Reforming Malpractice: The Prospects for Change

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Previous efforts to change the U.S. medical malpractice system have involved such initiatives as time limits on filing claims, caps on noneconomic damages, and limiting attorneys' fees. This column briefly reviews such past efforts and describes several new approaches. They include programs that encourage prompt disclosure of errors and offers of compensation, efforts to mediate complaints outside the courts, and use of administrative processes to adjudicate claims. "No-fault" systems, such as those in New Zealand, Sweden, and Denmark, may be most likely to satisfy the interests of both patients and physicians but may not be politically acceptable in the United States. (*Psychiatric Services* 62:6–8, 2011)

Concerns about the medical malpractice system have been voiced for at least the past four decades. The cost and availability of coverage are subject to recurrent crises, fear of suits often prompts physicians to practice "defensive medicine," and the stress of defending malpractice claims takes a significant toll on practitioners (1). Perhaps the most important concern is related to the seemingly irrational nature of the system: most patients who are harmed by medical negligence never file malpractice claims or receive compensation, and a substantial proportion of claims—37% in one notable study—are not based on negligent medical care (2).

Mental health practitioners have been spared many of the worst consequences of the malpractice system, such as the sky-high premiums that obstetricians and neurosurgeons pay in many states. Data from the insurance industry indicate that psychiatry ranks 22nd of 28 specialties in frequency of claims (3), and nonmedical mental health clinicians are even less commonly sued. Thus it should not be surprising that defensive practices account for only a small percentage of the overall costs of psychiatric care (4). However, psychiatrists have not escaped entirely unscathed. The rate of suits involving claims against psychiatrists has increased sharply since 1980, with some data suggesting that one in 12 psychiatrists is sued each year (3).

Previous reform initiatives

Psychiatrists and other mental health practitioners, therefore, share the interest of their colleagues in general medicine in achieving effective reform of the malpractice system. To that end, a variety of initiatives have been proposed over the past 30 years, including limiting the period after the allegedly negligent act during which claims can be filed; requiring prereview of claims to weed out frivolous complaints; restricting the pool of experts who can testify regarding the standard of care; capping noneconomic damages ("pain and suffering"), which often account for a significant proportion of the largest awards to plaintiffs; limiting attorneys' fees; and altering the apportionment of responsibility among defendants and the manner in which awards are paid (5).

When states have been persuaded to adopt one or more of these reforms, however, the results have often been disappointing. It has been difficult to identify approaches that consistently show an impact on the rates of claims or the size of awards, much less on the cost and availability of malpractice insurance policies (1). To be sure, some reforms seem more useful than others. One recent large-scale study suggested that placing caps on noneconomic damages, tightening standards for expert witnesses, and imposing penalties for frivolous suits have had the most consistent effects in decreasing the number of claims and the costs of the system (6).

Yet even if the findings are borne out by future research, implementing changes such as these will remain difficult. Trial lawyers, who exercise a good deal of political clout in many states, resolutely and often successfully oppose changes to the malpractice system. Even when reforms are passed, they may be subject to reversal by the courts; witness, for example, the decisions that have overturned the imposition of caps on noneconomic damages on the grounds that the determination of damages is properly the function of either judges or juries (5).

New approaches

There has been a good deal of interest in exploring new approaches to compensating patients for the injuries they suffer as a result of medical treatment, including approaches that bypass the malpractice system altogether. Among the most intriguing possibilities are programs that encourage prompt disclosure of errors and offers of compensation, efforts to mediate patients' complaints rather than relying on the courts, and the development of ad-

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ministrative processes to adjudicate malpractice claims.

Disclosure that an error has been made, often accompanied by an apology, goes counter to the usual practice of physicians and hospitals to withhold such information from patients for fear that it will trigger a malpractice claim and serve as an admission of negligence. Interest in rapid disclosure, though, has been stimulated by approaches such as the one developed by the University of Michigan Health System, which reported a sharp drop in lawsuits and costs of claims after implementing a disclosure program (7). Such programs come in several varieties; some include offers of compensation with or without a waiver of the subsequent right to sue. To reduce the concerns of practitioners and facilities that admissions of error may be used against them if a claim is filed, a number of states have passed legislation barring the introduction of such admissions into evidence in court (8).

