



# Medical Malpractice Tort Reform

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## EXECUTIVE SUMMARY

- A tort is generally defined as a civil wrong which causes an injury, for which a victim may seek damages, typically in the form of money damages, against the alleged wrongdoer.
- An overview of the tort system is detailed, specifically in the context of a medical malpractice lawsuit, in order to provide a better understanding of the practical evolution of medical malpractice litigation and its proposed reforms. Rising premiums and defensive medicine are also discussed as part of the tort reform dialogue.
- Because medical malpractice litigation will never disappear entirely, implementing sound risk management and compliance programs are critical to every radiology department in order to improve the safety and quality of the care that its radiologists and technologists provide.

**The mere mention** of the term “tort reform” is enough to evoke great passionate response from its myriad proponents and detractors.\* For the past three decades, medical malpractice tort reform has remained a highly polarizing, heavily contested legal issue which affects not only physicians and attorneys, but also the great many Americans seeking healthcare each year. But why does this legislation inspire such fervency in those that revile it and in those that champion it? Ask its critics, which typically include much of the plaintiffs’ bar, and the answer is simple: medical malpractice tort reform strips individuals of their ability to redress injuries that they have incurred and right the perceived wrongs that have been committed against them. To its advocates, the answer is equally clear: medical malpractice tort reform is the mechanism by which defensive medicine is prevented, doctors’ personal and pro-

\*Tort reform is a term that is often used interchangeably with medical malpractice reform. As will be described below, there are many different types of torts. Medical malpractice, also referred to as professional negligence, is only a subset of the tort family. For our purposes, however, the terms tort reform, medical malpractice reform and professional negligence will all be utilized within this article and will all mean the same thing.

fessional livelihoods are protected and litigious plaintiffs with frivolous lawsuits are deterred from bringing suit. While both sides make convincing arguments, the reality of medical malpractice tort reform lies somewhere in the middle.

## An Introduction to Tort Law

Medical malpractice, or negligence law, is just one subset of the legal behemoth that is tort law. A tort is generally defined as a civil wrong which causes an injury, for which a victim may seek damages, typically in the form of money damages, against the alleged wrongdoer.<sup>1</sup> Tort law is that body of law that serves as the vehicle by which tort liability can be sought in a court of law against such wrongdoers and generally serves to award damages to a victim sufficient to restore him to the position he would have been in, had the tortious conduct not occurred.<sup>1</sup> Tort law typically governs three legal theories of a lawsuit: negligence, strict liability, and intentional torts.

The element of damages in tort law is of major significance and is integral to understanding the overall concept of tort reform, mainly because the “runaway juries” have been the subject of great media attention and scrutiny. In tort law,

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compensatory money damages can be sought by a victim for both economic and noneconomic losses.<sup>1</sup> Economic damages seek to compensate an individual for quantifiable economic losses, such as lost income and medical bills, while noneconomic damages are more speculative and seek to compensate an individual for noneconomic losses, such as mental distress and pain and suffering.<sup>1</sup> In certain rare scenarios, generally involving egregiously reckless conduct or behavior, a victim may also seek punitive damages against a wrongdoer.<sup>1</sup>

A significant medical malpractice crisis in the United States occurred in the 1970s and 1980s.<sup>1</sup> During this time period, there was a rapid rise in the number of medical malpractice claims filed, as well as the size of awards made in medical malpractice actions. It has been estimated by the American Medical Association that in 1975 as many as 14,000 malpractice suits were filed against physicians. The average jury award in these suits was \$171,000.<sup>1</sup> The influx of medical malpractice claims and their subsequent jury awards created a chain reaction that had a far reaching effect. Many private insurance companies began withdrawing from providing insurance coverage, and the insurers that remained responded by raising malpractice premiums. In 1975, it was documented that malpractice premiums had increased from anywhere from 100% to 750%.<sup>1</sup> The sudden increase in insurance premiums, coupled with the loss of many private insurance companies from the market, resulted in some physicians leaving particular practice areas, or retiring from the practice of medicine altogether. It was the culmination of these factors that sparked a call for policy change at both the state and federal levels, and with that, modern medical malpractice tort reform was born.

