

Tort Reform: Alternative Models

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The primary means for patients in the United States to gain redress for grievances against hospitals and physicians is the tort system. Largely through rulings from state and federal courts, we rely on the tort system to incentivize individuals and firms to take appropriate care of those in their charge, compensate those who are harmed by their actions, manage risk, and punish those who fail to fulfill their duty of care. Although those may be laudable goals for any society to achieve, there is a lot to dislike about the U.S. tort system. High costs, poor efficiency, unpredictable and even bizarre outcomes, unintended consequences, and inequitable results seem to characterize the current U.S. tort system for many of us on the defense side of the court room.

This article reviews some of those issues, looks at what many state legislatures have done to ameliorate them, reviews the success those states have had in reforming their tort system, and finally looks at alternatives to our current tort system and what we can learn from the novel approaches of other countries in managing medical malpractice.

What Is a Tort?

A tort is a civil, not criminal, wrong against a person, his property, his rights, his reputation or, in some cases, his feelings.⁹ U.S. tort law takes its roots from English common law, which in turn refers to Biblical notions of “thou shalt love thy neighbor” as a basis for enforcing penalties on those who commit civil wrongs against others.¹⁷ Tort law in the U.S. has been developed over the past 2 centuries primarily by case law and, to a lesser extent, by state and federal statutes. For example, the tort of negligent infliction of emotional distress is a tort prescribed by law in some states.¹⁸ Yet no matter whether the tort arises from case law or code, enforcement is premised on the same social mores as providing incentive for individuals and firms to take appropriate care, compensating those who are harmed, reducing the risk of catastrophic injury, and to serve as punishment to those who fail to fulfill their duty to take adequate care.⁷

Tort covers a broad range of civil wrongs, including such things as nuisance, trespass, slander, fraud, and negligence. Medical malpractice is a tort of negligence and contains four basic elements: a duty to care for a patient, breach of that duty, harm suffered as a result of the breach, and a proximal relationship between the breach of duty and the harm suffered by the patient (i.e., not too remote in time or causation). Approximately 750,000 tort litigations are brought forward each year in the U.S., with 15% involving medical malpractice.⁸

Problems with the U.S. Tort System

Criticism of the current tort system has come from many groups, but perhaps most ardently from the physician, hospital, and malpractice insurance communities.^{2,7} The content of the criticism is well known to most neurosurgeons and includes concerns about high transaction costs, arbitrary assignment of punitive damages and damages for pain and suffering, abuse of class action mechanisms by plaintiffs’ attorneys, lack of fair compensation to deserving plaintiffs, frivolous lawsuits, and excessive awards of noneconomic damages.

Still one might question why medical malpractice should be treated differently than other forms of tort. For example, the makers of automobiles would most assuredly favor a tort reform package that gave special consideration or exemptions for automobile manufacturers and thus allowed them to conserve litigation costs and deliver better returns to their shareholders. Perhaps the best answer to that question is that health care and automobiles differ in that a large portion of health care (approximately 44%) is paid by federal and state governments that want to conserve public resources.⁴ A tort system that drives up costs of malpractice insurance, encourages defensive medicine, and pushes physicians out of litigious specialties or locations would not seem consistent with that notion of conservation.⁷ Furthermore, although the tort system may be inefficient for nonmedical cases, it seems to be very inefficient for medical malpractice. This is evidenced by data showing that 1) legitimate plaintiffs rarely file a malpractice suit (only 2% of patients injured by actual physician negligence ever file a case); 2) excessive amounts

of money are spent on undeserving plaintiffs (17% of medical malpractice cases filed appear to have real physician negligence, the cost to defend a case that goes to trial when no payment is made exceeds \$85,000, and 70% of all malpractice cases end in no payment to the plaintiff); and 3) there is a real burden on neurosurgeons as a result of disproportionate exposure (one of two neurosurgeons are sued on average each year).^{2,13}

Thus, some of the goals of a reformed tort system might include fewer unwarranted malpractice claims, more predictable and reliable compensation for victims of true malpractice as well as lower costs for malpractice insurance premiums, transaction costs (time, office staff), and perhaps a means of lowering healthcare costs in total.

