Medical Malpractice Reforms and Defensive Medicine

Effects on Obstetricians

Historical Paper submission

Michael Noland, MHA, FACMPE, CHFP

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Introduction

Medical malpractice reform and defensive medicine has been a particularly relevant conversation as the healthcare landscape changes. It is used in just about every specialty in the healthcare industry for reasons that will be discussed in this paper. Medical malpractice reform can be a mechanism to help in the reduction of healthcare costs if it is used appropriately. The role of defensive medicine tends to drive up healthcare costs and is one that is highly contended within the political and medical community. This paper will cover the topic of medical malpractice reforms and defensive medicine, and what it means for the obstetrical community. It will examine the medical malpractice arena as a driver of defensive medicine and will delve into how this affects the specialty of Obstetrics for certain procedures.

Background

Medical malpractice reform and defensive medicine are tools that historically effect medical practices and specialties in an adverse way. Stakeholders in the practice should be well versed in the different malpractice reforms, defensive medicine practices, and the costs that can affect the business. Practice leaders and physicians should have discussions around these topics as they are an important part of practice management when it comes to quality of care. The paper will cover the different types of reforms, proponents, opponents, costs, and defensive medicine practices by obstetricians.

Medical Malpractice History

Medical malpractice litigation has been an extremely hot topic for physicians, patients, and policy makers for quite some time. There is a universal theory among the healthcare industry that malpractice litigation passed reasonable levels and that tort reform is overdue. The tort theory of negligence under medical malpractice requires some elements to be met. A plaintiff must prove that there was a duty of care established by a reasonable prudent physician. The
physician breached the duty of care by not providing the standard of care that was expected. This breach of duty led to an injury of the plaintiff. (Studdert, Mello, & Brennan, 2004)

Theories behind the need for a medical malpractice tort-based system include ensuring that the injured party is “made whole again” (through monetary award), the healthcare professional or entity causing the injury is punished (retribution role), and notice is served to other healthcare professionals before they mirror the same practices as the accused (deterrence role). (Burke, 2011, p. 326) There have been several factors connected to why patients precede with medical malpractice claims. Some of these factors are patient dissatisfaction, physician’s communication, and poor interpersonal skills. (Studdert et al., 2004)

The concept of medical malpractice crisis is not new and between the 1950s and 1980s filing had increased by 1000%. During the same time the amounts awarded by juries for plaintiffs increased by more than 275%. (Williams, 2012) Medical malpractice has been a prominent issue for the past three decades with crises regarding availability of medical malpractice insurance, affordability of insurance, and then political interests. (Yackee, 2009) Liability insurance and malpractice reform are tied together because of the focus on the medical tort systems rise and fall and cost of insurance for malpractice. In times where low availability of insurance coverage exists and there are higher costs to providers is when legislative reform is at its highest. In the period before 1974-76, the cost of liability insurance rose for some specialties which led to the US Senate and Executive Branch to address malpractice for the first time. When the crisis hit in 1974, insurers left the market and therefore premiums increased dramatically. This led to policy change designed to increase insurance availability and reduce provider’s liability. (Davis, 2011) Some of the states enacted legislation in an effort to curb the number of lawsuits; decrease amounts awarded by juries, and reduce malpractice insurance premiums. Less than a decade later the premiums rose again. During the late 1980s and early 1990s, 70% of the medical malpractice claims ended with no payment, which led to new insurance companies
competing in the market. This led to lower premiums and resulted in not enough funds to cover losses in future years, which again led to higher prices to cover claims from previous years. (Williams, 2012) In 2002, another malpractice crisis surfaced but this time forty-four states introduced bills either to cap non-economic damages or lower existing ceilings. (Davis, 2011) President Bush proposed a cap of $250,000 on non-economic damages, along with reducing the statute of limitations, and to allow judges to review contingency fees. (Williams, 2012) The latest crisis is characterized by both the decreasing availability of insurance coverage because insurers are leaving the market due to increasing loss ratios and decreasing affordability of policies. The three factors that have a played a role in dramatic payouts since 1999 are: moderate increases in frequency of claims, the downturn in the economy affecting investment returns, and broadening the base too quickly with low premiums. (Studdert et al., 2004)