### **Tort Reform: What Has Been Done**

In response to the criticisms of medical malpractice litigation and the medical malpractice crisis of the 1970s and 1980s, physicians and malpractice insurance carriers began to lobby heavily for changes to reduce medical malpractice tort liability. Proponents of medical malpractice tort reform argued that as a result of changes to laws governing medical malpractice claims and their associated awards, malpractice insurance premiums would decrease. They further argued that lower insurance premiums for healthcare providers would increase the number of practicing physicians, lower the costs of healthcare for consumers and result in an overall improvement in available medical care. These arguments obviously struck a chord in state legislatures throughout the country because by the mid 1980s, medical malpractice tort reforms had been widely adopted. It is important to note that while medical malpractice reform legislation was introduced at both the state and federal levels, attempts to pass real reform have taken hold on the state level, while attempts at passing federal legislation have been unsuccessful.

### **State Reform**

Tort law is a function of state law, with each state providing different rules for bringing about a tort claim. Procedurally, various states may approach tort claims differently; however, the basic premise of a tort claim and the elements that a plaintiff must prove in order to bring a successful cause of action remains consistent across all 50 states.

State laws capping noneconomic damages has been just one of the legislatively implicated medical malpractice tort reforms. Advocates of tort reform argue that noneconomic damages are

arbitrary and unpredictable and, as such, complicate the settlement process. Further, it is argued that losses for emotional distress and pain and suffering are intangible and exceedingly difficult to assign a dollar value. Currently, over 30 states have caps on noneconomic damages as applied to medical malpractice actions.<sup>3</sup> These limitations on noneconomic damages vary across jurisdictions: some states employ caps on both economic and noneconomic damages in medical malpractice awards; some states apply noneconomic damage caps only to certain types of malpractice claims, such as obstetrics; and, other states allow for increased recovery in particular scenarios, such as where the patient has died or has substantial physical injury.<sup>1</sup> Typically, the limit on noneconomic damages varies on a state by state basis, with caps on damages ranging from \$250,000 to \$500,000.<sup>1</sup>

The tort law concept of joint and several liability has also undergone significant tort reforms in the context of medical malpractice claims. Traditionally, joint and several liability allows a plaintiff, who has been injured by two or more wrongdoers, to recover the full amount of his damages from any one of the defendants that may have been involved in the tortious conduct. This has historically resulted in a injured party seeking damages against the defendant with the most financial resources. A party sued under a theory of joint and several liability may then seek contribution from the additional parties at fault, so that the other defendants have to share in the payment of damages. Often times, however, contribution cannot be achieved because the additional at fault parties lack the financial means to contribute. As a result, proponents of tort reform argue that joint and several liability is an inequitable concept because one defendant, generally

the defendant with the most financial resources, is required to pay damages in an amount considerably more than his share of the total liability. This criticism has caused over 40 states to enact tort reforms to the joint and several liability system, either outright abolishing joint and several liability or requiring an individual defendant to pay an amount of damages proportionate to his share of the overall fault.<sup>4</sup>

Michigan serves as an illustrative example of how specific states have addressed medical malpractice tort reform. In recent years, Michigan has passed sweeping legislation curtailing frivolous litigation in the context of medical malpractice. For example, in 1986 the state passed a rule allowing a court to assess attorneys' fees and costs for filed actions that are perceived as frivolous.<sup>5</sup> In 1993, Michigan also enacted noneconomic damages caps in medical malpractice actions, limiting the award of noneconomic damages in medical liability cases to \$280,000 for ordinary occurrences and \$500,000 in cases where the plaintiff has suffered serious damage to the brain, spinal cord, or reproductive organs.<sup>5</sup> In 1995, the state passed a reform to the rule of joint and several liability, barring the application of joint and several liability in the recovery of all damages, except in cases of medical malpractice where the plaintiff is determined to have no allocation of fault.<sup>5</sup> The Michigan state legislature additionally passed reforms to the collateral source rule in the context of medical malpractice litigation.<sup>5</sup> Prior to passage, the collateral source rule prohibited the presentation of evidence at trial that an injured party has received compensation for his losses from another source, such as an insurance policy. The collateral source rule reform passed by the state of Michigan as part of the overall medical liability reform package now provides that medical malpractice awards be offset by the amount of collateral source payments received by the plaintiff.<sup>5</sup>