“Mainstream” Tort Reform

Starting in the 1970s, many state legislatures passed tort reform measures ostensibly to accomplish some or all of the goals listed here.³ These measures have included:

1. Joint-and-several liability: Joint-and-several liability directs plaintiffs as to who can be named in their tort allegation. Under this rule, a plaintiff may choose to bring a tort case against a single individual or entity although many other individuals or entities were also involved but not named in the allegation. Thus, a defendant who was only marginally involved in a plaintiff’s injury (e.g., a consulting neurosurgeon in a case alleging inadequate prehospital care) could be held liable for all damages suffered by the plaintiff and then expected to bring their own case against other defendants to recoup their losses. The result of this is that a plaintiff may choose to bring a claim against the defendant with the “deepest pockets” in anticipation that they will be able to pay the entire claim. As of 2003, 38 states have enacted reforms that limit the use of joint-and-several liability.⁷
2. Collateral-source payments: A plaintiff will often be required by the court to show evidence of economic damages suffered as a result of the defendant’s alleged tort. These may include hospital expenses, loss of wages, or damaged property. However, some of these expenses may be paid for from other sources such as health or disability insurance and are termed collateral-source payments. Typically, most courts do not allow evidence of these payments to be admissible in court so that juries are not influenced by knowledge of those payments; however, as of 2003, 23 states have passed statutes that do allow evidence of these payments.⁷
3. Noneconomic damage caps: Noneconomic damages include payments for items other than monetary losses. Examples would include damages for pain and suffering or loss of consortium. As of 2003, 18 states have placed a cap on the amount of noneconomic damages that a plaintiff may receive.⁷
4. Punitive damage caps: Punitive damages are awarded in addition to economic and noneconomic damages to punish a defendant. As of 2003, 22 states have placed a cap on the amount of punitive damages that a defendant must pay.⁷
5. Contingency fee: A contingency fee is the fee charged by an attorney in the event that a lawsuit is successful or favorably settled out of court. Some states such as California and Arizona restrict the contingency fee that an attorney can charge a client to limit the total amount of attorney compensation.¹
6. Statute of limitations: A statute of limitations is a law specifying the period of time that a lawsuit must be filed after the occurrence or discovery of an injury. Some states such as Nebraska have shortened the amount of time that a plaintiff may file a medical malpractice suit compared with other torts.¹
7. Alternative dispute resolution: Some states such as Connecticut require a plaintiff to reach a resolution with the defendant before bringing a tort action against the defendant in court. In some instances, the parties are bound to the outcome of Alternative Dispute Resolution and in some cases they are not.¹
8. Expert witness requirements: States such as West Virginia and Alaska require an expert witness called to testify in a medical malpractice case be in the same specialty as the defendant.¹

Has “Mainstream” Tort Reform Worked?

Several authors have looked at the effects of state tort reform once they have been passed by state legislatures and written into law. In the policy journal, *Health Affairs*, Waters et al. recently reviewed the relationship between state tort reform and malpractice insurance premiums.¹⁵ They note that states with lower payment levels per malpractice claim and per practicing physician have a pattern of tort reform in place that includes damage caps, more restrictive statutes of limitations, and expert witness requirements. As an example, they cite the California experience with the Medical Injury Compensations Reform Act of 1975, which has four primary reform components: a \$250,000 noneconomic damages cap, admissibility of collateral source income, periodic payment of damages (instead of an upfront lump sum), and a sliding scale for attorney contingency fees (40% of the first \$50,000 and up to \$221,000 of a \$1,000,000 verdict). Similarly, Born et al. found that joint-and-several liability reform, noneconomic damage caps, punitive damage caps, and collateral-source evidence rules all decreased losses incurred by malpractice insurers with joint-and-several liability reforms having the strongest correlation with that outcome.³

Earlier work by Viscusi et al. quantified the savings in malpractice premiums paid by physicians in states that implemented joint-and-several liability reform, damage caps, and “other reform.” They report that those physicians saved 13.4 to 17.4% compared with premiums before tort reform.¹⁴ A 1993 review article by the U.S. Office of Technology Assessment concluded that damage caps and collateral-source rule reform decreased malpractice costs in the form of payments made per claim but not on the total number of claims and that other reform measures did not have any significant effect on either payments per claim or total number of claims.¹²

The specific effect of noneconomic and punitive damage caps on payments to plaintiffs in Alabama was studied by Yoon et al.¹⁶ They found that the institution of damage caps in that state in the 1980s resulted in a decrease in plaintiff recoveries by \$23,000 per claim, but when that law was repealed by the Alabama Supreme Court starting in 1991, plaintiffs saw a \$48,000 increase in the recoveries per claim.

Taken together, these articles seem to indicate that mainstream tort reforms, including joint-and-several liability, noneconomic and punitive damage caps, and collateral-source rule reform in whole or in part, have had the effect of decreasing the amount plaintiffs recover with that decrease in payments to plaintiffs by malpractice carriers leading to lower malpractice premiums for physicians.

