



# GUIDE TO DEFENSIVE MEDICINE

## What is defensive medicine?

Merriam Webster defines defensive medicine as the practice of ordering medical tests, procedures, or consultations of doubtful clinical value in order to protect the prescribing physician from malpractice suits.

Further, as noted in a 2005 Journal of the American Medical Association article,

*Defensive medicine takes two main forms: assurance behavior and avoidance behavior. Assurance behavior involves charging for additional, unnecessary services in order to a) reduce adverse outcomes, b) deter patients from filing medical malpractice claims, or c) provide documented evidence that the practitioner is practicing according to the standard of care, so that if, in the future, legal action is initiated, liability can be pre-empted. Avoidance behavior occurs when providers refuse to participate in high-risk procedures or circumstances to avoid litigation.*

But there's more. Surveys consistently show that between 70% and 90%+ of doctors report that they practice defensive medicine. According to a 2009 survey conducted by Jackson Healthcare this is estimated to add up to a cool \$650-\$850 billion dollars a year. That's billion with a b! That's somewhere between 26-34% of the total annual cost of healthcare in the U.S. and stands in stark contrast to the roughly 8% of total healthcare costs that makes up physician compensation.

So, clearly defensive medicine is a problem. Even those who dispute numbers like those above, or think that doctors overestimate the amount of defensive medicine they practice (a seemingly odd assertion, but one that some make) acknowledge that defensive medicine is a real and substantial problem, and that reducing it is a key component in reducing the overall cost of healthcare. Further, any proposal that reduces defensive medicine does so by alleviating doctors' fears of litigation since that fear is by definition the cause of defensive medicine. This means that reducing the direct costs of defensive medicine also reduces the collateral costs that accrue through things like shortages of those willing to go into medicine or particularly into high risk specialties, and adverse effects of unnecessary tests that then have to be treated at additional cost.

So what are these proposals? How do we eliminate, or at least mitigate the practice of defensive medicine? Well, the answers range from the tried and true, traditional tort reform, to some very innovative, and in some cases drastic, proposals.

## 2 Traditional Tort Reform

This is the most common and probably the most popular proposal. A tort is a wrongful act that results in legal civil liability. Tort reform limits, or sets parameters on torts. The most common example is the

placing of caps on non-economic damages. These caps place an upper limit of liability on things like pain and suffering or loss of enjoyment of life. Other tort reforms include things like tightening up statutes of limitation, putting in place a loser pays system whereby attorneys fees accrue to the loser of the lawsuit, and limits on punitive damages awarded by juries.

However, there are some who think that broad support for traditional tort reform is as much a result of familiarity as it is evidence that it works. In other words, many don't know much about other proposals and so support for tort reform becomes the default of those trying to oppose defensive medicine.

Consider the following:

*In the Jackson Healthcare survey mentioned above 77% of physicians said that if caps on non-economic damages were put in place they would either increase or not change the amount of defensive medicine they practiced. Likewise, after Texas passed tort reform capping non-economic damages 77% of doctors there said they did not change their practice of defensive medicine.*

Reforms like caps on non-economic damages don't specifically target the reduction of procedures that are least likely to be medically valuable, and may disproportionately decrease liability for the most dangerous practices (i.e. those that lead to the most serious damages and thus the highest payouts).

On the other hand, tort reform has been shown in numerous studies to reduce the overall frequency and severity of lawsuits. It naturally lessens the incentive of trial lawyers by limiting what they can take away from a suit, and offers at least some peace of mind to doctors by ensuring that at minimum there is some limit to what their liability could be. Further, it tends to reduce malpractice insurance premiums because it provides a more stable risk evaluation environment for insurers and underwriters. Even many of those who doubt that traditional tort reform would offer dramatic savings in healthcare costs or reduction of defensive medicine acknowledge that it is a key component in an overall strategy. Traditional tort reform alone probably is not enough. But reform that does not include a tort component will understandably not be acceptable to doctors and will not ultimately address all the problems that contribute to the practice of defensive medicine and the high cost of healthcare in the U.S.