Through the adoption of comprehensive medical malpractice tort reform,

Michigan has achieved the near total elimination of all medical malpractice litigation. Indeed, reform began to gain traction in Michigan in the early 2000s following a series of conservative holdings by the State's Supreme Court strictly interpreting the key medical malpractice reform statutory provisions. Reported claims for the period 2000-2007 show a 77% decrease in court filings.<sup>6</sup> This is a significant drop in cases which has resulted in a modest drop in insurance premiums.

### Federal Reform

Despite the adoption of tort reform measures throughout a variety of United States jurisdictions, tort reform has yet to gain momentum on a federal level. Attempts at passing federal legislation restricting medical malpractice liability have failed since the 1970s. While contemporary politicians have campaigned for the adoption of far reaching federal tort reform, all have failed in their efforts. In 2004, President George W. Bush proposed tort reforms affecting the liability exposure of physicians and drug and medical equipment manufacturers; however, opposition in the United States Senate prevented the enactment of this federal legislation.<sup>7</sup> Additional proposals made in 2005 sought to cap non-economic damages in medical malpractice actions, restrict the availability of punitive damages, restrict the statute of limitations for medical malpractice suits, and limit contingency fees collected by plaintiffs' attorneys in jury awards.<sup>7</sup> Again, this federal legislation failed to get out of Congress.

With efforts at federal tort reform legislation stalled, it is impossible to determine the effect federally implicated restrictions on medical malpractice liability would have on overall national healthcare costs. It is, therefore, critical

to consider whether medical malpractice tort reform at the state level has achieved the movement's stated goal: to reduce healthcare expenditures.

### Rising Premiums and Defensive Medicine

One of the greatest criticisms leveled at the medical malpractice tort system is that the defense of medical malpractice actions needlessly increases the costs of healthcare in the United States. Advocates of reform have long argued that the ever present threat of litigation forces healthcare providers to charge higher rates to offset the costs of rising malpractice insurance premiums, as well as promotes the practice of defensive medicine (the overuse of diagnostic testing and health services in order to minimize a physician's liability exposure). The contention that medical malpractice tort reform is the soundest means by which to stabilize malpractice insurance premiums and generally lower healthcare costs remains a controversial stance among both the legal and medical communities.

Much of the research conducted on the medical liability system suggests that costs surrounding medical malpractice litigation are a small fraction of overall healthcare spending in the United States. The overall cost of defending medical malpractice claims and compensating victims of medical malpractice in 2007 was estimated at \$7.1 billion, a mere 0.3% of the annual healthcare costs for that year.<sup>8</sup> Even when these figures account for the use of defensive medicine, as well as the expense of defending medical malpractice claims and compensating plaintiffs, the total costs associated with medical malpractice litigation are modest relative to overall healthcare spending. In 2008, the annual medical malpractice tort system costs, which included the costs of

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defensive medicine, were estimated to be \$55.6 billion, or 2.4% of the total health-care costs for the year.<sup>9</sup>

So why have rising healthcare costs been routinely evoked to demand the adoption of medical malpractice tort reform? The answer may lie with the perception that the practice of defensive medicine, as well as increased malpractice insurance premiums, are the direct result of increased litigation. Empirical evidence has shown, however, that malpractice insurance premiums are much less affected by medical malpractice litigation than commonly believed and that the costs of defensive medicine are often exaggerated.