**Medical Malpractice Proponents and Opponents**

Physicians believe that they should have immunity from lawsuits for medical malpractice. They believe that there should be a higher standard of proof for malpractice trials or at least there should be damage caps that restrict the amount recovered in cases. Physicians have been worried about the medical malpractice crisis causing physicians to retire, relocate, change specialties, accept fewer high risk cases, or practice defensive medicine. Proponents of tort reform, such as physicians and insurers, suggest that medical malpractice lawsuits increase insurance premiums, causes younger physicians to walk away from high risk specialties, and adds to high healthcare costs. (Williams, 2012)

Alternatively, plaintiffs and patient advocacy groups do not believe it is the amount of litigation, but believe it lies with the unacceptable level of negligent medical care. They cite studies that medical negligence causes 98,000 deaths a year and the litigation costs combined are 2% of healthcare spending. The lawyers and advocacy groups argue that the states are creating
legal hurdles to starting medical malpractice claims and capping damages, both economic and non-economic. These two entities conclude that plaintiffs or patients are being pushed out of the system. (Williams, 2012)

The causes of increases in the number of claims over the years can be attributed to at least five factors. There is greater public awareness of medical errors. The decreased levels of confidence in the healthcare system among patients are a result of negative experiences with care. The technology advances in medical innovation and increases in the intensity of medical services help to increase claims. Expectation of medical care by patients has risen and the reluctance of plaintiffs’ attorneys to accept offers that in the past would have closed cases. (Studdert et al., 2004)

There has been a conflict between liability law and patient safety, which undermines efforts to improve the quality of care. Physicians are reluctant to engage in opening up about errors because there is little guarantee of legal protection. Malpractice insurance is expensive and hard to find plus even one claim can make insurance difficult to obtain. The proponents of litigation cite the frequency of uncompensated injuries and reiterating the importance of it as a deterrent. Critics want to ensure that reporting systems are closed to the public. They also need to convince healthcare providers that disclosure of errors will reduce the likelihood of litigation. (Studdert et al., 2004)

The performance of the malpractice system in its current capacity shows that is limited at best. The more convincing evidence that liability law influences the behavior of the physicians comes from several studies that detail an undesirable practice by encouraging the ordering of tests and treatments that may be negligible or provide no medical benefit, primarily for reducing risk. The size of the costs associated with defensive medicine is also highly unpredictable. There have been studies done, and one analysis stated that the estimated system wide costs were in the range of $5 billion to $15 billion in 1991. This practice of defensive medicine remains an issue in
policy debates around the malpractice system, which will be discussed in further detail around the topic of obstetrics. (Studdert et al., 2004)

Medical Liability Costs

There are various components to medical liability system costs that can be expressed in monetary terms. The major categories of costs are indemnity payments that plaintiffs receive from liability insurers, administrative expenses that consist of attorney fees or other legal expenses and overhead, defensive medicine costs, and other costs. The costs discussed in this section will be based on 2008 dollars. Indemnity costs are broken down between physicians at 65 percent and institutions at 35 percent. The estimated total national indemnity costs are around $5.72 billion per year. There are three main types of damages in medical malpractice cases: compensatory damages for the plaintiff’s financial losses, including lost wages; non-economic losses known as pain and suffering; and punitive damages designed to punish defendants. The split between damages to apply to the national indemnity is 55 percent economic damages, 42 percent non-economic damages, and 3 percent punitive damages. (Mello, Chandra, Gawande, & Studdert, 2010)