### 3 No Fault Administrative Patient Compensation Systems

One of the more comprehensive proposals for dealing with defensive medicine, as well as a number of other difficulties associated with direct liability, is the implementation of no fault administrative patient compensation systems. That's a mouthful to be sure, but the basic idea is pretty simple, and not that much different from the way workers' compensation works. In a nutshell these systems would set up administrative panels of medical experts that would decide on cases where patients claimed to have been harmed. The funding for payments would, in theory, come from current malpractice

insurance premiums and thus no taxes or new revenue streams would be required. Direct liability, as such, would be completely taken out of the picture. These types of systems are currently being seriously considered in Florida and Georgia.

So what are the benefits to such a system? Well, in theory there are quite a few. For one thing, this is the one approach that doctors said would actually cause them to change their practice of defensive medicine in the Jackson Healthcare survey mentioned above. In that sense it might seem like a good option for doctors. It could free them from the fear and anxiety associated with the constant threat of a lawsuit.

Additionally, the system might be good for patients, as more of them would have access to compensation for at least two reasons. First, trial lawyers are often only willing to take cases with very large potential payouts. This means that people who have experienced real but non-catastrophic harm or negligence are often not able to get compensation. But under a patient compensation system a lawyer is not even needed. The affected party simply files a claim, which is evaluated by the panel. So anyone can file a claim at no expense. Secondly, such a system, by removing fault from the equation, allows for compensation in both situations where there was true negligence and situations that ended with adverse outcomes but were not a result of malpractice. Sometimes an adverse outcome is just a result of bad luck, an unforeseen circumstance, a miscommunication, etc. No one has to be named and blamed for a patient to be compensated for an adverse outcome in a patient compensation system. Instead of focusing on blame administrators, doctors, and institutions are freed up to focus on improving systems to reduce the likelihood of mistakes or accidents going forward.

Another major benefit that proponents of this model point to is the time savings it is supposed to provide. While malpractice trials often stretch out over years administrative panels could likely render decisions within the course of a few weeks. And this isn't all just speculation; as with the cost savings there is a certain amount of historical evidence due to the fact that such systems have been in place in countries like Sweden, New Zealand, and Denmark for some time. New Zealand, for instance, who has had a no fault system since 1974 spends about \$29 million per year on patient compensation while the US spends over \$122 billion a year on malpractice. Granted that New Zealand is a much smaller country (about 71 times smaller by population) but even if you scale for population equivalence it only puts their compensation price tag at about \$2 billion to our \$122 billion. Likewise in the case of timely resolutions, we know that the average decision in New Zealand is processed in a few weeks and that all decisions are processed in no more than nine months. Also, because these systems are being considered in Florida and Georgia models have been put together by public policy experts that show substantial projected savings. For more on the statistics about New Zealand and a thoughtful consideration of the role of malpractice as compared to systemic flaws in causing adverse outcomes you can read this helpful article.

So what's the downside of the patient compensation model? Well, of course it raises the obvious question, what about accountability? Is it really reasonable for doctors not to be accountable

to those they harm in a situation of true negligence? That's a complex question, and touches on morality, justice, and all kinds of questions for the ages. But it is worth noting that the U.S. is relatively unique in allowing people to sue physicians directly. Many of the doctors from other countries Jackson Healthcare surveyed didn't even know what the term defensive medicine meant and those that did overwhelmingly reported not practicing it.

Further, a system like this would not have to take all accountability away from doctors. Administrative sanctions would likely be used in cases of genuine negligence or malpractice. However, that raises another question: would sanctions just move the goal posts, so to speak, making the threat of sanctions the driving factor in promoting defensive medicine? Proponents say no because sanctions would be less likely to be arbitrary or frivolous than malpractice suits are under the current system. But there are other potential pitfalls. The very same factors that would give patients increased access to compensation could potentially lend the system to being overrun. Do we really want people to be able to file for compensation at no cost or potential risk? Would such a system not lead to abuse? This is a serious consideration, especially in light of the cost of workers compensation fraud and abuse, given that the model is very similar.

