THE TRUTH ABOUT "DEFENSIVE MEDICINE"

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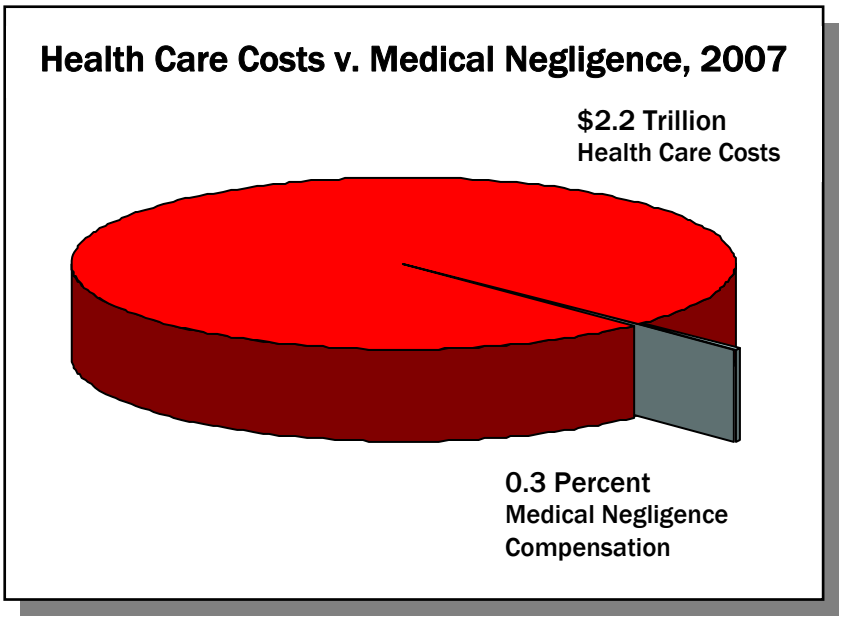
Those opposed to comprehensive health care reform have used the current debate as an opportunity to introduce tort reform. The evidence is clear that the direct costs of medical malpractice are actually a tiny fraction of health care costs, but tort reformers are now resorting to new arguments related to savings from indirect costs, namely that doctors run more tests fearing potential legal liability ("defensive medicine"). However, the vast majority of academic and government research has found liability does not lead doctors to run extra tests, and proposed reforms would generate little to no savings. Additionally, such testing is likely not motivated by liability concerns, but the desire to generate more income or the benefits such testing provides to patients.

Introduction

The direct costs associated with medical malpractice are a tiny fraction of health care costs. According to the National Association of Insurance Commissioners, the total spent defending claims and compensating victims of medical negligence in 2007 was $7.1 billion—just 0.3% of health care costs.[1] Any restriction on compensation to victims would thus reap only negligible savings at best, as it sought to reduce what is already a fraction of costs.



The total amount of money spent defending medical negligence claims and paying out settlements and jury verdicts accounts for just 0.3 percent of the $2.2 trillion spent on health care in 2007.

Therefore, those focused on limiting patients' legal rights have turned to the idea of indirect costs, namely "defensive medicine." Some claim that doctors are frightened into ordering hundreds of billions of dollars worth of unnecessary tests to avoid litigation. Despite the fact that the cost of all settlements, jury awards, and even the cost of defending claims makes up only 0.3% of health care costs, tort reformers allege that this "defensive medicine" accounts for 10% of health care costs.

The problem with this concept is that the vast majority of academic and government research has found that:

- The idea that medical providers run more tests because of liability concerns is not as prevalent as tort reformers suggest;
- There are little or no savings to be gained from reforms aimed at eliminating such tests;
- Much of what can be identified as "defensive medicine" is motivated not by liability concerns but by the desire to generate more income or for diagnostic reasons that ultimately benefit patients.

Government Researchers Question the Prevalence of "Defensive Medicine"
A 2008 report released by the Congressional Budget Office (CBO) notes that the evidence of "defensive medicine" *"is not conclusive, and whether limits on malpractice torts have an impact on the practice of medicine has been subject to some debate."*[2]

The Government Accountability Office (GAO) has issued similar statements questioning its occurrence, saying:

> *"[T]he overall prevalence and costs of [defensive medicine] have not been reliably measured. Studies designed to measure physicians' defensive medicine practices examined physician behavior in specific clinical situations, such as treating elderly Medicare patients with certain heart conditions. Given their limited scope, the study results cannot be generalized to estimate the extent and cost of defensive medicine practices across the health care system."*[3]