What is less clear is whether the savings on malpractice premiums can be translated to overall lower health care costs in the form of less defensive medicine. Publications by former U.S. Food and Drug Administration directors Daniel P. Kessler and Mark B. McClellan in 1996 and 2002 concluded that states that enacted tort reform saw a 6% drop in hospital expenditures for heart attack care and a 9% drop in hospital expenditures for heart disease without changes in mortality or complications.^{10,11} Those findings by respected public figures prompted further investigation culminating in a Congressional Budget Office review looking at expected changes in government expenditures for health care under various tort reform measures.⁶ This study concluded that eliminating joint-and-several liability and placing noneconomic damage caps would indeed result in decreased malpractice premiums for physicians but would increase overall Medicare costs. This study also concluded that caps on attorney fees, implementing collateral-source reform, and placing caps on punitive damages would be unlikely to have any effect on Medicare costs. One major difference between the Congressional Budget Office and Kessler/McClellan studies was the presumption by the Congressional Budget Office that some defensive medicine was actually good patient care because it was likely to catch some illness earlier.

Thus, one might conclude from the work that has been done on the effects of tort reform that although tort reform with provisions such as joint-and-several liability, collateral-source rules, and noneconomic and punitive damage caps

may be good for physicians in terms of cost savings for medical malpractice insurance, it is less clear whether those same tort reform measures would improve patient safety or outcomes, help compensate legitimate plaintiffs, or contain overall health care costs.

Tort Reform: Alternatives

Discontent with the tort system and medical malpractice is not confined to the U.S., New Zealand and several Scandinavian countries have faced similar problems and have found alternative means to deal with that issue.

In New Zealand, compensation of injured patients is part of a comprehensive social welfare system that includes universal health coverage.⁵ A patient who claims that an injury was caused by medical treatment files a claim with the Accident Compensation Corporation regardless of the rarity or severity of the injury. That patient is then precluded from bringing a tort case to court. The New Zealand Accident Compensation Corporation reviews 3000 claims annually (compared with more than 100,000 in the United States) with 60% of claimants receiving an award. Awards cover treatment, rehabilitation, and 80% of earnings plus up to \$70,000 (U.S.) for miscellaneous expenses. The Accident Compensation Corporation also collects data on safety threats and reports them to medical regulatory entities. The system runs on an overhead of approximately 10% in comparison to the U.S. rate of 60%.¹ Perhaps what is most significant about the New Zealand system is that it is as close to “no-fault” as any system in the world. There, patients are compensated for injuries occurring during treatment regardless if the patient alleges any negligence on the part of the physician or hospital involved in the patient’s care.

Similar to the New Zealand system, the Scandinavian countries of Sweden, Denmark, Finland, Norway, and Iceland also provide compensation of injured patients as part of universal health care coverage benefits.⁵ Also like New Zealand, patients in these countries must use an administrative process to file their individual claims. However, in contrast to New Zealand, they retain their right to appeal in civil court if they want to dispute the outcome of the administrative process. Scandinavian patients filing a malpractice claim must be able to show that their injury was sustained during medical treatment and that the injury could have been avoided if the physician adhered to the best medical practice. This level of liability would lie somewhere between the no-fault standard of New Zealand (very low burden for the plaintiff) and the negligence standard of the U.S. tort system where the plaintiff has to show that a standard of care (not necessarily the best medical care) was breached. Between 30 and 50% of claims result in compensation for the patient. The system runs on an overhead of 15 to 20%. Claims are paid on a uniform scale according to the type of injury and only patients with severe injuries or long hospitalizations are eligible for administrative

review. Like in the New Zealand system, data are aggregated and provided to physicians and researchers but separated from the physician disciplinary process. This is notable in that the separation between the patient compensation system and physician disciplinary system is thought to be responsible for the fact that 80% of patients filing claims receive the support and advocacy of the physician involved in the patient's care, a rarity in the U.S. tort system.

Within the U.S., two states have approached specific problems in their tort system in a novel way. In both Florida and Virginia, birth-related injuries historically resulted in large verdicts placing a heavy malpractice burden on many obstetricians. To continue to provide affordable malpractice coverage of obstetricians and keep them in their states, the Florida and Virginia legislatures separately initiated administrative processes outside the tort system for infants born with specific neurological injuries incurred in the perinatal period.⁵ Both state systems are mandatory for patients cared for by participating physicians; however, appeals may be made within the state court system. Similar to New Zealand, the systems are no-fault and not based on provider negligence. Remuneration covers treatment, rehabilitation, economic losses, and other benefits, including attorney fees and up to \$100,000 in noneconomic damages, but does not cover injuries incurred by the mother. Both systems run on an overhead of 8 to 10% and are funded by a \$5000 per year assessment by the state government on participating physicians who deliver babies (\$250 for nonparticipating physicians who deliver babies) and a \$50 assessment per birth for hospitals up to \$150,000 per year. Virginia also assesses a levy against malpractice carriers to pay for that state's system. Legislative review of these programs has demonstrated that patients preferred the administrative system over the conventional tort system and that children fared better in that half of the patients compensated would not have been under the state's tort system and were compensated more quickly. Nonetheless, very few claims have been filed in either state with 171 in Florida since 1988 and 110 in Virginia since 1987.⁵

Tort Alternative Proposals

Although in the U.S., individual states have been the traditional laboratories for tort reform, there have been several Congressional bills that have gathered some momentum on the federal level, but never enough to be passed by both houses into law. Still several of these proposals continue to have advocates in various academic centers, think tanks, and advocacy groups.

