: "predictions are risky—especially about the future." Our predictions should be discounted accordingly, particularly because our compensation does not depend on our accuracy.

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60. *See* Leape & Berwick, *supra* note 35, at 2387; Robert M. Wachter, *The End Of The Beginning: Patient Safety Five Years After 'To Err Is Human,'* HEALTH AFF. (2004), http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.534v1.pdf.