

An Ounce of Prevention is Worth a Pound of Cure: Distribution of Medical Malpractice Claims - Implications for Healthcare Organizations

In today's emphasis on reducing healthcare costs and spending, many commentators have noted that reforms to the U.S. system of medical malpractice, such as noneconomic damages caps, could reduce overall healthcare spending.¹ While the effectiveness of "tort reform" measures on reducing healthcare spending has been challenged,² new data regarding the concentration of paid medical malpractice claims among physicians may offer new insight into future medical malpractice reform efforts. Specifically, a January 2016 study published in the New England Journal of Medicine (NEJM) found that "approximately 1% of all physicians" accounted for 32% of paid claims"³ and positively correlated the risk level of a physician for a malpractice claim with the number of previous paid malpractice claims against the physician.⁴ Identifying physicians with increased risk levels for a malpractice claim, as well as designing protocols and training regimens to decrease this risk, prior to the onset of legal implications could serve as a proactive means by which health systems can reduce the burden of medical malpractice while also reducing unnecessary healthcare expenditures.⁵ This Health Capital Topics article will discuss the results of the NEJM study on medical malpractice claim distribution, as well as detail how health systems can utilize claims data to take proactive measures that may reduce the burden of medical malpractice and the costs associated with this quality control measure.

There is much debate concerning whether the U.S. tort system governing medical malpractice adequately protects patients, through the reduction of medical errors, while reducing healthcare costs. As stated in Chapter 11 of *Risk Management, Liability Insurance, and Asset Protection Strategies for Doctors and Advisors*:

"The goal of medical malpractice is to function as a quality control measure, creating an incentive to prevent medical errors and reduce accident producing behavior by awarding damages, i.e., "money claimed by or ordered to be paid to a person as compensation for loss or injury,"⁶ to plaintiffs who have been found to have been harmed by the physician's error."⁷ While the payment of damages provides some form of recourse to the injured party after the medical malpractice, economists and physicians have questioned the efficacy of the U.S. tort system to reduce medical errors and healthcare costs. In response to the threat of medical malpractice claims, many physicians resort to defensive medicine, defined as the instance "when doctors order tests, procedures, or visits, or avoid certain high-risk patients or procedures, primarily (but not solely) because of concern about malpractice *liability.*^{**} Defensive medicine practices been widely noted as a driver of unnecessary care and increased healthcare costs.9 Further, many "tort reform" efforts to reduce the scope of liability for physicians, such as noneconomic damages caps, may not adequately reduce defensive medicine practices, as physician overestimation of their risk of facing a malpractice claim was driven more by subjective fears of a lawsuit instead of the presence or absence of specific tort reform laws.¹⁰ This attitude toward malpractice risk and the use of defensive medicine calls into question the efficacy of various "tort reform" laws in reducing healthcare costs.

In addition to defensive medicine concerns, concerns about litigation costs also impact discussions regarding improvements to the U.S. tort system governing medical malpractice. According to the Physician Insurers Association of America (PIAA) Data Sharing Project, national indemnity payments for 2013 amounted to \$704 million (in 2013 dollars).¹¹ Additionally, defense and cost containment expenses, not including indemnities, were \$228 million (in 2013 dollars).¹² Over a 10 year period (2004-2013), total indemnity paid in claims amounted to nearly \$9 billion (in 2013 dollars), with 26% of all claims resulting in indemnity payment. Among the \$9 billion spent on total indemnity payments, defense and cost containment expenses not including indemnities were \$2.4 billion (in 2013 $1/4^{th}$ dollars), accounting for nearly of all indemnity spending.¹

Medical malpractice claim concentration data may provide insight into identifying specific forces underlying the overall efficacy of the U.S. tort system in preventing medical errors. According to the NEJM study, 1% of the approximately 915,000 active U.S. physicians in 2014 had two or more paid malpractice claims levied against him/her; this subset of the active physician population accounted for 32% of the approximately 66,000 paid medical malpractice claims between 2005 and 2014.¹⁴ In addition, physicians with three or more paid malpractice claims levied against him/her (approximately 0.2% of the 2014 active physician population) accounted for 12% of all paid malpractice claims.¹⁵ The incidence of levied claims against a particular physician has a positive correlation with the risk level of facing a future claim for medical malpractice. According to the NEJM study, physicians with two paid malpractice claims levied against him/her possessed nearly double the risk of facing a malpractice claim in the future, in comparison to physicians who previously faced one paid malpractice claim.¹⁶ For physicians with three paid malpractice claims levied, the risk of facing a malpractice claim in the future tripled against physicians with only one levied paid claim, and had a 24% probability of occurring within 2 years of being levied with their third paid claim.¹⁷ In consideration of this data, the authors noted that "the instantaneous risk of further paid [malpractice] claims was highest soon after a payment was made."¹⁸ The February 2016 NEJM study reflects what previous studies have also noted: a small minority of physicians are associated with a grossly disproportionate share of paid medical malpractice claims.¹⁹

Claims distribution data provides hospitals, integrated delivery systems, and other healthcare providers with an opportunity to impact the U.S. tort system governing medical malpractice claims by proactively seeking to reduce medical errors before a patient and physician enter litigation. Notably, healthcare organizations can access claims data through the National Practitioner Data Bank (NPDB) and run queries to track the status of each affiliated physician in regards to paid malpractice claims.²⁰ Healthcare organizations have the potential to utilize data on paid medical malpractice claims to identify at-risk physicians and develop protocols to reduce the potential of further medical errors.²¹ With the heightened risk of future malpractice suits after being levied with a second paid claim,²² preventing the occurrence of a second paid claim may eliminate a large portion of the claims filed against physicians for medical malpractice.

In the future, it is worth tracking the actual impact of targeted institutional efforts, using NPDB data, in reducing medical errors, healthcare costs, and defensive medicine practices. However, in the present, healthcare organizations can view both the existence and their access to NPDB data on medical malpractice claim distribution not simply as a risk to manage, but as an *"exciting opportunity"* to improve the quality of care provided by its member physicians with the potential of reducing costs in the long run.²³

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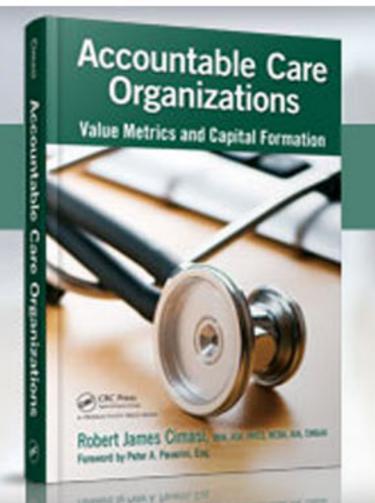
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