Two of seven pilot projects funded under the Patient Protection and Affordable Care Act—the Obama administration's health care reform legislation—to examine ways of reducing malpractice claims are early disclosure efforts, which should augment the available data on the effectiveness of this approach (9). However, skeptics point out the likely effects of admitting error, given the current system in which the majority of patients harmed by negligence never learn the cause of their injuries: the number of patients who would not otherwise have filed suit but may be induced to do so may be greater than the small number of would-be litigants who are deterred (10). Disclosure to patients may be desirable for many reasons, but it remains to be seen whether disclosure reduces the number of malpractice claims when implemented in a variety of settings.

Another innovative approach to reducing the cost and increasing the fairness of the malpractice system has looked to voluntary mediation rather than litigation as a way of dealing with claims. A pilot project from the public hospital system in New York City reported on 19 cases that went to nonbinding mediation (11). Mediation took an average of under 2.5 hours and led to settlements in 13 of the 19 cases. The attorneys for the parties reported that they spent about one-tenth the time preparing for the case than for cases that go to trial, and both plaintiffs and attorneys were reasonably satisfied with the process. Notably, apologies on behalf of the health system or the physicians seemed to play an important facilitative role in achieving closure—ten of 11 cases in which an apology was offered reached settlement.

The process of mediation typically involves facilitating the parties' discussion of their perspectives on the facts of the case and their feelings about what occurred. In addition, the mediator—sometimes two mediators will work jointly—will focus on the strengths and weaknesses of each party's position, evaluating the likelihood of success in court and suggesting a range within which the case can settle. Mediators may shuttle back and forth between private meetings with the parties, helping to bring them closer together (11). Among the pilot projects currently funded by the federal government is a program of judge-directed settlement negotiations, essentially using the judge assigned to the case as a mediator to achieve resolution before going to trial (9).

Administrative approaches to dealing with malpractice cases that take them out of the courts completely are another idea that is being tested. The theory behind these initiatives is that administrative decision makers who specialize in malpractice cases can develop more expertise and render faster, fairer, and more consistent judgments than juries of lay people with little knowledge of medical care. Virginia and Florida developed model programs of this sort for newborns with birth-related neurological injuries, and a report on how they have functioned is now available (12). In both states, eligible claims are reviewed and appraised by medical experts before being forwarded to the decision maker. Virginia relies on its Workers' Compensation Commission to resolve claims, and Florida turns to an administrative law judge. Both states specify compensable components of a claim but exclude pain and suffering.

Perhaps the most notable deviation from standard approaches to adjudicating malpractice claims in these administrative compensation programs is their "no-fault" basis. Claimants must prove only that the adverse outcomes were caused by oxygen deprivation or mechanical injuries during or immediately after labor and need not establish negligence on the part of the physician or hospital. Despite a variety of challenges for the programs in both Virginia and Florida, they are generally viewed as successful, but they have not inspired the development of similar programs around the country (12). The limited scope of administrative compensation initiatives may be a testament to the degree to which traditional approaches to malpractice are embedded in the American legal system.

Many of the leading scholars of the malpractice system, however, endorse even broader no-fault approaches as the only remedy that is likely to satisfy the interests of both patients and physicians (13,14). By not requiring that fault or negligence be shown, no-fault systems permit patients to more easily obtain compensation for their injuries, much as workers' compensation programs do. Because most patients who are injured by medical treatment currently go uncompensated, a no-fault approach offers a fairer alternative to traditional tort-based models. From physicians' and hospitals' perspectives, no-fault systems reduce the stress and cost of litigation and remove the stigma associated with settling or losing malpractice cases. Although it is often asserted that health care professionals will lose the incentive to avoid errors if not faced with the prospect of malpractice claims, that contention seems dubious. Indeed, no-fault–based systems may encourage the reporting of adverse events and hence the development of prophylactic approaches (14).

Several countries have already moved to no-fault systems, including New Zealand, Sweden, and Denmark (13). New Zealand's approach is the best known and is part of the country's rejection of fault-based liability for accidents of all kinds. Patients seeking compensation must merely

prove that they were injured as a result of medical treatment, and claims are processed administratively. Sweden, in contrast, compensates only for injuries that would have been avoidable in the hands of the most skillful practitioner. It has been suggested that the latter approach offers an affordable alternative to the American tort-based system (14). However, given the entrenched opposition of trial lawyers and other interested parties, there is little likelihood of adoption of a general no-fault model in the United States for the foreseeable future.

Although it is difficult to hold out hope for radical reform of the malpractice system, interest in methods of diverting cases before they reach the courts may help to ameliorate some of the worst aspects of the current approach. In the meantime, psychiatrists and other mental health professionals can expect the specter of a lawsuit to continue to hover over their interactions with patients.

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