Finally, there are the legal and political challenges. While such a system may sound more efficient it does involve taking away the right to a trial by jury in cases of malpractice. That makes it a very major reform and one that would have to get a great deal of popular support to ever be implemented. It also means that there is huge potential for such a proposal to become very political, and in some ways it is inherently political. For all it's supposed savings and efficiency a patient compensation system, as it's typically proposed, takes another element of the healthcare industry out of the private sector and puts it under government management. Many people these days are not too sanguine about the government's ability to follow through with promises of savings and efficiency when it comes to questions of healthcare management.

## 4 Safe Harbor

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In addition to tort reform and patient compensation systems another model that has been suggested by some public policy analysts is what is often called the safe harbor model. The idea here is to create clinical guidelines that, if adhered to, would function as a safe-harbor for doctors, shielding them from liability in a malpractice case. In other words, these clinical guidelines would function as a universal standard of care, recognized by the courts, and providing a definitive course of action for doctors to follow and remain safe from malpractice liability. Of course, this proposal would depend on new legislation codifying the requirements for clinical guidelines to have such status, and laying out the specifics of how such guidelines are to be understood and applied in the courts and in terms of documentation.

So what are the supposed benefits of this model? One is that clinical guidelines could be created that were strictly evidence based. This would afford physicians the ability to avoid practicing rule

out medicine in which, to avoid liability, they feel that they have to order every test and procedure that could potentially rule out one diagnosis or another. Instead doctors would be able to proceed straight to the treatment that is best according to the evidence without fear of liability.

Another benefit of the safe-harbor proposal, according to its advocates, is standardization of practice. Not only would the safe-harbor guidelines cut back on defensive medicine, but they would also give doctors guidance on best practices and would eliminate a lot of confusion in the courtroom. As it is standards of care are admissible as evidence in court cases as a means of bolstering expert witness testimony, but there is no norm governing what standards carry what weight, and there are any number of "standards" one may cite. Having a legislatively recognized standard of care eliminates such questions, reduces the value of "experts" who testify as needed for pay, and, in the strongest version of the proposal, creates an irrebuttable presumption that care was not negligent. In other words, in its strongest application this solution would be legislatively written such that if the doctor followed the standards of care he or she could not be found negligent.

So what are the pitfalls? Well, there are more than a few. Let's start with the practical and then we can consider the political and philosophical. Practically speaking the kinds of standards that would be necessary for such a robust proposal would be extremely hard to come up with. The practice of medicine is not like working on a car where if you know the make, model, and year and have the right tools available it's just a matter of following the manual. Human beings are more complicated than that. Coming up with definitive answers to what should be done in every conceivable instance, it seems to us, would be nearly impossible. Likewise, how many guidelines would there be? It seems that if you were going to try to cover every possibility you'd end up with a volume larger than the OED, maybe even larger than the Affordable Care Act! And what about patients with multiple diagnoses? Would there be an algorithm for combining the risks, benefits, and compatibility of treatment recommendations under two or more sets of clinical guidelines.

Besides, even if such guidelines were produced it seems that keeping them up to date would be a herculean task. Things are always changing and developing in the medical world, as in any industry. Yet if doctors feel compelled to slavishly follow the official guidelines to avoid liability the proposal could actually lead to worse care because doctors might be afraid to implement new and better methods until they were incorporated into the official safe-harbor guidelines.

Additionally, having safe-harbor clinical guidelines would not keep doctors out of court. Doctors would still have to prove that they followed the guidelines, and that their execution was without fault. It's not as though simply checking off a list or making the right diagnosis would be sufficient to avoid being sued and brought to court. Patients can always argue that although you attempted to do the recommended thing, you did it in such a way that it caused harm, or you did it without taking into account another set of applicable guidelines, or that you followed the wrong guidelines, etc.

But beyond all these practical hurdles there are the more philosophical questions about conformity, uniformity, and choice. Ultimately a top down, legislatively dictated standard of care takes freedom

away from both doctors and patients. Even though the standards in such a system aren't something that doctors are technically required to follow, in practice not doing so would likely end up leading to a de facto presumption of negligence. "Why weren't you following the recognized standard of care, Dr. Smith? Don't you know these standards are evidence based?" Any doctor not following such standards, were they put in place, would be taking a serious gamble.