Theories of "Defensive Medicine" Rely on Quarter-Century Old Data, Debunked by Government Research Agencies
Claims of cost savings from the elimination of "defensive medicine" originates with one set of data a quarter century old. In 1996, two Stanford economists, Daniel Kessler and Mark McClellan, examined data on the costs of treating cardiac patients covered by Medicare in 1984, 1987, and 1990. The authors took this small subset of data and extrapolated the findings to the entire health care system to conclude that tort reform could reduce medical costs by five to nine percent because doctors no longer felt the need to run tests because of liability concerns.[4]

Subsequent academic and government analysis of the study was critical of its conclusions, and the vast bulk of empirical research since has consistently found no such savings. The GAO questioned the validity of the study's results in 1999, saying, "*Because this study was focused on only one condition and on a hospital setting, it cannot be extrapolated to the larger practice of medicine. Given the limited evidence, reliable cost savings estimates cannot be developed."*[5]

The CBO tried to replicate the authors' findings but were unable to find a relationship between health care spending and state medical liability laws. The CBO stated it, "*found no evidence that restrictions on tort liability reduce medical spending. Moreover, using a different set of data, CBO found no statistically significant difference in per capita health care spending between states with and without limits on malpractice torts*."[6]

Kessler / McClellan Study Recycled to Further Support False Claims
In 2003, the Bush administration's Department of Health and Human Services (HHS) calculated the savings tort reform would achieve, using the much criticized 1996 study from Kessler and McClellan. HHS relied on the premise that doctors would no longer run any tests because of potential liability, and calculated that between $60-108 billion could be saved if tort reforms were enacted.[7]

Several years later, and with all other contemporary academic work finding no such savings, the most influential health insurance trade group, America's Health Insurance Plans (AHIP),

contrived to recycle the Kessler-McClellan statistic once again. AHIP commissioned accounting giant PricewaterhouseCoopers to analyze health care costs, and PricewaterhouseCoopers in turn used the HHS estimate of the costs of "defensive medicine," and, in fact, inflated it from 5-9% to 10%.[8]

Thus, when proponents of tort reform cite the huge savings that can be reaped by eliminating such testing, know that they are referring to a 2006 report funded by the health insurance industry, which recycled a 2003 report from the Bush administration, which recycled a controversial 1996 study, which used data on a small subset of patients from 1984. This quarter century old data is the basis for all theories that doctors run extra tests solely because of liability concerns, and completely eliminating these tests will lower health care costs.

QUESTION: Where did the "defensive medicine savings" concept originate?

1984 Data on cardiac patients covered by Medicare is collected.

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1996 Kessler-McClellan publish study using this data.

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1999 GAO questions the validity of Kessler and McClellan's results.

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2003 The Bush administration's HHS uses Kessler and McClellan's findings to estimate costs.

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2004 CBO is unable to recreate Kessler and McClellan's results and finds no evidence of cost savings from tort reform.

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2006 Report by PricewaterhouseCoopers, paid for by health insurance industry, recycles and inflates the statistic from HHS.

ANSWER: Disputed data from a quarter century ago.

Eliminating "Defensive Medicine" Would Not Reduce Costs

Multiple studies have concluded that eliminating liability-related testing would have only a minimal effect on reducing overall health care costs.

According to the CBO, "*some so-called defensive medicine may be motivated less by liability concerns than by the income it generates for physicians or by the positive (albeit small) benefits to patients. On the basis of existing studies and its own research, CBO believes that savings from reducing defensive medicine would be very small.*"[9]

The GAO reported that even "*officials from AMA [American Medical Association] and several medical, hospital, and nursing home associations…told us that defensive medicine exists to some degree, but that it is difficult to measure.*"[10]

One explanation for these findings is that doctors do not practice as defensively as they believe. One government agency found that doctors chose not to order any tests or diagnostic procedures 95 percent of the time. Doctors who ordered tests almost always did so because of medical indications, and only one half of one percent of all cases involved doctors who ordered tests due solely to malpractice concerns.[11]

CBO: Doctors May Actually Practice "Defensively" to Generate More Income

Instead of practicing "defensive medicine" due to liability concerns, some health officials cited "*revenue-enhancing motives*" as a reason for utilizing diagnostic tests and procedures.[12] As previously noted, the CBO has found that, "*some so-called defensive medicine may be motivated less by liability concerns than by the income it generates for physicians.*"[13]

Health care costs in McAllen, Texas, have been growing at a faster rate than any other area in the country, and the cost of health care per patient is currently the second highest in the nation. An article published in *The New Yorker* found that some physicians and hospitals went to an extreme length in applying business principles to the practice of medicine. "Health-care costs ultimately arise from the accumulation of individual decisions doctors make about which services and treatments to write an order for. The most expensive piece of medical equipment, as the saying goes, is a doctor's pen."[14] Because Texas has a strict cap on damages that can be collected in medical negligence lawsuits, there should be little motivation for physicians in McAllen to practice "defensively."