The overall estimated national costs of administrative expenses are approximately $1.06 billion. The administrative expenses come from plaintiff attorney fees and expenses, defendant attorney fees and expenses, and other overhead expenses such as risk management. Attorney contingency fees typically range in the 35-40 percent if the award is for plaintiffs’ , the defendant attorney cost will typically average nineteen cents for every indemnity dollar paid out, and other costs around $1.8 billion dollars. The other overhead costs include operating expenses, taxes, licenses, and fees. Relevant to the other expenses is risk management offices that work to minimize and respond to medical injuries and because of liability risk, these are needed. The overall estimated national costs for hospital (38.8 billion) and physician (6.8 billion) spending for defensive medicine is $45.6 billion. (Mello et al., 2010)
There are a number of other indirect costs of the medical liability system. The cost for lost clinician work time produces costs of time away from patient care for legal proceedings, which leads to lost productivity and income. The total value of lost work days for clinicians is an estimated $200 million dollars. The effects on health care prices can be affected by reducing supply of medical services due to defensive medicine practices and rising malpractice premiums. This will cause physicians to abandon or reduce their clinical practices leaving the remaining providers to increase price due to demand. There is the reputation and emotional toll placed on clinicians by being involved in litigation and they cannot avoid the effects to their reputation, which affect their income as well as their status. The total amount of combining all the different cost components for the medical liability system is estimated to be $55.6 billion, which is equivalent to approximately 2.4 percent of national health care spending. (Mello et al., 2010)

**Medical Malpractice Reform Part 1**

The medical malpractice crisis has stimulated enthusiasm for tort reform. This paper will discuss conventional tort reform policies and alternative tort reform policies in Medical Malpractice Reform Parts 1 and 2. Conventional tort reform can be divided into one of three categories. The first category is the limitation on access to courts, which includes shortening of the statute of limitations, enacting statutes of repose, and establishing screening panels. The second category is a modification of the liability rules, which may be eliminating joint-and-several liability rules. The third category is damages reform, consisting of caps on damages, limiting attorney fees, mandating collateral source offsets, and requiring periodic payments. (Studdert et al., 2004)

**Conventional Tort Reforms – Category 1**

**Statute of limitations** - The principle of the statute of limitations is that if a plaintiff seeks the courts help for malpractice litigation then the plaintiff should do so in a timely manner. The limitation periods were created for three important functions. First, they protect the defendant
against any claims brought after a reasonable amount of time. Otherwise the defendant would be continually vulnerable where he or she could be sued at any time. The limitation period ensures fairness for both the defendant and the claimant with a balance that is beneficial to society. The second objective is to ensure that the evidence is clear. Claimants that undergo harm are more likely to remember the events leading to harm whereas defendants have a hard time tracing events over a longer duration of time. The third objective is to avoid any unnecessary delays in conflict resolution. By shortening the statute of limitations the objectives can be met. (Tan, 2009)

Statute of Repose – This is the period of time that has lapsed from the date of the negligent act. This actually affects the limitation period used for preventing late claims so even if an individual brings a claim within the allowed limitation period they may still be prevented if it is after the period of repose. (Tan, 2009)

Screening Panels – The concept for screening panels stemmed from the belief that most malpractice lawsuits have no justification. Screening panels are comprised of medical professionals and lawyers that review all cases and discourage cases with no merit from going to court. Panels can provide an affordable avenue for patients to find answers to their injuries instead of going directly to litigation. Critics argue that there are higher costs due to extensive discovery and paying experts twice. Screening panels may also increase the number of claims unless fees are priced appropriately to prevent overuse. On the positive side, it could reduce the amount of trial lawyers who charge contingency fees because it would diminish their returns on smaller cases. (Tan, 2009)

Conventional Tort Reforms – Category 2

Joint-and-Several Liability Rule – The rule permits a claimant to recover damages from multiple defendants collectively or from each of the defendants liable for the injury. For example, if a defendant is 5% responsible but two other defendants are 95% responsible but are also bankrupt, then the claimant can recover all damages from the defendant that is 5% responsible if they are
solvent. The problem with the rule is the fairness of it for the defendant that has less blame for the injury. The solvent defendant should not be penalized based on the ability to pay. This reform can lead to an increase in the litigation rate as claimants bring separate legal actions against each defendant in order to obtain adequate compensation. The costs will increase as claimants need to prove relative fault for each defendant, which takes more work and time. (Tan, 2009)

**Conventional Tort Reforms – Category 3**

**Caps on Damages** – The reform works by informing the jury of the maximum limit of damage recovery or requiring the judge to reduce any jury award within the limit set. Most of these caps are around $250,000. The cap serves to reduce financial incentives in litigation because the competence of juries in evaluating evidence is not always fair and equitable. The jury can easily feel sympathetic to the claimant and damages may be connected to that instead of the severity of the injury. Proponents believe that it prevents enormous damages from being awarded but opponents believe that claimants with the most severe injuries are at high risk for receiving inadequate compensation. (Tan, 2009)

**Limit Attorney Fees** – There is a belief that the contingency fee system encourages medical litigation because plaintiff lawyers seek cases of negligence such as ambulance chasing. Proponents believe the contingency fee system is valid because it will prevent low-quality claims from litigation versus an hourly-rated system. Opponents argue it incentivizes the lawyer to obtain a settlement for every case even if it is less than what is acceptable by the claimant. The reduction in the rate of the attorney fee could reduce the amount of litigation for low level injury.

**Collateral Source Offsets** – Under the collateral source offsets rule, the injured party will have the amount of the settlement reduced by amounts paid from other sources such as insurance and workers compensation. Proponents believe that payments from other sources, in addition, to jury awards provide the insured person with much more that they are entitled to. Opponents believe
that a negligent defendant benefits by having their liability reduced because the injured person
may have received awards from other sources. The proposal essentially has the same effect as
reducing damage caps and lawyers would have a reduced incentive to bring suits on behalf of
patients. (Feldstein, 2011)

**Periodic Payments** – Normally damages are awarded in a lump sum whereas periodic payments
under this reform are used for the purpose of paying future economic damages. The benefit of
periodic payments with respect to minimizing costs is that it excludes the need for long-term
estimates of economic damages because they are generally imprecise. For example, if the
claimant dies then the damages would turn out to be excessive and go to the family at the
defendant’s expense. This is not in line with the principle of restoring the claimant to a position
that they were prior to the injury. Unlike damage caps it does not necessarily control costs of
medical litigation. (Tan, 2009)

**Medical Malpractice Reform Part 2**

Over the years, the tort system has prompted the formulation of new opportunities for
achieving compensation and deterrence. The alternative tort reform categories can be divided
into three approaches. The first category is using alternative mechanisms to resolve disputes,
which includes encouraging early offers/disclosure offers for settlement, the use of medical
courts, and alternative dispute resolution under private contracts. The second category is using
alternatives to the negligence standard, which includes compensating claims through a no-fault
administrative system. The third category is using relocation of legal responsibility, which
includes shifting the liability from individuals to the organization coined as enterprise liability.
(Studdert et al., 2004)

**Alternative Tort Reforms – Category 1**

**Early Offers/Disclosure Offers** – It is a reform that takes the mistakes that occur in healthcare that
are clearly compensable and removes them from the tort system. This alternative to legal action
triggers a series of events that include disclosure of the mistake to the patient or family who is harmed and an offer of compensation by the institution or insurer. This can be implemented by private parties of the healthcare system as opposed to traditional reforms that come from state legislatures. (Davis, 2011) The reforms envision patients and providers working hand in hand to resolve disputes promptly through private agreement contracts. Many states have implemented legislation with certain degrees of legal protection to providers who communicate with patients after adverse incidents. A strong partnership between state legislation and institutional programs will give early disclosure programs greater success rates. (Burke, 2011) The reform has five steps to work. There must be an unanticipated outcome in the delivery of care, the provider must report the occurrence to a risk manager and disclose the unanticipated outcome to patients or family, there must be an investigation into the cause of error, the institution makes an expedited determination about the amount of compensation if any at all, and if the patient and institution do not come to an agreement then the incident continues to the tort system. (Davis, 2011)

This type of reform competes against the disadvantages of the current malpractice system and values patient safety. The model allows the patient to be informed of what happened and strengthens the physician-patient relationship. The result of this model is immediate and decisive quality measures and peer review opportunities. The goal is to provide economic relief quickly when the patient needs it the most and moves litigation to a last resort option. Opponents believe that the reform model will only encourage lawsuits and disputes about compensation amounts. They believe that it could provoke an unsustainable increase in costs for medical malpractice. (Davis, 2011)