This proposal would also chip away at the freedom of patients to choose a doctor that they feel treats them well. Getting a second opinion becomes much less valuable when there is a universal standard of care that tells doctors what they should do in your situation. What would happen to doctors interested in alternative medicine, cutting edge technological developments, or any kind of non-traditional treatment? It seems that they would become liability magnets.

Ultimately, while we understand and appreciate the motivation behind a suggestion like safe-harbor clinical guidelines and creating a standard of care that a doctor can operate within and feel assured of freedom from negligence, the proposals as they have been made don't seem tenable. More than that, some of the outcomes that would likely attend such a policy are quite disturbing. Doctors are professionals and experts. They spend years in graduate school and residency training to be able to evaluate individual situations and circumstances in light of all kinds of variables and make the appropriate decision for that particular situation. A universal standard, apart from which one would be in the unfortunate position of not following the "safe" clinical guidelines, ultimately reduces doctors' freedom to do their jobs well and it limits the options available to patients by putting a damper on any treatment not meeting a clinical guideline.

For more on the safe harbor solution you can read this article from Zeke Emanuel with the Center for American Progress (very much in favor) and this one by Randall R. Bovbjerg and Robert A. Berenson with the Urban Institute (favorable but more balanced). We pretty clearly disagree with some of what these authors suggest, nevertheless these articles are good introductions to the concept and proponents always explain their own ideas best.

## 5 Disclose, Apologize, & Offer

One of the more promising and at the same time less radical models for mitigating defensive medicine is commonly referred to as the Disclose, Apologize, and Offer (DA&O) model. This is a model that attempts to allow doctors and hospitals to be proactive in dealing with adverse outcomes rather than feeling that they have to retreat to a de facto deny-and-defend posture. Under a DA&O model when an adverse outcome occurs doctors and practices are encouraged to acknowledge it in a timely fashion, apologize to the patient when appropriate, make assessments as to how risk management can be improved and similar outcomes avoided going forward, and, when appropriate, make a reasonable offer of compensation.

While this kind of approach may sound too simple and straightforward to be of any value, or may

even strike some as naïve, there is some evidence that suggests that such a model offers significant benefit. The University of Michigan Health System adopted a DA&O approach over a decade ago and has seen an increase in error reporting from physicians along with a decrease in malpractice claims, costs per claim, and insurance reserve requirements, as well as a decrease in the average claim resolution period.

Following UMHS's example Massachusetts became the first state to adopt a full-fledged DA&O system statewide in 2012. The system, signed into law by Governor Deval Patrick, provides for a six month, pre-litigation, cooling off period in which doctors are encouraged to acknowledge and disclose adverse outcomes, apologize to patients, explain how systems are being improved to prevent similar problems in the future, and make a reasonable offer of compensation. Under the law patients of course still have the right to work with an attorney and can always refuse the offer made and take the case to court, however, apologies made during this process would be inadmissible in a trial making it more feasible for doctors to make a serious effort at resolving issues prior to litigation. While it's too early to say what the long- term impact of the reform will be in Massachusetts, early reporting is positive and the evidence from UMHS and other similar programs, such as the one at Stanford Hospital, point to good results.

One of the promising aspects of DA&O as a model is its broad appeal. Unlike tort reform or the safe harbor model, DA&O tends to unite the various stakeholders in the malpractice arena. In Massachusetts, for example, the Massachusetts Medical Society, the Massachusetts Bar Association, and the Massachusetts Academy of Trial Attorneys were able to come to an agreement on language that eventually made its way into the healthcare cost control bill that shaped the DA&O system for that state. These are groups that rarely agree on proposals relating to medical malpractice, and that have very different, some would even say competing, interests. Nevertheless, disclose, apologize, and offer is a model that they were apparently all able to get behind.

So the positives are pretty clear. DA&O models hope to benefit doctor- patient relationships while relieving pressure by allowing doctors to be frank and honest with their patients. They are also intended to help retain the human element by allowing doctors to apologize when appropriate. This, in turn, will presumably make some, maybe even most, patients more open to a settlement that is non-adversarial. In the meantime, because errors are reported early and with greater openness and less hesitation the information gleaned from that reporting can be synthesized into a process of regular reform and improvement of systems and procedures to reduce mistakes and adverse outcomes.

Additionally, by settling more cases out of court overall costs are reduced both through the reduction of legal representation costs and through reduced payouts—the idea being that a patient whose circumstance has been acknowledged and apologized for is more likely to be satisfied with a reasonable amount of compensation rather than going for all he or she can get in a combative trial situation.

Finally, advocates of DA&O systems point to a reduction in the time it takes to process claims as yet another benefit. We all know that malpractice cases can take years to work through the courts, but in the DA&O model one of the chief strategies is to deal with issues that arise early and in a timely fashion. Dragging things out is as likely to upset the patient as it is the doctor, so timeliness is a chief element in the conflict resolution scheme.

We've heard the positives, but what about the negatives? What do critics of the DA&O model say? Well, there aren't a lot of people actively criticizing the DA&O model say? Well, there aren't a lot of people actively criticizing this model but there are some challenges. The first is simply that we don't know how well it would work on a large scale. Yes, it has been a success at Stanford and the University of Michigan, but those are both relatively small systems. Would it work across an entire state with multiple insurance markets, varying interpretations of the law, and all the complexities that come with scaling something from a single private entity to a statewide standard? Hopefully so, and we can be optimistic, but the reality is that it will be a few years before we have hard data to work with.

Another hurdle to get over if DA&O is going to effectively address the costs of defensive medicine is simply convincing doctors. While claim numbers may go down when a DA&O model is implemented, according to the Jackson Healthcare survey we mentioned in the introduction over 90% of doctors surveyed in Massachusetts said that regardless of the program they would increase or leave unchanged their practice of defensive medicine. Physicians in Oregon, where a similar law is being considered said the same—90% would increase or leave unchanged their practice of defensive medicine.

So even if DA&O reduces costs overall, will it actually reduce defensive medicine? Perhaps over time if doctors see a substantial reduction in claims and begin to feel that the legal environment is more secure their responses will change, but at the moment there doesn't seem to be enough confidence in the proposal to substantially change the way doctors practice.

Overall it seems that DA&O is a promising model for reform, and could likely save quite a bit of money for states that implement it. It might even lead to significant reductions in the practice of defensive medicine over time. But as with any reform of this scale it will be a slow process with states like Massachusetts (and maybe Oregon soon) pioneering the approach and hopefully giving us data with which to assess effectiveness and consider ways to improve the model. And as with other reforms DA&O likely won't be sufficient to combat the costs of defensive medicine on its own, but coupled with common sense tort reform, including caps on non-economic damages, it could be a very promising piece of the puzzle. For more information and regular updates on DA&O reform you can check out this advocacy site.

Finally, we turn to arbitration. Arbitration is certainly nothing new, and doesn't come with the glitz of being a revolutionary approach, but is it a more potent means of combating the costs of defensive medicine than we realize? Could arbitration play a significant role in reforming a system that is gobbling up money and resources while frustrating physicians?

## 6 Arbitration

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Well, first let's be clear on what arbitration is and what forms it takes. Arbitration is essentially a method of settling a malpractice dispute outside of court. Like a jury trial it involves two sides making their cases—giving opening statements, evidence, rebuttals, etc. However, rather than doing so in a court of law before a judge and jury, the process is carried out before one or more arbitrators—professionals and experts hired to determine the merits of the case and render a judgment.

The value of arbitration is typically seen in its potential to reduce time and cost in a malpractice dispute. Arbitration is typically a much speedier and somewhat less formal affair than the, often protracted, jury trial alternative. Further, many believe that arbitrators, as professionals with experience, are less likely to offer the kind of astronomical rewards that we sometimes see in jury trials, and that they are generally more conservative and even-handed than a jury might prove to be.