One doctor told CNN that the doctors ordered more tests to generate more income, explaining, "*doctors are able to profit not just from being physicians like we have traditionally but by ordering tests on equipment that they own or x-rays on equipment that they own or sending patients to facilities that they own or have a financial interest in.*"[15]

In Florida, the majority of diagnostic-imaging centers and clinical labs are owned by physicians. Health officials in the state found that owning such facilities and ordering additional tests has provided a lucrative stream of income to physicians. Federal law now prohibits the referral of Medicare patients to certain physician-owned facilities, many of which charge double the amount in lab fees.[16]

The American Hospital Association is currently debating a policy that would ban doctors from referring patients to hospitals in which they have a financial stake.[17] Many researchers believe that physicians cherry-pick patients and self-refer profitable procedures and insured patients to their own hospitals, pulling much-needed income from community hospitals.[18] These self-referral "*behaviors may damage the health care system at large by adding costs and by weakening the health care safety net as community hospitals see their mix of patients becoming more complex and less well financed.*"[19]

President Obama's Budget Director Doubts the Existence of "Defensive Medicine"

Peter Orszag, President Obama's budget director, stated in June 2009, "*If you ask any doctor in the United States they quickly point to medical malpractice as a key driver of defensive medicine. It turns out that the academic literature on this question – in terms of medical malpractice on costs – is not as compelling in favor that proposition as the view among doctors would suggest.*"[20]

Academics Question the Existence of "Defensive Medicine"

Many in the academic community have questioned the extent to which "defensive medicine" exists, debated the costs associated with it, and evaluated the benefits of prudent health care to patients.

Harvard School of Public Health

- "*In medicine practiced as a business, defensive medicine is understood and may even be profitable. In a fee-for-service environment, increased use of services that a medical group controls, or that a hospital offers, will create revenue. Thus, overutilization is acceptable in that it may allay legal concerns while simultaneously increasing reimbursements.*"[21]

- "*Defensive medicine is a slippery concept. Its measurement is notoriously difficult. The science of quality measurement, still in its adolescence, is capable of delineating appropriate from inappropriate care for selected treatments but not across the board. Even more vexing is the task of disentangling liability concerns from other influences on clinical decision making. Providers' treatment decisions are driven by a collage of factors, including training, habit, colleagues, eagerness to maintain good relations with patients (independent of the possibility that they will sue), and dedication to high quality care. Where do these influences end and defensiveness begin? The separation is further complicated by the fact that what are perceived as defensive practices today may morph into tomorrow's standard of care.*"[22]

- "*Physicians typically invest a great deal of emotion in the malpractice issue, usually to a degree that is out of proportion to the actual risk.*"[23]

Frank A. Sloan and Lindsey Chepke, Duke University

- "*Although defensive medicine is said to be a major driver of health care cost growth, there is really no evidence of how much it is.*"[24]

- "*A more patient-oriented practice style is good defensive medicine, a point rarely mentioned in public discourse on medical malpractice.*"[25]

- "*The lack of an adequate definition for defensive medicine has led to much confusion; the vast majority of assertions have not been based on a precise definition of defensive medicine, nor has quantification of the extent of this practice been attempted.*"[26]

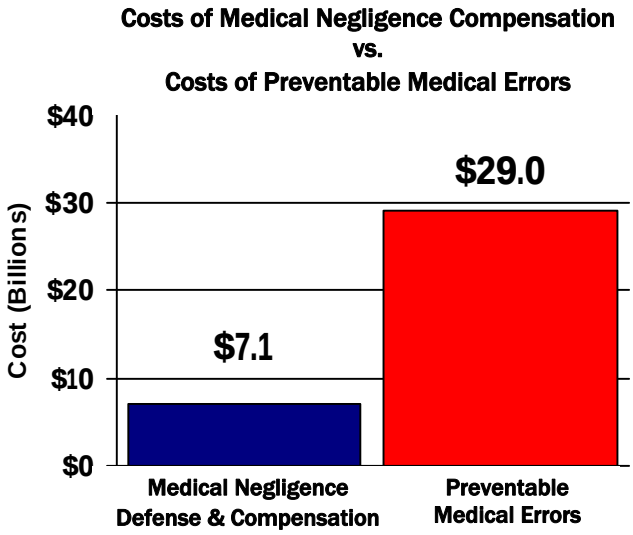
Tom Baker, University of Pennsylvania School of Law