### **The Rising Costs of “Doing Business”**

Advocates of medical malpractice tort reform point to insurance premium increases as evidence that medical malpractice claims drive the rising cost of healthcare. While there is no question that rising insurance premiums place an additional financial burden on physicians seeking malpractice coverage, premium rates are not based solely, or even in large part, upon medical malpractice claim or settlement payouts.<sup>7</sup> This is because most insurance companies' profits are not generated from the premiums they receive from their insured physicians.<sup>7</sup> Most malpractice insurance carriers face a delay between the time they receive premium payments from their insured physicians and the time they have to pay out medical malpractice claims. Due to this delay, many insurance companies invest the premiums they receive in bonds or other financial securities.<sup>7</sup> It is the return on these investments, not malpractice insurance premiums, that generate an insurance company's profits. Therefore, even if the number of malpractice claim payouts an insurance company makes is stable, the company may still be forced to raise premiums if their investments fail to yield adequate returns.<sup>7</sup>

In addition, premiums do not only represent a malpractice insurer's indemnification costs. Malpractice insurance premiums represent a variety of costs

*[Research] indicates that rising malpractice premiums are not tied to an influx of medical malpractice filings.*

assumed by an insurance company and passed on to their insured physicians. These costs may include a company's estimated indemnification costs, defense costs, operating fees, reinsurance costs, and profit or surplus building.<sup>9</sup> Tort reform opponents argue that even with legislature in place to limit jury awards or settlements in medical malpractice actions, rising insurance premiums would still be a financial hardship faced by the medical community, as the underwriting cycle and malpractice premiums are affected by much more than the threat of medical malpractice litigation.

Research performed in states that have enacted tort reform in the context of medical malpractice litigation also indicates that rising malpractice premiums are not tied to an influx of medical malpractice filings. In 1986, Florida enacted medical malpractice tort reforms; however, despite this legislation, malpractice premiums in the state have increased on average from 30% to 50% since 2000.<sup>7</sup> In 2003, Florida, after a second bout of tort reform measures, experienced an increase in insurance premium rates by as much as 45%.<sup>7</sup>

This evidence challenging the connection between tort reform and malpractice premiums is not just limited to the state of Florida. In 1995, Texas passed legislation limiting the amount of punitive damages available in jury awards.<sup>7</sup> Despite this measure, insurance premiums in the state continued to increase. These statistics cast doubts on the claim that tort reform is the most effective way to manage skyrocketing malpractice premiums rates and reduce overall healthcare costs.

### **The Real (Or Perceived) Costs of Defensive Medicine**

Tort reform proponents also typically cite the rise of defensive medicine as the other major negative residual effect of

medical malpractice litigation. Those favoring reform argue that litigation weary physicians order unnecessary and exhaustive tests on their patients, which in turn, drives up the cost of healthcare. Evidence appears to suggest, however, that both the impact and the prevalence of defensive medicine has been overstated.

Much of the support for the proposition that the practice of defensive medicine is the costly offshoot of medical malpractice litigation comes from a controversial 1996 study. In it, the costs of care for hospitalized elderly Medicare patients with heart disease in states both with and without medical malpractice tort reforms were analyzed.<sup>7</sup> Based on the findings, it was concluded that tort reforms resulted in hospital costs savings of 5% to 9%.<sup>7</sup> These findings were then applied to the entire healthcare system, hypothesizing that tort reform could lead to a reduction of over \$50 billion annually in healthcare expenditures.<sup>7</sup> Tort reform supporters used this study to buttress their claim that without the ever looming fear of litigation, physicians are freer to order fewer diagnostic tests which, in fact, reduces their medical spending and lowers overall healthcare costs.

While these findings became vindication for advocates of medical malpractice tort reform, subsequent research has criticized many of the hypotheses contained within the study. In 2003, the United States Government Accountability Office (GAO) issued a statement questioning the applicability of the findings to the entire healthcare system.<sup>7</sup> The GAOs report argued that due to the limited scope of the study and its examination of patient behavior in the specific clinical situation of elderly patients with cardiac issues, “the study results cannot be generalized to estimate the extent and cost of defensive medicine practices across the health care system.”<sup>10</sup> The report also concluded

that while members of the medical community admitted that defensive medicine exists to some degree, the instance of its actual practice is extremely difficult to measure.<sup>10</sup> This difficulty in quantifying the prevalence of defensive medicine in turn makes it more onerous to hypothesize any sort of costs savings for its reduction in practice.

More recent studies also reflect the tenuous connection between tort reform and its impact on the practice of defensive medicine. A 2004 study performed by the Congressional Budget Office (CBO) applied the methods employed by the 1996 study to a wider set of medical ailments.<sup>7</sup> It was concluded by the agency that there is no evidence linking restrictions on tort liability to reduced medical spending. A second analysis of the link between defensive medicine and healthcare costs performed by the CBO additionally confirmed no significant statistical difference in medical spending between states with and without medical malpractice tort limits.<sup>7</sup>

One of the major reasons that medical malpractice tort reform has not definitively been found to effectively manage the practice of defensive medicine is because defensive medicine has been shown to be motivated by more than just a fear of litigation on physicians' parts. Some behavior that could be characterized as defensive medicine may be motivated more by the increased income additional diagnostic testing can generate for physicians, or the benefits a patient receives from additional testing, and less by fears of liability exposure.<sup>7</sup> Additionally, it is unclear exactly how strongly concerns over medical malpractice liability actually affect a physician's treatment decisions.

Medical malpractice tort reform may also do little to curtail the practice of defensive medicine because empirical evidence seems to suggest that physicians typically have high levels of malpractice concern, in states both with and without tort reform. Research has shown that physicians in states with high malpractice risks have reported nearly the same level of concern over liability exposure

as physicians in states with the low malpractice risks due to heightened medical malpractice tort reform.<sup>11</sup>

### Risk Management and Compliance Programs

No matter the level of success in instituting tort reform, medical malpractice litigation will never disappear entirely. As such, every radiology department must focus its efforts at reducing risk by establishing a comprehensive risk management and compliance program to improve the safety and quality of the care that its radiologists and technologists provide. A key component of any program is the continuous assessment of the department's quality management processes with the focus on implementing changes where necessary to ensure patient safety, to ensure the provision of high quality and accurate medical care, and to allow the imaging department to achieve and maintain a competitive edge.

The structure of any risk management and/or quality and performance improvement program will certainly vary depending on the size of the radiology department or group. However, it is widely accepted that with varying degrees of focus, any risk management program must include implementing processes to monitor performance; analyzing and depicting data; implementing change and meeting regulatory requirements in the areas of patient safety, process implementation and improvement, quality and compassionate customer service, and professional staff education and assessment.<sup>12</sup>

Importantly, although *voluntarily* implementing these quality related programs in order to reduce risk to avoid allegations of medical malpractice is necessary

for success, many of these processes are required by the very organizations that regulate the radiology profession—thus making such implementation of these programs *mandatory*.

Every radiology department or group must focus considerable effort and invest time in the development and maintenance of a comprehensive risk management and compliance program to improve patient safety and quality of care not only for the welfare of patients and to maintain a competitive edge, but to reduce the ever present risk of and exposure related to medical malpractice.

### Conclusion

Whether a champion of comprehensive tort reform or a critic, tort reform is here to stay. The question that remains is what form tort reform will take in the future. With recent federal healthcare reform creating sweeping changes to the American healthcare landscape, there is a question of how state legislatures will respond to an environment where healthcare services are more widely available to a vast number of Americans. Will the greater accessibility to healthcare create an onslaught of medical malpractice litigation? Will additional tort reforms be adopted prophylactically to defend against such a possibility? At this point in time, it is too soon to discern exactly how states and lobbyists alike will attempt to address this conceivable increase in medical malpractice litigation across a variety of physician practice areas. However, no matter what changes federal healthcare reform brings to the area of medical malpractice litigation, it is prudent to employ a broad gauge risk management and compliance program that offers future protection from needless litigation. ☸

*Medical malpractice litigation will never disappear entirely. As such, every radiology department must focus its efforts at reducing risk by establishing a comprehensive risk management and compliance program.*

## References

- <sup>1</sup>Hubbard FP. The Nature and Impact of the “Tort Reform” Movement. *Hofstra Law Review*. 2006;35:438,439.
- <sup>2</sup>Black’s Law Dictionary. Second Pocket ed. 2001.
- <sup>3</sup>American Tort Reform Association. Available at: <http://atra.org/issues/index.php?issue=7338>. Accessed December 6, 2010.
- <sup>4</sup>Shepherd JM. Tort Reforms’ Winners and Losers: The Competing Effects of Care and Activity Levels. *UCLA Law Review*. 2008;55(4): 905,920.
- <sup>5</sup>American Tort Reform Association. Available at: <http://www.atra.org/states/MI>. Accessed December 6, 2010.
- <sup>6</sup>State of Michigan Office of Financial and Insurance Regulation. “Evaluation of the Michigan Medical Professional Liability Insurance Market.” October 2009.
- <sup>7</sup>Kysar DA, McGarity TO, Sokol K. Medical Malpractice Myths and Realities: Why an Insurance Crisis is Not a Lawsuit Crisis. *Loyola of Los Angeles Law Review*. 2006; 39(2):785,789.
- <sup>8</sup>National Association of Insurance Commissioners. “Countrywide Summary of Medical Malpractice Insurance Calendar Years 1991–2008.” 2009.
- <sup>9</sup>Mello M, Chandra A, Gawande AA, Studdert DM. National Costs of the Medical Liability System. *Health Affairs*. September 2010; 29(9):1569–1577.
- <sup>10</sup>Government Accountability Office. “Medical Malpractice: Implications of Rising Premiums on Access to Health Care.” August 29, 2003.
- <sup>11</sup>Carrier ER, Reschovsky JD, Mello MM, Mayrell RC, Katz D. “Physicians’ Fears of Malpractice Lawsuits Are Not Assuaged by Tort Reforms.” *Health Affairs*. September 2010;29(9):1585–1592.
- <sup>12</sup>Kruskal JB, Anderson S, Yam CS, Sosna J. Strategies for establishing a comprehensive quality and performance improvement program in a radiology department. *Radiographics*. 2009;29:315–330.
- <sup>13</sup>American College of Radiology. Available at: [http://www.acr.org/SecondaryMainMenuCategories/quality\\_safety](http://www.acr.org/SecondaryMainMenuCategories/quality_safety). Accessed January 10, 2011.
- <sup>14</sup>American Board of Radiology. Available at: [http://www.theabr.org/moc/moc\\_landing.html](http://www.theabr.org/moc/moc_landing.html). Accessed January 10, 2011.

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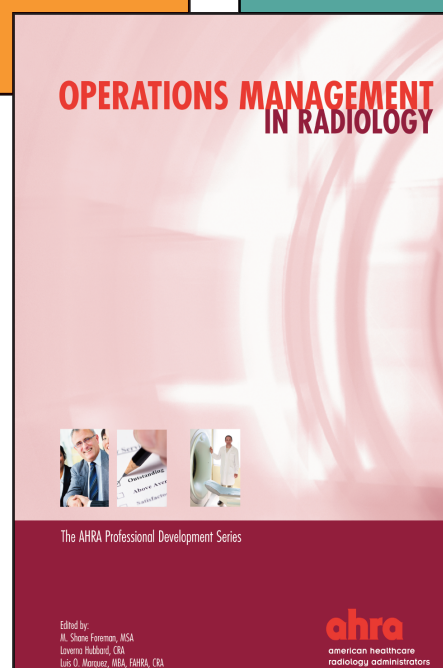
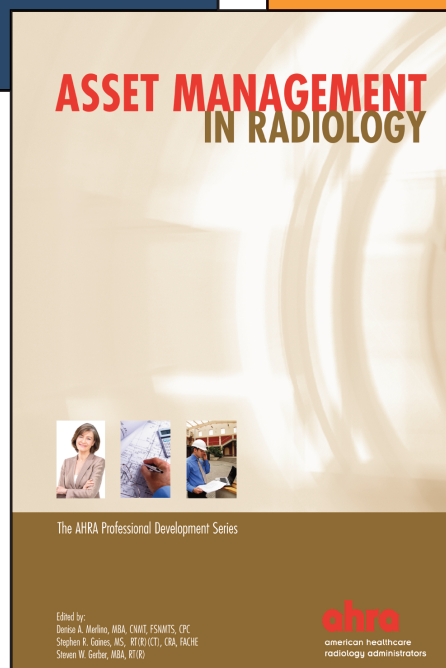
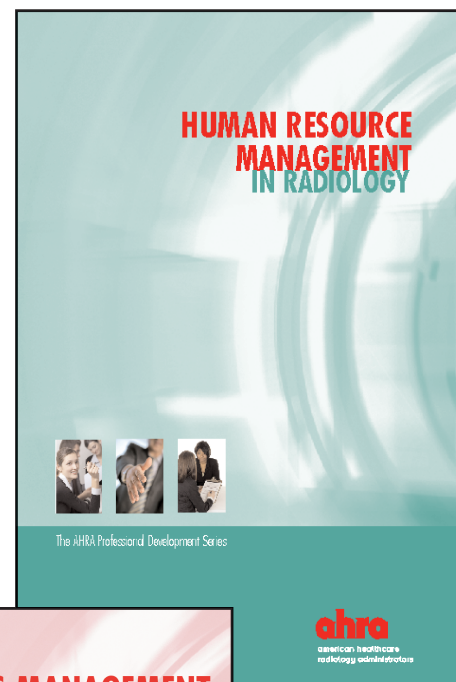
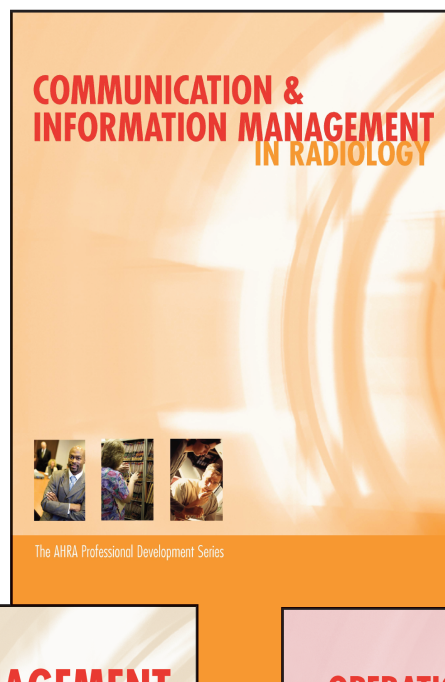
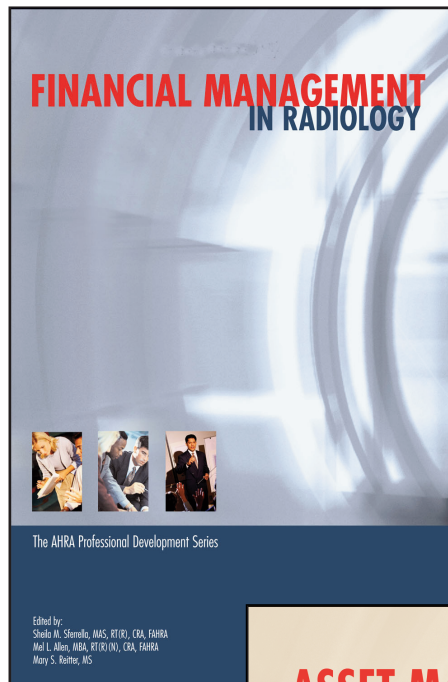
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