But what are the circumstances in which a case would be arbitrated rather than go to court? This is where things begin to get sticky. In most cases for arbitration to happen a patient will have had to have knowingly and willingly signed a waiver of their right to a trial by jury. This is called an arbitration agreement. And because courts have emphasized the knowingly and willingly aspect, at times refusing to enforce arbitration agreements that they believed were signed either in ignorance or under duress, the reality is that doctors must call attention to the arbitration agreement to ensure that it is signed knowingly and willingly and thus will be binding. Needless to say, this isn't a particularly attractive prospect to most physicians. Talking about the possibility of malpractice at the beginning of a doctor-patient relationship doesn't set a great tone, and asking the patient to waive a constitutional right in that conversation could really sour things.

But even if a doctor can find a way to get patients to sign an arbitration agreement freely and willingly there are a few other possible drawbacks that have to be considered. The first is hinted at above, that is, the legal uncertainty that goes with relying on an arbitration agreement. While most states allow for arbitration agreements (again, assuming they are knowingly and willingly agreed to), they still reserve the right to find them invalid in some circumstances. For instance, if the agreement is deemed to be substantially at odds with state laws it may be ruled void. An example would be an arbitration agreement with a non-economic damages cap substantially lower than the state cap, as was the situation in this Florida case where the court did in fact rule an arbitration agreement void.

Likewise, if a court finds an arbitration agreement to be unfair, limiting one party's options in an inequitable fashion, the agreement may be deemed void. Finally, some states have specific statutes allowing either party to challenge the outcome of an arbitration agreement in court should they choose to. This is unusual, but it is the case in some states. While none of these legal issues eliminate the potential value of arbitration, collectively they create added hesitation because they add an element of subjectivity that is hard to account for. What will the courts find unfair? What will they

deem sufficiently at odds with state law to make an agreement invalid? How do you prove sufficient knowledge and willingness?

Finally, there is the question of value. While there are risks with a jury trial the initial costs are limited to representation. In the case of arbitration the arbitrator must be paid as well. Further, arbitrators tend to be relatively conservative as mentioned before. While that does mean seldom ordering huge awards for patients it also means seldom dismissing a plaintiff. They typically make a decision that could not be labeled a pure victory or loss for either side. On the other hand, courts routinely dismiss frivolous lawsuits, and even if a defendant's motion to dismiss is denied, counsel can always at that point seek an out of court settlement. In other words, going through the courts gives the doctor a better chance of dismissal and still preserves the right to negotiate apart from going to trial. This seems unlikely to change since, if arbitrators got into the habit of dismissing plaintiffs' claims patients would probably be even less likely to be willing to sign arbitration agreements.

So, it sounds like arbitration isn't much of an answer to anything, right? Not quite. There is one situation in which arbitration can be an effective tool and can work very well. Arbitration agreements built into employer provided group coverage plans which require employees to settle claims via arbitration are not uncommon. As Alex Stein of the Harvard Law Petrie-Flom Center notes, "A group health plan that obligates employees to arbitrate medical malpractice claims is valid and enforceable: see *Madden v. Kaiser Foundation Hospital*, 552 P.2d 1178 (Cal. 1976). The plan's designers—employers on one side and MCOs/HMOs on the other side—have roughly equal bargaining powers and cannot easily take advantage of one another. Their preference for arbitration is part of a well thought-through deal that includes an attractively priced health benefits package for employees..." So, arbitration isn't wholly out of the picture when it comes to controlling costs and mitigating defensive medicine, but if we're honest it's probably a pretty small piece of the puzzle. In many cases it's just too difficult to implement, too uncertain when implemented, and offers too little in the way of value to make it attractive. Some will no doubt continue to employ arbitration agreements and find them useful. One can imagine certain specialties where they would be more useful than others (i.e. lower risk).

## 7 In Conclusion

What you find when you begin considering ways to mitigate the costs and psychological frustration caused by defensive medicine is that there is no silver bullet. Things like caps on non-economic damages, arbitration, DA&O, and other tort reform efforts all have a potential place in an overall strategy that aims at reforming the system in ways that promote sound decision making, reasonable standards, avoidance of waste, and equity for all parties.