Among these tort alternative proposals has been the so-called "early offer" plan.¹³ This system was originally backed by Senators Gephardt, McConnell, and Dole and proposed that an injured patient file an administrative complaint against a hospital or physician and show evidence of economic damages (treatment, rehabilitation, lost wages, and

attorney fees). The hospital and/or physician would have 6 months to settle the complaint. If a settlement was reached, the patient would be precluded from seeking noneconomic damages. If there was no settlement, the dispute would be settled in court. This system has the potential to compensate patients quickly and possibly decrease the high overhead of medical malpractice litigation, but does not seem to offer the benefit of discouraging frivolous lawsuits or controlling health care costs.

Another proposal that has received some support is the idea of patient indemnity insurance.¹³ With this proposal, patients could purchase insurance against the risk of an adverse medical event similar to airline crash insurance for air travelers. This would give patients the flexibility to purchase as much or as little insurance as they desired with a clear description of what injuries are compensable under what conditions contained in the policy. Implementing this system has the potential advantage of decreasing litigation time and, when coupled with a damage cap, might discourage frivolous lawsuits. However, downsides to this system include a question of how to provide coverage for low-income patients as well as how to fund and spread the risk of an insurance system that could incur significant costs.

Finally, there has been significant recent interest in the idea of health courts.^{5,13} Health courts could function in a similar manner as current U.S. patent, bankruptcy, and workmen's compensation systems using judges with specialized training. Some have argued that a judge with adequate health care training in combination with written guidelines for compensating noneconomic damages, compensation tables for specific injuries, and a different liability standard other than negligence that emphasized evidence-based standards of care or preventable injuries may offer significant improvement to the current U.S. tort system. Potentially, these measures may discourage frivolous lawsuits, improve the chances for legitimate plaintiffs to collect compensation, and improve the reliability of litigation outcomes for both plaintiffs and defendants. Still, a health court proposal has yet to be put forth and is surrounded by many questions. Examples include: How should judges be trained? Should all clinical areas be covered? Should jurisdiction be mandatory or voluntary? Who should handle appeals and disputes? How should costs be covered? This has led some to push for a state demonstration project that could be studied on a microlevel before expending to a larger level.^{5,13}

CONCLUSION

In summary, the U.S. tort system has many critics with legitimate concerns about its efficiency, cost, fairness, and predictability. Thus far, state legislatures have led the way in implementing "mainstream" tort reform such as joint-and-several liability, collateral-source admissibility, noneconomic damage caps, punitive damage caps, attorney contingency fee, and

statute of limitations restrictions. These mainstream reforms enacted in whole or in part have resulted in a decrease in the amount of losses malpractice insurance carriers incur and a resultant decrease in malpractice premiums for physicians. At the same time, mainstream tort reform has decreased the amount of money that plaintiffs recover, arguably has not been able to control overall health care costs, and does not seem to have had any impact on patient safety or outcomes or identifying and compensating legitimate plaintiffs.

Tort reform alternatives in countries such as New Zealand and Sweden have some attractive components such as a liability standard that does not rely on courts defining physician negligence and placing a disconnect between patient compensation and physician culpability. Yet these alternative approaches have only been carried out in smaller countries with universal health care coverage and a more socialistic public welfare system that is richer in government benefits than the U.S. Similarly, tort reform measures in Florida and Virginia that compensate infants injured in the perinatal period use a liability standard that de-emphasizes court-defined physician negligence but has arguably been too focused and underused to justify implementation on a larger scale. Tort alternative proposals such as health courts also offer some appeal in the form of disincentivizing frivolous lawsuits, but probably need to show efficacy on a smaller scale before being advocated for on a state or federal level.

Thus, we are left with a problem that seemingly has few good, well-tested solutions and no consensus. This lack of consensus is likely responsible for the failure of a federal solution to medical malpractice problems, but has set the stage for state legislatures to take novel and innovative approaches. This focus on state legislatures and their relative small scale compared with the U.S. Congress may provide interested neurosurgeons with the opportunity for effective advocacy at the state level whether they be mainstream efforts such as joint-and-several liability changes or damage caps in states that have been unable to move those initiatives forward or alternative reforms such as redefining the liability standard or initiating health courts for litigation of medical malpractice cases.

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