- *"[R]esearch shows that while the fear of liability changes doctors' behavior, that isn't necessarily a burden. Some defensive medicine is, like defensive driving, good practice. Too often, we can't distinguish between treatments that are necessary and those that are wasteful."*[27]

- As cited in *The Medical Malpractice Myth - "Blaming defensive medicine on the legal system is likely to continue. It provides physicians with a convenient excuse for certain, often self-serving, clinical practice behavior, as well as providing organized medicine with what has been termed a rhetorical tool to resist an intrusion on clinical care by tort law."*[28]

Real Health Care Savings Could be Achieved by Reducing Medical Errors

According to the Institute of Medicine, as many as 98,000 Americans die each year as a result of medical errors. The costs associated with these errors are thought to be as high as $29 billion annually.[29] This does not include the number of patients, or associated costs, of those severely injured by preventable medical errors, but survive the trauma.



This report is one of a series from the American Association for Justice (AAJ) highlighting the issue of medical negligence. AAJ previously released *Medical Negligence: A Primer for the Nation's Health Care Debate*, which examined some of the chief myths and facts surrounding medical malpractice, patient safety and access to health care. This information can be found at www.justice.org/medicalnegligence.

[1] Insurance numbers from *Countrywide Summary of Medical Malpractice Insurance Calendar Years 1991-2008*, National Association of Insurance Commissioners (NAIC), 2009 – note, in 2008 compensation and defense costs dropped even lower, to $6.2 billion. Health care costs from *National Health Expenditure Data*, Centers for Medicaid Services (CMS), U.S. Department of Health and Human Services.
[2] *Budget Options, Volume I, Health Care*, Congressional Budget Office, December. 2008, 21.
[3] *Medical Malpractice: Implications of Rising Premiums on Access to Health Care*, Government Accountability Office, August 29, 2003.
[4] Daniel P. Kessler and Mark B. McClellan, *Do Doctors Practice Defensive Medicine?* Quarterly Journal of Economics, May 1996; *President Uses Dubious Statistics on Costs of Malpractice Lawsuits*, Annenberg Political Fact Check, January 29, 2004.
[5] General Accounting Office: *Medical Malpractice: Effects of Varying Laws in the District of Columbia, Maryland, and Virginia*, October 1999.
[6] *Limiting Tort Liability for Medical Malpractice*, Congressional Budget Office, January 8, 2004.
[7] *Addressing the New Health Care Crisis*, U.S. Department of Health and Human Services (HHS), March 3, 2003, http://aspe.hhs.gov/daltcp/reports/medliab.htm.
[8] *The Factors Fueling Rising Healthcare Costs 2006*, PricewaterhouseCoopers, 2006, http://www.ahip.org/redirect/PwCCostOfHC2006.pdf.
[9] Congressional Budget Office, *supra* note 6.
[10] Government Accountability Office, *supra* note 3
[11] Alexee Deep Conroy, *Lessons Learned from the 'Laboratories of Democracy': A Critique of Federal Medical Liability Reform,"* CORNELL LAW REVIEW 1159, 1176 (2006).
[12] Government Accountability Office, *supra* note 3
[13] Congressional Budget Office, *supra* note 9.
[14] Atul Gawande, *The Cost Conundrum*, The New Yorker, June 1, 2009.
[15] *Doctor vs. Doctors*, CNN, September 18, 2009, http://www.cnn.com/video/?/video/bestoftv/2009/09/18/tuchman.doc.vs.docs.cnn.
[16] Janice Castro, *Cover Story Condition: Critical*, TIME, June 24, 2001; *See also* John K. Iglehart, *The Emergence of Physician-Owned Specialty Hospitals*, New England Journal of Medicine, 2006.
[17] Gary Jacobson, *Cost of Care: Doctor-Owned Hospitals a Lucrative Practice, Though Opinions Split on Benefits*, Dallas Morning News, September 21, 2009.
[18] *Physician-Owned Specialty Hospitals' Ability to Manage Medical Emergencies*, Office of the Inspector General, U.S. Department of Health and Human Services, January 2008.
[19] *Physician Ownership and Self-Referral in Hospitals: Research on Negative Effects Grows*, Trendwatch, American Hospital Association, April 2008.
[20] Orszag, Peter, address to Brookings Institute, June 9, 2009, video available from AAJ upon request.
[21] Troyen A. Brennan, Michelle M. