REPORT OF THE
JOINT COMMISSION ON HEALTH CARE

STUDY OF DEFENSIVE MEDICAL PRACTICES AND PROCEDURES PURSUANT TO SJR 159 OF 1994

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 24

COMMONWEALTH OF VIRGINIA
RICHMOND
1995

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Preface

Senate Joint Resolution (SJR) 159 of the 1994 Session requested the Joint Commission on Health Care to study the impact of defensive medicine and negligent medical care.

Defensive medicine is practiced by physicians and other providers to avoid the potential liability of a malpractice lawsuit. Defensive medicine typically occurs in two ways. *Positive* defensive medicine occurs when physicians order additional tests or procedures because of perceived malpractice risk. *Negative* defensive medicine occurs when physicians avoid high risk procedures or restrict their practices to low risk patients.

Numerous studies have attempted to estimate the cost of defensive medicine. Estimates of the national cost of defensive medicine range from $14 billion to $81 billion annually. The Congressional Office of Technology Assessment recently concluded that while defensive medicine certainly exists, there is no acceptable method for measuring its full extent and cost. Whatever amount of true defensive medicine is occurring, there is a cost associated with it which contributes to the problem of affordable health care. As such, efforts to reduce the amount of defensive medicine without compromising the ability of the malpractice system to detect and deter negligent medical practice are necessary.

Virginia is considered to have a conservative malpractice environment due largely to a $1 million cap on total damages. While conventional tort reforms can lower malpractice insurance premiums, there is little evidence that these reforms will significantly reduce defensive medicine. Research findings suggest that medical practice guidelines hold the most promise for reducing defensive medicine. In addition, refinements to Virginia's Malpractice Review Panel process may improve the effectiveness of this process in resolving disputes.

The study offers two policy options for consideration. Option I would maintain the status quo. Option II would establish a task force comprised of medical, legal and risk management experts to review the concept of practice guidelines as a means of reducing defensive medicine, and recommend other strategies for improvement such as improving the medical malpractice review panel process.

Our review process on this topic included an initial staff briefing which you will find in the body of this report followed by a public comment period during which time interested parties forwarded written comments to us on the report. In many cases, the public comments, which are provided at the end of this report, provided additional insight into the various topics covered in this study.

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Executive Director

December 30, 1994

TABLE OF CONTENTS

Authority for Study

Senate Joint Resolution (SJR) 159, which was passed by the 1994 Session of the General Assembly, directed the Joint Commission on Health Care to study defensive medical practices and procedures. The resolution also directed the University of Virginia Medical Center, the Medical College of Virginia, and the Medical College of Hampton Roads to provide technical assistance for the study.

SJR 159 specifically directed the Joint Commission to examine the effect of defensive medical care and negligent medical care upon: (i) health care costs; ii) health care providers' perceptions of the risk of medical malpractice and its impact upon their behavior in determining which health care services will be rendered to a particular patient; (iii) the effectiveness of managed care systems in reducing or eliminating prescribed services that are determined not to be cost effective or medically necessary; and (iv) deterrents such as the medical malpractice system and risk management practices by health care providers or managed care organizations.

Background

Medical Malpractice System Seeks to Reduce Negligence and Compensate Those Who Are Injured Due to Negligence

The most important goal of the medical malpractice system is to reduce the rate of medical injury due to negligence. A second goal is to compensate fairly those patients who experience a medical injury. (Physicians Payment Review Commission, 1994). However, physicians and other health care providers argue that the medical malpractice system causes them to routinely practice defensive medicine in an effort to avoid the potential liability of a malpractice lawsuit.

The Cost of Medical Negligence Is Generally Underestimated

It does not appear that there has been a comprehensive, published study of the costs of medical negligence. Focusing on one component of the economic cost of medical negligence, a recent study by the National Insurance Consumer Organization found that a total of $2.7 billion was paid out in medical malpractice claims in 1991. However, this figure, by itself, is not an adequate indicator of medical negligence costs because there is no way of knowing the amount of true or actual damages suffered by the plaintiffs who collected awards. (West, 1994).

Moreover, there is evidence that only a fraction of those who suffer a negligent injury ever file a malpractice claim. For example, in a 1976 study by the California Medical Association, it was estimated that slightly less than one percent of California hospital admissions involved compensable events caused by negligence. A subsequent analysis of this data revealed that fewer than one in ten of these negligently injured patients brought a suit.

More recently, a Harvard Medical Practice Study conducted in 1990 found that between 1975 and 1989, 3.7 percent of hospitalizations in the state of New York resulted in adverse events, 27 percent of which were due to negligence. The majority of the adverse events resulted in disability, but 14 percent of the patients died, at least in part because of the negligent event. The researchers further concluded that only about one out of eight of those who suffered negligent injuries ever filed malpractice claims. (Brennan, 1991).

There are Two Types of Defensive Medicine

Despite the fact that research has shown a small percentage of persons who experience a negligent medical injury actually file a malpractice complaint, physicians have practiced defensive medicine as a precaution against malpractice liability.

Generally speaking, there are two types of defensive medicine. *Positive defensive medicine* includes tasks or procedures performed because of perceived malpractice risk, such as additional diagnostic tests and additional specialist referrals. *Negative defensive medicine* includes tasks or procedures not performed because of perceived medical malpractice risk, such as a physician restricting his/her practice to low-risk patients or ceasing to perform certain high-risk procedures.

Over the past two decades there has been growing concern about the cost of defensive medicine as well as the effectiveness of the medical malpractice system in deterring negligent medical practices. This report examines the extent to which defensive medicine may be practiced; attempts to estimate the potential costs of defensive medicine; and presents several approaches recommended by various groups for reducing the negative effects of defensive medicine without compromising the detection and deterrence of negligent practice.

The Causes and Extent of Defensive Medicine

Physicians Report That Uncertainty in The Medical Malpractice Environment Breeds Defensive Medicine.

Over the past decade there has been a great deal of debate over the extent to which the malpractice system actually achieves its goals. Critics of the system identify the following as major shortcomings:

* failure to detect the great majority of negligent injuries;

* failure to compensate deserving victims in a timely and consistent manner;

* seeming haphazardness in assigning liability to medical management;

* seeming haphazardness in determining damages;

* high operating expenses, such that too little of the liability dollar returns to the injured patient as compensation; and

* encouragement of acrimonious disputes. (Tancredi and Bovbjerg, 1992).

A number of studies point out that the system fails to detect the great majority of medical injuries because most injuries do not result in claims, and the claims databases that do exist are fragmented. In the absence of comprehensive data about the causes and prevention of medical injury, malpractice cases can be long-drawn-out affairs which are highly dependent on battles between expert witnesses. Consequently, judicial rulings on what is or is not medical injury are sometimes inconsistent. At the same time, compensation for negligent injuries often is not consistent, timely, or proportionate to losses. Awards for non economic damages, in particular, can be highly subjective and variable.

This variability in the system creates uncertainty in the minds of providers about what is or is not negligent practice, as well as uncertainty about the amount of economic damages they and their insurers might have to pay if negligence is proven. Consequently, in some cases there is an incentive to practice various forms of defensive medicine.

Defensive Medicine Studies Reach Varying Conclusions

Physicians Change Practice Patterns: In studies conducted in the 1980s, a significant proportion of physicians reported implementing changes in their practice patterns due to the threat of a malpractice suit. A 1983 AMA survey of

physician responses to increases in professional liability insurance premiums showed that:

* 57 percent of physicians surveyed maintained more detailed records in response to premium increases;

* 45 percent referred more cases to other physicians; 41 percent prescribed additional diagnostic tests;

* 36 percent spent more time with their patients;

* 35 percent declined to accept certain types of cases;

* 31 percent increased their fees; and

* 27 percent prescribed additional diagnostic tests.

(Zuckerman, 1984).

A 1987 survey of Maryland physicians in three specialties (internal medicine, family practice, and OB-GYN) showed generally similar results. (Wesismann, et. al., 1989).

Malpractice System Reduces Physicians' Tolerance for Risk: In a study that has just been released, the U.S. Congress' Office of Technology Assessment (OTA) concluded that "the malpractice system pushes physicians' tolerance for risk and uncertainty to their lowest levels, leading physicians to practice defensive medicine. In many cases defensive medicine may benefit certain individual patients, but at a very high cost on a population basis."

The OTA concluded that "less than 8 percent of diagnostic tests are performed by physicians because of *conscious* concern about the risk of being sued, but the actual amount is impossible to know. And, this estimate does not consider the many practices that were originally motivated by fear of liability but have since become so ingrained in medical practice that they are no longer consciously considered defensive."

Not All Defensive Medicine is Bad

In interpreting the data on defensive medicine practices, it is important to recognize that not all defensive medicine is "bad medicine." For example, spending more time with patients can be a positive activity in most cases. Furthermore, as will be discussed in the following sections, there are other

incentives besides fear of liability which might encourage providers to deliver more services.

Some Question the Amount of Defensive Medicine

Other researchers (such as Black, 1990) have critiqued the results of some studies on the basis of methodological weaknesses in the surveys. Black concluded that the methodological weaknesses of some physician self-reported surveys, such as the Zuckerman and Weismann surveys, identify "possible" adverse effects of fear of litigation, but do not provide reliable measures of the impact of these effects. The study recently released by the OTA also questioned the reliability of such survey methodologies.

In its 1992 analysis of the economic implications of rising health care costs, the Congressional Budget Office stated that:

> *[M]uch of the care that is commonly dubbed "defensive medicine" would probably still be provided for reasons other than concerns about malpractice. Physicians have always sought to provide patients with the best possible care at the lowest risks and would continue to do so even without the threat of lawsuits. Because much of this "defensive care" helps to reduce the uncertainty of diagnoses, it seems unlikely that physicians would change their practice patterns dramatically in response to malpractice reform.*

The Association of Trial Lawyers of America argues that much of the care that the medical community labels as defensive medicine is actually the result of self-referrals (i.e. physicians referring patients to laboratories or other facilities in which the physician has a financial interest). While Virginia passed a law in 1993 prohibiting such practices in the Commonwealth, this remains an issue of contention in other areas of the country.

Others point to the fee-for-service reimbursement system in the health insurance industry as a contributing factor in defensive medicine. While managed care systems (e.g. HMOs) which capitate their providers are increasing, fee-for-service is still the predominant reimbursement system. In the fee-for-service environment, physicians not only can practice defensive medicine without incurring costs, it can also be profitable for them. Hence, it often is argued that at least a portion of what is referred to as defensive medicine is actually the result of an open-ended reimbursement system and not concern over litigation.

While the Amount of Defensive Medicine Is Uncertain, It Does Exist

While various studies have reached different conclusions about the amount of defensive medicine that is practiced by physicians and other health care providers, and while the percentages associated with each defensive medicine practice may be unreliable, it clear that these practices are in fact implemented by a number of physicians. This conclusion is indirectly supported by various clinical studies which strongly suggest that defensive medicine is practiced by American clinicians particularly in such areas as anesthesia, emergency care, and obstetrics.(Lewin-VHI, 1993).

Impact of Defensive Medicine and Negligent Medical Care Upon Health Care Costs

The Cost of Defensive Medicine Is Significant But Difficult To Quantify

Various researchers' estimates of the national cost of positive defensive medicine have ranged from $3 billion to $6 billion in 1975, from $15 billion to $40 billion in 1983, to $25 billion in 1991, and from $14 billion to $81 billion in 1993. (West, 1994). A study completed by Lewin-VHI in 1993 estimated the national cost of defensive medicine to be $26 billion in 1992, and projected this cost to increase to $28 billion in 1993, and to $30 billion in 1994.

Generally speaking, the available estimates place the cost of defensive medicine somewhere between one percent and 12 percent of national health expenditures. Given Virginia's annual health care expenditures of roughly $16 billion in 1994, and assuming that defensive medicine practices in Virginia are about the same as those for the rest of the nation, the methods used by these researchers would estimate the cost of defensive medicine in Virginia to be anywhere from $160 million to $1.9 billion.

As seen in these widely varying estimates, there is no accepted methodology for measuring the cost of defensive medicine. Estimates of the cost of positive defensive medicine vary because of differing assumptions about the extent to which fear of a malpractice suit actually drives excess utilization of services. Theoretically, positive defensive medicine would include changes in medical practice implemented for the sole purpose of avoiding malpractice claims.

However, as a practical matter, it is difficult to isolate defensive medical practices from other incentives for providers to over-use services. Such incentives may include (i) patient preferences to pursue highly aggressive treatment; (ii) requirements of peer review organizations and hospitals;

(iii) financial incentives to provide more services; (iv) premature application of new medical technologies; and (v) lags in response to new clinical information. This complex network of incentives should be kept in mind when interpreting estimates of the impact of positive defensive medicine. (Lewin-VHI, 1993).

Congress' Office of Technology Assessment Concludes that Accurate Estimates of Defensive Medicine are Impossible

In its recently completed study of defensive medicine, the OTA reviewed the methodologies and results of previous studies. Based on its analysis, the OTA concluded that all estimates of the cost of defensive medicine known to it "are unreliable and may either grossly under- or over-estimate the extent or costs of defensive medicine." The OTA further concluded that "[T]here is simply *no* acceptable method for measuring the full extent and national cost of defensive medicine."

Trial Lawyers Argue that Medical Malpractice Insurance Practices Unnecessarily Increase Health Care Costs

The Association of Trial Lawyers of America has identified certain malpractice insurance practices rather than defensive medicine as a driving force behind the increasing cost of health care. The trial lawyers point to statistics released by the National Association of Insurance Commissioners (NAIC) which indicated that malpractice insurers' profit was 29.2% of the direct premiums paid in 1991. According to the NAIC statistics, medical malpractice as a line of insurance has the highest profit as a percentage of premiums earned (29.2%), with the next highest percentage being 15.6% realized by other liability lines.

Impact of Managed Care and Risk Management Techniques on Defensive Medicine

The Impact of Managed Care Systems on Defensive Medicine Has Not Been Widely Studied

While there have been numerous studies on the effectiveness of managed care systems in reducing health care costs, there has been little research on the impact of managed care in reducing defensive medicine. Managed care systems can refer to specific activities such as utilization review and pre-certification of inpatient hospital stays. Managed care is used also in a much broader context to describe certain health care delivery systems such as Health Maintenance Organizations (HMOs).

Various research has shown that utilization review and pre-certification programs have reduced the number of unnecessary services. A number of studies have been conducted regarding the effectiveness of managed care delivery systems such as HMOs in reducing health costs. As with much of the research in the health care and health insurance industries, these studies have reached different conclusions. However, a recently completed study by Lewin-VHI concludes that network models of managed care can and do produce substantially more savings than they have been credited for in the past.

While the literature contains a great deal of research on the cost-effectiveness of managed care systems, there is little if any research on the impact of managed care on defensive medicine. To the degree that managed care programs are effective in eliminating services which are not medically necessary, it is reasonable to assume that managed care also would reduce the amount of defensive medicine being practiced. As previously noted, under a capitated payment arrangement, physicians do not have the same financial incentives to order additional tests and procedures as in a fee-for-service environment. Thus, some argue that managed care provides a "balance" to physicians' tendency to practice defensive medicine.

On the other hand, some physicians have expressed a concern that managed care systems further complicate the issue of what is an "appropriate level of care." These physicians indicate that concern over potential malpractice litigation (i.e. defensive medicine) and the pressure from managed care systems to provide only necessary care "squeeze" practitioners from two different directions. As a result, physicians often feel that a certain level of care provided to satisfy one demand often is in conflict with the other.

Risk Management Strategies Are Practiced, But Their Deterrent Effect Has Not Been Widely Studied in the Context of Medical Malpractice.

Risk management practices include utilization review and peer review programs performed, not by insurers, but by hospital medical staff and administrators. Other risk management techniques include basic instruction for physicians to improve communication skills with patients, and to document more thoroughly their patients' medical records. While these and other risk management practices attempt to reduce the likelihood of adverse medical situations and potential liability, there is little published research that has evaluated the impact of these practices on reducing medical malpractice.

In reviewing the relationship between risk management practices and defensive medicine, it is clear that defensive medicine is, itself, a risk management technique. The key issue appears to be that if physicians can

maximize other risk management techniques, the less they will need to rely on defensive medicine. However, there appear to be no comprehensive studies which have analyzed this issue.

Approaches to Reducing Defensive Medicine

To the extent that it exists, defensive medicine is a reaction to uncertainty about key components of the malpractice system, including judgments about what is and is not negligent practice, the risk of being sued for negligent practice, and the associated risk of paying substantial economic damages. As such, the most frequently cited options for reducing undesirable defensive medicine practices are focused around reforming the malpractice system and reducing the uncertainty of the "appropriate" level of care.

When considering changes to the malpractice system, it is important not to lose sight of the central goal of the malpractice system, which is to detect and deter negligent medical practice. Therefore, the objective of malpractice reform as it relates to defensive medicine should be to reduce the uncertainty which breads defensive medicine while maintaining, and, if possible, strengthening the system's ability to detect and deter negligent practice.

In this context, there are a number of potential malpractice system reforms. However, there appear to be five approaches which receive the most consideration. One option is to implement *conventional tort reform,* primarily in the hope of reducing the amount and uncertainty of malpractice damages. A second option is to use *medical practice guidelines* to reduce uncertainty about what constitutes negligent practice. A third option is to streamline the system for adjudicating cases through an *alternative dispute resolution* system. A fourth option is to implement *no-fault malpractice insurance* for certain types of malpractice. A fifth option for streamlining the current system is to adjudicate cases according to widely recognized negligent practices called *accelerated compensation events.*

Conventional Tort Reforms

Conventional Tort Reform Can Include a Number of Different Actions

Tort reforms are changes in the legal rules governing malpractice lawsuits. Over the past 20 years, almost every state has passed some type of medical malpractice tort reform. The goal of most of these state-level reforms has been to reduce malpractice insurance premiums by limiting the number of claims, the costs of resolving a claim, or the damages that can be paid. (Office of Technology Assessment, 1994).

The traditional reforms most widely adopted include:

* limits on non economic damages;
* limits on attorneys' contingency fees;
* modification of the collateral source rule;
* restrictions on application of joint and several liability;
* periodic payments on large awards; and
* reductions in statutes of limitation.

These reforms have been discussed in the literature as having the potential for controlling malpractice insurance premiums, and perhaps limiting defensive medicine because they are aimed at reducing the economic uncertainty in the system.

Virginia's Cap on Total Malpractice Awards and its Statute of Limitation Have Resulted in a Relatively Favorable Malpractice Environment

Virginia has not limited attorneys' fees, modified its collateral source rule, or restricted its application of joint and several liability. However, Virginia has placed a cap on the total amount that can be awarded in a malpractice case, and has a relatively short statute of limitations.

Cap on Total Malpractice Award: According to information published by Congress' Office of Technology Assessment (OTA) in 1993, Virginia is one of only eight states that has placed a limit on the total amount that can be awarded in a malpractice suit. As provided in §8.01-581.15 of the Code, Virginia's limit on malpractice awards is $1 million. The limits on total awards in the other seven states range from $500,000 in Louisiana to $1,250,000 in Nebraska. Thirteen states have placed limits on non economic awards (pain and suffering). Twenty-nine states have no statutory limits on malpractice awards.

Statute of Limitation: Long statutes of limitation on malpractice cases create a high degree of uncertainty in the malpractice system. At least fifteen states have reduced their statutes of limitations to five years or less. In Virginia, except for a few specific situations which are identified in the Code of Virginia (e.g. injury to an infant, or a foreign object being left in a surgery patient's body), the statute of limitations is two years. While some other states' statute of limitations is two or three years, in many of these states there are more exceptions to the general rule than exist in Virginia. Relative to other states, Virginia is considered to have a conservative statute of limitations (i.e. favorable for the defendant).

Some Tort Reforms May Reduce Malpractice Insurance Premiums, But Impact on Defensive Medicine is Unclear

One of the more comprehensive, available studies regarding the effects of tort reforms on the medical malpractice system was conducted by Zuckerman, Bovbjerg, and Sloan in 1990. These researchers examined state-level data on physician malpractice premiums, claims, and awards provided by insurance companies for the years 1974 to 1986, to evaluate the effectiveness of various tort reforms that have been legislated during the 1970s and 1980s. The authors found that the only reforms which appeared to significantly lower malpractice premiums were limits on the amount of physician liability and limits on the amount of time a plaintiff had to initiate a claim. However, the authors did not examine the impact of tort reforms on defensive medicine in particular.

A study just completed by the U.S. Congress' Office of Technology Assessment (OTA) corroborated the findings of Zuckerman, et. al., and concluded that some conventional tort reforms effectively reduce malpractice insurance premiums. The OTA also concluded that evidence of the effect of conventional tort reform on defensive medicine is weak. The OTA stated that:

> *"[C]onventional tort reforms that tinker with the existing process for resolving malpractice claims while retaining the personal liability of the physician are more likely to be successful in limiting the direct costs of malpractice claim frequency, payment per paid claim, and insurance premiums than in altering physician behavior."*

Tort Reforms are Opposed by Some

The Association of Trial Lawyers of America (ATLA) published a document in February, 1994, in which it stated its opposition to tort reforms. The ATLA argues that these reforms would: "(1) make it harder for injured medical consumers to bring lawsuits, (2) make it tougher for consumers to prevail when they do, and (3) arbitrarily limit the amount an injured consumer can recover, even after a judge or jury decides that the consumer is entitled to compensation."

Medical Practice Guidelines

Medical Practice Guidelines Seek to Define an Appropriate Level of Care

A medical practice guideline may be defined as "a standardized specification for care developed by a formal process that incorporates the best scientific evidence of effectiveness with expert opinion." Practice guidelines should be specific for a condition or procedure, and they should be based on

clinical research literature and the collective judgments of expert physicians. (West, 1994).

Over the last several years, increasing attention has been focused on the potential of medical practice guidelines for improving quality and reducing undesirable variation in the delivery of care. At the broadest level, the federal government is investing in such ventures as the Agency for Health Care Policy Research in an effort to develop medical practice guidelines for the purpose of improving quality and reducing health care costs in general. Numerous state and private sector organizations are investing in practice guideline research for the same reasons.

Practice Guidelines May Contribute to a More Effective Malpractice System

The intent of medical practice guidelines is to offer physicians guidance about what the Courts will accept as a standard of care. As such, the use of medical practice guidelines has the potential to improve the system and reduce the costs of defensive medicine. This potential may be realized in two general ways. Consistent with the broader goals outlined above, medical practice guidelines could reduce the frequency of negligent medical practice, thereby reducing the demand for malpractice awards. In addition, medical practice guidelines also could elucidate the standard of care and make malpractice litigation more efficient.

One potential contribution of medical practice guidelines could be to provide additional, objective evidence in malpractice litigation. In this instance, medical practice guidelines, in and of themselves, would not necessarily represent the standard of care. However, medical practice guidelines could provide an objective benchmark against which to judge the validity of expert testimony for the claimant and the defense. The few cases in which medical practice guidelines have been used in court generally fall into this category. At least one author feels that the use of practice guidelines in this manner could shake "charlatan" expert witnesses out of the system. (West, 1994).

Another possible contribution of medical practice guidelines could be a reduction in the number of claims brought. Practice guidelines could help to educate attorneys regarding the standard of care at issue in a case, and in some cases discourage the attorney from bringing a case to trial if it appears that the provider's actions were generally within the specifications of the guideline.

Four States Have Adopted Medical Practice Guidelines

Florida, Maine, Minnesota and Vermont are in varying stages of implementing and utilizing practice guidelines. Of these states, Maine has made the most progress in implementing the guidelines.

Maine has developed a program to implement practice guidelines in four different specialized areas of practice, including anesthesiology, emergency medicine, obstetrics and gynecology, and radiology. A total of 22 guidelines have been developed by Medical Specialty Advisory Committees in each area of specialization. In Maine, these guidelines can be used as an affirmative defense. An affirmative defense is a response by the defendant in a legal suit which, if true, constitutes a complete defense against the plaintiff's complaint. Another key element of Maine's practice guidelines program is that plaintiffs are not permitted to introduce guidelines developed under the program as evidence against the defendant.

Although it is too early to tell the impact of this program on malpractice costs and defensive medicine, recent reviews of the program development process by the GAO and others have been positive. The Office of Technology Assessment concluded that while there is some early evidence that Maine's practice guidelines have substantially reduced cervical spine x-rays in emergency rooms, it is too soon to tell the full impact of this program on reducing defensive medicine.

Medical Practice Guidelines Have Limitations

On a cautionary note, medical practice guidelines have limitations. Because much of medical practice is subject to uncertainty, opportunities may be limited for developing guidelines explicit enough to be truly protective and to reduce defensive medicine. (Office of Technology Assessment, 1994). Another potential limitation of practice guidelines is that the Courts may have difficulty discerning the authority represented by a given guideline. For instance, medical negligence is typically defined in terms of a breech of minimum standards of care. If the purpose of a guideline is not clearly understood, a practice guideline for optimal care could be construed a guideline for minimal care, and be used against a defendant. Also, in cases where a guideline was not followed for legitimate reasons, the guideline may be given more authority than it was intended to provide, and become a de facto standard of care rather than an additional piece of evidence.

Guidelines Are Costly to Develop and Update: The cost of developing, reviewing and updating practice guidelines is quite expensive. Some have

estimated the cost of developing a single guideline to be $500,000 or more. In addition to the cost of developing a practice guideline, some argue that by the time the guideline is developed, published, and put into use by physicians, it is out-of-date, and in need of revision.

Practice Guidelines Have Potential to Reduce Defensive Medicine

Medical practice guidelines should be developed based on consensus among medical experts, and their purpose and scope must be clearly articulated. Also, medical practice guidelines should be implemented along with effective educational programs and clear incentives for physicians to use the guidelines.

Because guidelines can selectively target defensive medicine that does not improve the quality of care, they have the potential to reduce defensive medicine. Also, guidelines present an opportunity for experts to reevaluate clinical practices that are performed routinely but with little evidence that they make any real difference to patient care. Therefore, guidelines have the potential to reduce both conscious and unconscious defensive medicine. (Office of Technology Assessment, 1994).

Alternative Dispute Resolution

Alternative dispute resolution can take many forms, but its basic characteristic is that disputes are heard by one or more arbitrators or mediators rather than by a jury. The arbitration proceeding often is less formal, less costly, and less public than a trial.

Alternative Dispute Resolution Can Be Binding or Non-Binding

A critical feature of alternative dispute resolution is whether the process is *binding* or *non-binding*. In non-binding alternative dispute resolution, if a party is not satisfied with the outcome, he or she can continue to pursue the claim through the legal system. Therefore, non-binding alternative dispute resolution may not eliminate physicians' anxiety about a potential malpractice trial.

The more common form of binding arbitration is one in which both parties agree to waive their rights to a trial and instead retain one or more arbitrators to render a decision. While binding arbitration may be the most effective type of alternative dispute resolution in terms of reducing physicians' anxiety about a malpractice trial, this type of arbitration has not been used frequently in malpractice cases. (Office of Technology Assessment, 1994).

There are Several Types of Alternative Dispute Resolution

The most common types of alternative dispute resolution are:

* *mediation,* in which a neutral third party assists the plaintiff and defendant in reaching a settlement;
* *arbitration:* wherein the parties present their cases at a formal hearing where a final decision is reached that may be binding or not, depending on the parties' prior agreement;
* *neutral evaluation:* in which a legal or medical expert provides an objective opinion on the merit of the claims to assist the attorneys' decision-making process; and
* *screening panels:* where expert panels evaluate the merits of a claim before trial to encourage early and less expensive disposition of cases.

Virginia Has Implemented a Medical Malpractice Review Panel Process

Virginia's medical malpractice review panel process, which is outlined in §8.01-581.1, et seq. of the Code of Virginia, was established in 1976. This review panel is composed of two impartial attorneys, two impartial health care providers, and the judge of a Circuit Court in which the action was filed. The judge presides over the panel. Either party may request a review by a medical malpractice review panel within 30 days of the date the action was filed. Virginia's medical malpractice review panel process is non-binding.

In 1985, the review panel process was studied by a Joint Legislative Subcommittee, which concluded that "...panels effectively evaluate complex claims in a relatively short period of time at a reduced cost to the parties and are generally viewed favorably by claimants and health care providers."

According to information released July 12, 1994, by the Supreme Court of Virginia in its *Virginia State of the Judiciary Report* , approximately 2,843 panels have been requested since the process began in 1976. Of this number, 1,177 have been concluded; 228 were dismissed; 1,234 requests were withdrawn; and 204 cases were pending. In 1993, 228 medical malpractice review panels were requested, a decrease of 71 (31%) from 1992. Since 1976, an average of 167 panels have been requested per year.

Medical Society of Virginia Has Proposed Modifications to the Medical Malpractice Review Panel Process

While the Medical Society of Virginia supports the medical malpractice review process, it believes certain aspects of the process can be improved. Specifically, they suggest that the panel process can be improved by:

* initiating a formal settlement conference following the panel decision to move the parties toward an active settlement of the claim;
* permitting the panel decision alone to be admissible in court, rather than the panel's discussions, thus encouraging full participation in the panel process by all parties; and
* requiring that any party that proceeds to trial following an adverse panel decision be responsible for the other party's costs and attorneys' fees from the time of the panel decision if the trial verdict agrees with the panel decision.

These suggested modifications to the review panel process were proposed in Senate Bill 434 which was introduced by Senator Goode during the 1994 Session of the General Assembly. However, the bill was not passed by the General Assembly.

Impact of Alternative Dispute Resolution in Reducing Defensive Medicine Is Unclear

The effectiveness of alternative dispute resolution in reducing defensive medicine is not well documented. To the extent that physicians believe an alternative dispute resolution system is more fair than the judicial system, they might practice less defensively. Similarly, in a binding alternative dispute resolution process, the case would not go to public trial. So if physicians strongly dislike the publicity of a trial, perhaps they would be relieved of that concern, and practice less defensively.

On the other hand, alternative dispute resolution may increase the number of suits because the cost of bringing a claim through this process should be lower and plaintiffs may find the alternative dispute resolution process less intimidating than civil litigation. Accordingly, if physicians feel that the alternative dispute resolution process has increased claims, they likely will become more defensive.
(Office of Technology Assessment, 1994).

Virginia's medical malpractice review panel process was viewed favorably by claimants and defendants in 1985. However, concerns have been expressed by some physicians that the process is not effective in expediting the resolution of claims. The significant decrease (31%) in the number of panel requests in 1993 appears to be an indication of this concern.

No-Fault Insurance

No-Fault Insurance Provides Compensation to Victims of Adverse Medical Outcomes Regardless of Negligence

In response to dissatisfaction with the current malpractice systems, some malpractice reform proponents have pushed for the replacement of fault-based tort litigation with an administrative system in which the victims of adverse outcomes of medical care would be compensated for economic loss, regardless of negligence. (Lewin-VHI, 1993). In other words, a no-fault system is triggered by outcomes, whereas, the tort system is triggered by negligence.

Proponents of the no-fault approach cite its advantages as being swifter and less expensive resolution of claims and more equitable compensation of patients. Opponents are largely concerned that this approach does not afford the patient an opportunity to pursue an award through the legal system. Opponents also are concerned about the loss of whatever deterrence effect the present tort system now exerts on health care providers. (Robert Wood Johnson Foundation, 1991).

Limited No-Fault Systems Have Been Implemented Only in Virginia and Florida

Thus far, there have been no broad-based no-fault systems implemented in the United States. However, two states, Virginia and Florida, have implemented limited no-fault systems. In both states, the no-fault system applies only to birth-related neurological injuries.

Virginia's Birth-Related Neurological Injury Compensation Act: Virginia's no-fault insurance program was enacted in 1987 and became effective January, 1988. The program was implemented out of necessity when several malpractice insurers stopped issuing new obstetric policies after a Virginia Supreme Court decision upheld an $8 million obstetric malpractice award.

Section 38.2-5000, et seq. of the Code of Virginia establishes the Virginia Birth-Related Neurological Injury Compensation Act. Pursuant to this act, a birth-related neurological injury means injury to the brain or spinal cord of an infant caused by deprivation of oxygen or mechanical injury occurring in the course of labor, delivery or resuscitation in the immediate post-delivery period in a hospital which renders the infant permanently motorically disabled, and developmentally disabled or cognitively disabled. To meet the definition of birth-related neurological injury, the disability must cause the infant to be permanently in need of assistance in all activities of daily living.

Under the provisions of the act, the remedies provided an infant through the program exclude all other rights and remedies arising out of or related to a malpractice suit with respect to the injury. However, a civil action is not foreclosed if there is evidence that the physician or hospital willfully caused or intended to cause the injury.

The Virginia Workers' Compensation Commission reviews and evaluates all claims filed under the program. If an infant is determined to meet the definition for a birth-related neurological injury, the Commission makes an award which provides compensation for a wide range of expenses including medical, hospital, rehabilitative, residential and custodial care, special equipment or facilities and related travel. (The award does not cover expenses that are paid by any insurance benefit or other program.) The award also provides compensation for loss wages from the time the child reaches age 18 through age 65.

Only Nine Claims Have Been Filed Since Program Began: Since Virginia's program became effective in 1988, only nine claims have been filed. All but one claim has resulted in an award. Conversely, a total of 92 claims have been filed in Florida during the same time period for basically the same type of injury. Several reasons have been posited for the small number of claims in Virginia, including the definition of "birth-related neurological injury" is too restrictive, and there is a lack of public knowledge about the program.

No-Fault Insurance Programs Have Resolved Specific Malpractice Insurance Concerns But Their Impact on Defensive Medicine is Unknown

Virginia's birth-related neurological injury program resolved the severe malpractice insurance problems that existed prior to the program being implemented, and has helped to keep insurance premiums down for obstetricians. However, the impact of the program on obstetricians' practice of defensive medicine is unknown.

There have been only two no-fault programs implemented throughout the country, and both of these programs have a very limited focus (i.e. birth-related neurological injuries). Therefore, there is very little information to determine the impact of no-fault insurance programs on reducing defensive medicine. Until such time that a more broad-based no-fault insurance program is implemented and evaluated, it is unclear whether this type of program has any value in reducing defensive medicine. In reviewing the efficacy of no-fault insurance programs, one potential drawback which must be considered is that no-fault insurance eliminates the ability of the patient to sue, and, consequently, the deterrent effect of the malpractice system.

Accelerated Compensation Events

Accelerated Compensation Events Define Negligent Practices

Accelerated compensation events, or ACEs, are a relatively new concept in malpractice reform. In one sense, they may be viewed as the alter-ego to medical practice guidelines. While medical practice guidelines are intended to describe good practice, ACEs are intended to describe negligent practice. More specifically, ACEs are predefined classes of medically-caused injuries that do not normally occur when patients receive good care.

ACEs offer the prospect of reforming legal liability by relying on advance determinations of medical injury rather than on the slow, sometimes adversarial process currently used to determine medical injury after the fact. ACEs have the potential to resolve medical malpractice with lower administrative and legal costs than the current system. By using accelerated compensated events, it would not be necessary to determine anew in each case the proper standard of care and to evaluate the physician's behavior against this standard. Like medical practice guidelines, the primary benefit of accelerated compensation events is that they promote predictability and consistency in the disposition of claims.

Accelerated compensation events are not applicable to all medical injuries because experts cannot always agree on medical responsibility for the injury. Because accelerated compensation events would not account for all claims, this proposal would have to operate within a larger injury compensation system such as the present tort system.

Currently, Accelerated Compensation Events Are Not Widely Used

As yet, there is no experience with the concept of accelerated compensation events to gauge their impact on reducing defensive medicine. The potential impact of this concept depends largely on whether an accelerated compensation event can be developed for the clinical events that trigger the most defensive medicine. If this can be accomplished, this concept may be quite effective. However, if accelerated compensation events are not developed for the clinical situations that breed the most defensive medicine, the concept will have only limited impact.

Summary

There Is No Agreement on the Amount and Cost of Defensive Medicine

A great deal of research and analysis has been focused on the degree to which physicians practice defensive medicine and on the corresponding cost of defensive medicine. An equal amount has been written on various ways to reduce defensive medicine.

Despite the volumes that have been written on this topic, there is no agreement on the amount and cost of defensive medicine. This is not to say that defensive medicine does not exist; it clearly does exist. However, determining which medical practices are driven by a need to be certain of a diagnosis, which are performed because of the incentives in the reimbursement system to perform additional services, and which services are performed purely to avoid litigation is extremely difficult.

However, whatever amount of true defensive medicine is occurring, there is a cost associated with it which contributes to the statewide and national problem of affordable health care. As such, efforts to reduce the amount of defensive medicine without compromising the ability of the malpractice system to detect and deter negligent medical practice are necessary.

Virginia Generally is Considered to Have a Favorable Malpractice Environment for Health Care Providers

Virginia generally is regarded as having a favorable malpractice environment compared to other states. The principal reasons for the favorable environment is the cap on total malpractice awards ($1 million) , and, to a lesser degree, Virginia's statute of limitation. Only seven other states have placed a cap on total malpractice awards. Virginia's birth-related neurological injury compensation program, while narrow in focus, also has contributed to the favorable environment for obstetricians.

Research Indicates that Conventional Tort Reforms Can Lower Malpractice Insurance Premiums, But Have Little Potential For Significantly Reducing Defensive Medicine

The research of Zuckerman et.al. and Congress' Office of Technology Assessment indicate that some tort reforms can lower malpractice insurance premiums. However, the Office of Technology Assessment also concluded that there is little evidence that these reforms will significantly reduce defensive medicine.

Medical Practice Guidelines May Help to Reduce Defensive Medicine

Several studies have concluded that while the types of policies implemented by Virginia (e.g. cap on total damages, statute of limitation, and no-fault insurance) appear to have an impact on malpractice insurance premiums, there is little evidence that they have any substantial impact on reducing defensive medicine.

While various researchers and malpractice experts have identified different approaches that may help to reduce defensive medicine, it appears that medical practice guidelines and their counterpart, accelerated compensation events, may hold the most promise for targeting defensive medicine and directly affecting physicians' practices.

It May Be Helpful to Evaluate Virginia's Malpractice Review Panel Process

Virginia's medical malpractice review panel process has provided a basis for an effective non-binding alternative dispute resolution process. However, the recent decline in the number of panel requests may indicate that enhancements to the process are needed to make it more effective in expediting the resolution of malpractice cases.

Defensive Medicine and Medical Malpractice are Complex Issues Which Require A Collaborative Effort of Both Medical and Legal Experts

Given the number and complexity of the issues surrounding medical malpractice and defensive medicine, there is no one policy, program or law change that will resolve these issues. However, a comprehensive strategy that is developed collaboratively by both medical and legal experts could be helpful in addressing these issues in Virginia. By involving physicians, hospitals administrators, and attorneys in the process, perhaps certain strategies could be developed that would reduce defensive medicine without compromising the malpractice system's ability to detect and deter medical negligence.

Policy Options

As previously noted, defensive medicine and medical malpractice are extremely complex issues. In view of the complexity of these matters, it appears that there are two viable policy options at this time. The first option is to maintain the status quo, and not pursue any changes to the current system. The second option would be to form a task force comprised of attorneys, physicians, hospital administrators, medical malpractice insurance company representatives,

and other experts to identify specific recommendations for reducing defensive medicine and improving the malpractice system in Virginia.

Option I: Maintain Status Quo

This option recognizes that while defensive medicine does occur and that there is a cost associated with it, there are no specific strategies that have been proven to be effective in reducing defensive medicine. Moreover, this option recognizes that Virginia already has implemented some policies which have lessened the uncertainty of malpractice awards which some believe to be one of the factors that breeds defensive medicine.

Option II: Form a Task Force Comprised of Various Medical and Legal Experts to Develop a Strategy for Reducing Defensive Medicine

This option recognizes the numerous issues and complexities involved in defensive medicine and the malpractice system, and further recognizes that any meaningful changes to the current environment will require a collaborative effort by the physicians, hospitals, and attorneys who work within the system. The task force likely would be comprised of attorneys, physicians, hospital administrators, malpractice insurance representative and other experts. The task force would be charged specifically with reviewing the concept of practice guidelines and accelerated compensation events as a means of reducing defensive medicine. The task force also would identify and recommend other strategies for improvement such as improving the medical malpractice review panel system.

APPENDIX A

SENATE JOINT RESOLUTION NO. 159

Directing the Joint Commission on Health Care to study defensive medical practices and procedures.

Agreed to by the Senate, March 2, 1994

Agreed to by the House of Delegates, February 28, 1994

WHEREAS, every health care reform proposal introduced into Congress and many presentations made to the Joint Commission on Health Care include the need to manage rising medical costs; and

WHEREAS, it is estimated that as much as $20,000 annually per doctor is passed on to patients in the form of additional diagnostic tests, record keeping and consultations, just to protect physicians from the threat of liability, which in Virginia totals $200 million a year; and

WHEREAS, there is considerable potential to reduce the frequency of maloccurance by better addressing the problem of negligence-prone physicians; and

WHEREAS, recent studies have researched and examined in detail what constitutes defensive medical care and negligent medical care and the causative factors and how those can be prevented; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Joint Commission on Health Care be directed to study defensive medical practices and procedures. The commission shall study the effect of defensive medical care and negligent medical care upon (i) health care costs; (ii) health care providers' perceptions of the risk of medical malpractice and upon their behavior in determining which health care services will be rendered to a particular patient; (iii) the effectiveness of managed care systems in reducing or eliminating prescribed services that are determined not to be cost effective or medically necessary; and (iv) deterrents such as the medical malpractice system and risk management practices by health care providers or managed care organizations.

The University of Virginia Medical Center, the Medical College of Virginia, and the Medical College of Hampton Roads shall provide technical assistance for the study.

The commission shall complete its work in time to submit its findings and recommendations to the Governor and the 1995 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

APPENDIX B

Joint Commission on Health Care

Summary of Public Comments on Draft Issue Brief 6: Impact of Defensive Medicine

Comments regarding the "Impact of Defensive Medicine" Issue Brief were received from the following 8 interested parties:

Secretary of Health and Human Resources, Kay Coles James
The Virginia Chamber of Commerce
The Virginia Hospital Association
The Virginia Trial Lawyers' Association
The Medical Society of Virginia
The Virginia Association of HMOs
The Virginia Academy of Family Physicians
Roger Lewis

Policy Options Presented in Issue Brief

Two policy options were presented in the Issue Brief for consideration by the Joint Commission on Health Care.

Option I: Maintain status quo.

Option II: Form a Task Force of Medical and Legal Experts and Others to Develop a Strategy for Reducing Defensive Medicine

Summary of Comments

There was no clear consensus of opinion among those interested parties who submitted comments. Secretary of Health and Human Resources, Kay Coles James, and the Virginia Chamber of Commerce supported Option II. The Medical Society of Virginia recommended that the Joint Commission support changes to the medical malpractice review panel process and consider studying medical liability carriers. The Virginia Trial Lawyers' Association

recommended the Joint Commission encourage it and the Medical Society of Virginia to continue their discussions on these issues.

The Virginia Hospital Association recommended implementing several approaches to reducing defensive medicine that were discussed in the issue brief. The HMO Association and Academy of Family Physicians recommended further study of related issues.

Summary of Individual Public Comments

Secretary Kay Coles James

Secretary James indicated that the current no-fault system used in the worker's compensation system could similarly operate to control health costs while providing care that is needed. She also indicated that a better preventive measure against malpractice than the current system is an aggressive and active monitoring of medical practice by the Board of Medicine.

Secretary James supported Option II.

The Virginia Chamber of Commerce

Sandra D. Bowen, Senior Vice President, commented that there are opportunities for improving the present system and those ought to be fully explored by a task force comprised of those who work within the system. Ms. Bowen urged the Commission to include in its legislative package a resolution to form a task force, as provided in Option II.

The Virginia Hospital Association (VHA)

Susan C. Ward, Director of Legal & Regulatory Affairs, commented that the VHA does not support Option I or II. Ms. Ward stated that the issues of defensive medicine have been studied sufficiently in Virginia and elsewhere. She suggested the implementation of several approaches to controlling the cost of defensive medicine:

* develop and use clinical practice guidelines;
* maintain current cap on malpractice awards, and institute a program where victims could be compensated for treatment costs which exceed the current cap, as proposed in SB 1062 of 1993 Session of General Assembly;
* remove external barriers to provider risk management;

* implement reforms such as limits on joint and several liability, structured settlement and consideration of collateral sources;
* increase use of non-judicial procedures possibly through improvements to the current Medical Malpractice Review Panel process;
* place reasonable limits on attorneys' fees; and
* maintain the current Virginia Birth-Related Neurological Injury program.

The Virginia Trial Lawyers' Association (VTLA)

Mark E. Rubin, writing on behalf of the Virginia Trial Lawyers' Association, commented that the issue brief should have focused more attention on the effect of negligent medical care upon health care costs. Mr. Rubin noted that it is time to look elsewhere than the medical malpractice system as a means of reducing health care costs associated with negligent medical care.

Mr. Rubin also noted that a study of the high levels of profitability of medical malpractice insurance carriers is needed. He stated that the VTLA has entered into voluntary discussions with the Medical Society of Virginia to seek common ground in improving the system. He recommended that the Joint Commission encourage the two associations to continue their discussions to develop a more efficient system.

The Medical Society of Virginia

K. Marshall Cook, General Counsel, recommended that the Joint Commission consider legislation to improve and strengthen the current Medical Malpractice Review Panel process (as proposed in SB 434 of the 1994 Session of the General Assembly). Mr. Cook stated that the Joint Commission should consider this type of legislation or enact mandatory panels as a method of handling medical negligence disputes more fairly and efficiently.

Mr. Cook commented that the Joint Commission should consider studying medical liability insurance issues as a means of reducing health care costs. Mr. Cook also commented that clinical practice guidelines are being developed without government mandates, and that the development of such guidelines is something government simply does not need to do.

The Virginia Association of HMOs

Mr. Reginald N. Jones of the law firm of Williams, Mullen, Christian & Dobbins submitted comments on behalf of the Virginia Association of HMOs. Mr. Jones indicated that the HMO Association is opposed to extending medical malpractice liability to utilization review agents as proposed in SB 508 of the

1994 General Assembly. Mr. Jones recommended that the Joint Commission actively seek and review testimony regarding SB 508.

Virginia Academy of Family Physicians

Roger A. Hofford, M.D., commenting on behalf of the Virginia Academy of Family Physicians, stated that the Joint Commission should review the amount of defensive medicine associated with Medicare patients. Dr. Hofford also recommended that the Joint Commission explore the impact that participation in managed care systems has on a physician's medical liability insurance costs. Dr. Hofford suggested that the Joint Commission explore this issue with Virginia's malpractice carriers.

Roger Lewis

Mr. Lewis, a private citizen, did not express support for either Option I or II. He commented that medical providers and consumers should form a voluntary, malpractice-free delivery system. In this voluntary system, consumers would forego their right to sue and would be served by physicians and other providers who would utilize computerized information and a panel of specialists to determine most appropriate treatments.

JOINT COMMISSION ON HEALTH CARE

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