Medical Courts - The health court model uses a specially-trained judge as a fact finder and arbitrator in place of the current system of judge and jury. The proposal for the medical court model is that medical negligence compensation would be decided by a separate administrative agency, not the court. If this model were adopted, filing a claim would be less expensive, a
greater number of patients would file claims, and more injured patients would be compensated. Since there will be more patients that are compensated then the amounts might be lowered. Proponents believe that proceedings would be expedited, costs would be lower than the current system, and it would provide a system based on accepted medical standards, thereby, reducing defensive medicine. (Feldstein, 2011)

**Alternative Dispute Resolution** - This refers to agreements between providers and patients to submit disputes to third parties other than the courts. (Kessler, 2011) The disputes can be resolved through negotiation, mediation, and arbitration. Negotiation is one of the most common methods because it is least costly. If the negotiation did not work it would go to litigation. The primary purpose of alternative dispute resolution is to avoid litigation. (Tan, 2009)

 Arbitration is a less expensive and more efficient way to resolve disputes without limiting a party’s right to compensation and the only difference is that the meeting of parties moves to an arbitration room instead of a court. Arbitration allows for simpler procedures, rules, flexible scheduling times, and venues for hearings and discovery. The disputants can come to a resolution more quickly. (Tan, 2009) Proponents argue it compensates victims faster, more equitably, and with lower transaction costs. It can also improve deterrence by providers because of the consistent decision-making process. The opponents believe that it is biased toward defendants because they believe that arbitrators are more likely to have ties to provider organizations rather than patients. Opponents also do not agree with limited appeal rights and thus limited ability to correct erroneous decisions. (Kessler, 2011) Opponents also argue that arbitrators are less likely to grant large awards and arbitration has little impact on costs from the defendant’s perspective. Claimants are generally happier because they can get the same portion of damages within a shorter period of time. (Tan, 2009)

 Mediation is a method for resolving disputes that involve a third party who does not have the authority to impose an outcome. This is the difference between arbitration and mediation.
The outcome for mediation is binding by contract whereas arbitration is binding by statutory law. Mediation allows for preservation of relationships, which can be beneficial in medical disputes and the reciprocity of the process enhances the sustainability of the agreement. A patient with a significant injury would probably never used mediation as an ideal alternative dispute resolution method. (Tan, 2009)

*Alternative Tort Reforms – Category 2*

**No-Fault Administrative System** – The no-fault model allows for prompt investigation and compensation of claims without the need to prove negligence. (Tan, 2009) The no-fault administrative model offers compensation for injuries that are either preventable or avoidable. An avoidable adverse event under this model is derived from current medical literature and is described as one that should rarely occur under best practice standards. These avoidable acts fall between negligence and automatic strict liability. The greatest advantage of the no-fault system will be the promotion of patient safety measures. (Burke, 2011) The system revolves around open disclosure in order to deal with the problem of medical litigation upfront. It bars the right to sue by focusing on compensating the injured party without identifying the alleged individual committing the injury. (Tan, 2009) The model will compensate a larger group of patients but at a lesser degree without provider negligence or fault. This model will be coupled with other policy changes and encourage an experience-rated malpractice insurance rating to lessen any unfavorable effects on incentives. The model would require legislative action and will conflict with the rights of access to courts and jury trials. (Kessler, 2011) The problem is that a no-fault system would result in more claims and higher expenditures even though the amount of each claim may be reduced. The idea is that any increase in compensation costs would be offset by lower administrative costs compared to litigation. The costs of compensation can be controlled under this system through compensation criteria and level of awards. (Tan, 2009) Proponents emphasize that the models have the potential for direct compensation to patients more accurately
and reduce costs. Opponents believe a larger pool of compensable injuries will lead to higher spending and no-fault will reduce incentives for precaution and increase medical injuries. (Kessler, 2011)

The second no-fault based reform system incorporates automatic compensation for injuries that occur outside the preset protocols and guidelines for medical practices and is termed as a Guideline Based Reform. Under this system, physicians and hospitals would be non-negligent if they abide by the clinical practice guidelines. These guidelines are written statements of what makes up an appropriate treatment for a specific illness, symptoms, or type of patient. The proponents of this reform believe it will promote evidence-based medicine if the physicians abide by the best practices. Opponents claim that it will promote cookbook medicine and fails to account for differences in patients and problems. The guideline-based system would retain most of the current tort system but would change how the negligence element of the malpractice claim is settled. Since the current system usually bars general guidelines under the “hearsay rule”, and no one set of guidelines usually trumps another, then it would require legislative action to change this. (Kessler, 2011)

*Alternative Tort Reforms – Category 3*

**Enterprise Liability** - Enterprise liability states that not only will the physician be liable for malpractice but also the healthcare organization. (Kessler, 2011) The enterprise liability proposal would shift some legal responsibility from the individual physician to the health care entity such as a hospital or clinic. (Burke, 2011) The hospital can provide insurance to the physician known as channeling and the other way this can be done is by making changes to state and federal law that would vest physician’s liability for all claims in hospitals or health plans. Proponents believe it will make the existing system more efficient, arguing that healthcare organizations have the ability to monitor physicians at lower costs. (Kessler, 2011) Since the responsibility for compensating the patient falls on the healthcare entity, there would be economic
incentives that would appropriately monitor and discipline substandard care. (Burke, 2011)

Essentially, the organization could serve as an intermediary between physicians and the tort system. Assigning system-wide liability to institutions could lead to quality improvement and it might improve the functioning of the medical malpractice insurance market. (Kessler, 2011)

These proposals would work great in group practices where physicians are employed by or have financial ties within the practice. The trend is that more practitioners are migrating from solo practices to hospitals and clinics. This migration might give enterprise liability the foothold it needs to become a viable option for the future. Opponents believe that it will increase the size of claims and the amounts of award. Yet no states have adopted this and there is little empirical evidence it would work. (Burke, 2011)

**Defensive Medicine Background**

The performance of the malpractice system as a whole shows evidence that is limited at best. The more convincing evidence that liability law influences the behavior of the physicians comes from several studies that detail an undesirable practice by encouraging the ordering of tests and treatments that may be negligible or provide no medical benefit, primarily for reducing risk. This paper will explore this idea of defensive medicine in greater detail. The field of obstetrics has attracted the most in-depth research on evidence of this defensive medical practice. The size of the costs associated with defensive medicine is also highly unpredictable. There has been studies done, and one analysis stated that the estimated system wide costs were in the range of $5 billion to $15 billion in 1991. This practice of defensive medicine remains an issue in policy debates around the malpractice system. (Studdert et al., 2004)

The causes of increases in the number of claims over the years can be attributed to at least five factors. There is greater public awareness of medical errors. The decreased levels of confidence in the healthcare system among patients are a result of negative experiences with care.
Expectation of medical care by patients has risen and the reluctance of plaintiffs’ attorneys to accept offers that in the past would have closed cases.

**Defensive Medicine Categories**

Defensive medicine takes place in two different capacities, which are positive defensive medicine and negative defensive medicine. Positive defensive medicine is performed when a healthcare professional (nurses or doctors) orders excessive treatment, tests, or other procedures to protect themselves against medical liability instead of furthering the patient diagnosis. Negative defensive medicine is performed when healthcare professionals are trying to avoid high risk procedures or patients that can lead to medical liability. The two types of defensive medicine approaches: involve a tendency to carry out certain procedures to an excessive level; the other involves avoiding certain procedures that are risky. These defensive medical practices are not always unnecessary but are used sometimes to reduce their exposure to damage claims. (Hermer & Brody, 2010)

The debate is that defensive medicine increases the costs of healthcare and may expose patients to the risks associated with it. (Catino, 2009) The evidence actually suggests that defensive medicine only accounts for a non-negligible amount of healthcare costs. (Hermer & Brody, 2010) The larger number of legal cases over the years taken by patients has initiated a practice of defensive strategy by physicians. (Catino, 2009) The practice of defensive medicine can threaten the quality of care in a variety of ways. It can lead to unnecessary concern over false-positives, over diagnosis, and excessive economic costs. (Anderson, Strunk, & Schulkin, 2011) The practice of defensive medicine is frequent, leading to potential issues of cost, accessibility, and quality of healthcare. (Catino, 2009) “This has been reiterated by numerous studies (Tancredi and Barondess 1978; Thompson and King 1984; Rubin and Mendelson 1994; Baldwin et al. 1995; Kessler and McClellan 1996; Bassett et al. 1995; Passmore and Leung 2002; Murphy 2004; Studdert et al.2005; Kessler et al.2006; Hiyama et al. 2006) in which is it
repeatedly noted that doctors operating in specialties subject to high risk (in particular, obstetrics and gynecology, surgery, anesthetics and reanimation) maintain that the increase in litigation constitutes the principal reason for the emergence of defensive approaches.” (Catino, 2009, p. 248)

A study in Italy has drawn three main conclusions: 1) there is a high level of defensive medicine practiced. In the study, 77.9% of the physicians used some form of defensive medicine in the working month prior to the study. 2) It showed a remarkably high prevalence of medical litigation fear. In the study 80% of the physicians who indicated they used a defensive approach stated that they feared a legal dispute, while 60% feared receiving a damages claim. 3) They also feared negative publicity. A substantial amount of the physicians interviewed (43.5%) expressed a blamed approached by the media. (Catino, 2009)

The physician’s perspective in the United States has believed that defensive medicine must be practiced to offset litigation risk. The Studdert survey in 2005 found that 93% of high risk specialty’s in Pennsylvania reporting using defensive medicine. Another study done in 2008 elicited comparable data, at 83%, for physicians in Massachusetts. These studies argue that there are significant costs associated with defensive medicine. Massachusetts physicians laid claim that between 20% and 30% of x-rays, CT scans, MRIs, and specialty referrals and consultations were ordered primarily for defensive purposes. The physician’s contend that legal reform must occur to reduce the expenses of defensive medicine. (Hermer & Brody, 2010)

**Obstetrics and Cesarean Section**

First of all, obstetrics is the specialty dealing with all women’s reproductive tracts and their children during pregnancy, childbirth, and post-natal period. Early 1980’s literature began to contain studies that offered more conclusive evidence that defensive medicine increased the chances of a cesarean delivery versus the traditional delivery. The belief at the time and moving forward is that legal concerns are a factor in the higher rate of cesarean delivery. A study by Rock
(1988), evaluated data for Illinois and New York State in 1981 and 1983 and the data included information on malpractice premiums paid by obstetricians to insurers in the state. The states were divided into territories in which physicians located in the territory paid a malpractice premium to the insurer. The study found that there were higher premiums associated with a higher incidence of cesarean deliveries in their corresponding region. The data also showed a stronger relationship in New York State most likely due to the greater regional differences in premium rates. The field of obstetrics is more severe than most specialties by increases in both the number of claims and size of awards. Most obstetricians are using negative defensive medicine when dealing with high risk pregnancies. They are reducing the number of high-risk pregnancies seen in their practices. (King, 1996) “The study cited surveys by state medical societies that indicated that 16% to 49% of the physicians surveyed had reduced the amount of time spent with high risk pregnancies.” (King, 1996, para. 5) The possibility of legal consequences has compromised the physician-patient relationship and is leading to altered care for the patient. (King, 1996)

A report by the state health department of Pennsylvania revealed that the number of women who deliver babies by cesarean section continues to increase significantly. The numbers are increasing for low-risk, first-time mothers, as well. In 2002, Pennsylvania recorded the highest rate for deliveries by cesarean section at 24.8% according to the Bureau of Health Statistics. The numbers through much of the 1980s and 1990s were practically just about the same reaching 24.4% in 1987, but had dropped to 19.3% in 1997. The rate of cesarean section continues to increase in the state of Pennsylvania. These statistics are believed to be correlated to the higher rate of negative defensive medicine practice throughout the years. ("Medical Letter of the CDC & FDA," 2004) "Because all these different groups are affected, the only common issue is that doctors are afraid of liability. We have a real problem," Jitendra Desai, MD, president of the Pennsylvania Medical Society, said. "Ob-gyn people have become so spooked
that in case of any doubt they'll go for the safer thing. ... It's defensive medicine." ("Obesity, Fitness & Wellness Week," 2004, para. 9)

**Obstetrics and Breast Care**

There is a study that was conducted to determine how malpractice concerns and experiences with malpractice lawsuits are associated with obstetricians and gynecologists for breast care. The two hypotheses of the study were: (1) ob-gyns whose malpractice insurance has increased leads to changes in their business and reduced career satisfaction; and (2) changes in their practices will be associated with liability lawsuits, practicing defensive medicine, and career satisfaction. Breast cancer is the second leading cause of cancer death in women according to the American Cancer Society. Patients that have this kind of cancer frequently file delay-in or failure-to-diagnose claims. (Anderson et al., 2011)

**Study and Methods:** The study randomly selected 400 American College of Obstetricians and Gynecologists (ACOG) who were members of the Collaborative Ambulatory Research Network (CARN). Out of the 400 surveyed, there was a 62% response rate. The survey was developed by the authors of the study with the collaboration of an ob-gyn expert in breast care. The survey contained eleven questions: (1) in the past five years has your malpractice insurance changed? (2-8) seven different breast care practices were listed and asked to indicate whether their malpractice concerns had caused them to change certain practices. (9) They were asked to rate their defensive medicine practices on a scale of one to ten. (10) They were asked whether they had been sued. (11) Finally, they were asked how happy they were with their career. (Anderson et al., 2011)

**Results:** The study found that ob-gyns rated their satisfaction at 8.5 on a scale of 1 to 10. Almost three quarters of the participants claimed to have been sued with a greater percentage of
specialists than generalists. There was not much of a change for the way they conducted their practices except for two out of the seven. The two practices that were seriously affected were referrals for diagnosis of breast abnormalities and referrals for treatment of breast disease. Over half of the physicians in this study indicated that their malpractice insurance had increased in the past 5 years, and for the sake of this study, having been sued was not associated with malpractice insurance increases. The study showed that over 50% of the physicians use more screening and testing than they would otherwise use because of fear of litigation. The respondents were grouped based on their state of malpractice crisis level and 42% of the respondents practice in a crisis state, and 30% of the group practice in a cautious state. Over half of both of these groups, reported an increase in their malpractice insurance over the past five years. The physicians in the crisis and cautious groups had higher means of practicing defensive medicine. The study stated that the numbers were particularly telling. If there was a legal implication in their career, they were more likely to practice defensive medicine. (Anderson et al., 2011)

The research shows that there is a commonality between malpractice concerns and the self-reported cases of ob-gyns who provide breast care. The first hypothesis stated that ob-gyns whose malpractice insurance increased would report changes in their business have lower career satisfaction. The study proves that there is no correlation between increased malpractice insurance and lower career satisfaction. The study did show that low career satisfaction is linked to the likelihood of litigation in the past and changes made to their business due to the fear of malpractice. The second hypothesis acknowledged changes in ob-gyns practices would be associated with liability lawsuits, an increase in defensive medicine, and career satisfaction. The analysis also shows that prior experiences with litigation predicted the physician’s frequency of practicing defensive medicine. (Anderson et al., 2011)
Conclusion

In review, we see that the history for medical malpractice has been extremely volatile throughout the decades. There’s a trend of upward and downward movement of premium values, a trend toward higher lottery payouts, and reactive history of legislative reform in handling medical malpractice measures. The total cost of medical malpractice legislation is a small percentage of national health care spending, yet the amount is not trivial. The system currently provides compensation for plaintiffs that are injured due to substandard care and denies compensation if they received the right care. The medical malpractice system has many conventional reform policies and mechanisms that have negative and positive attributes regarding claimants and defendants. The alternative reform measures are not fully proven and also have their own negative and positive attributes in dealing with medical malpractice litigation. Most likely, we will see a trend for medical malpractice reforms that are focused on improving care and, if effective, will reduce malpractice claims with a reduction in errors.

The current malpractice reform measures will eventually change the landscape of future litigation and reduce the amount of defensive medicine used. The research in this paper for obstetrics shows that defensive medicine is an overused mechanism. There is contradicting evidence as to whether defensive medicine increases the costs of healthcare even though it is used as a tool to reduce litigation by obstetricians. There is hope that defensive medicine practices are reduced in the face of malpractice reform for the future for better quality to the patient.
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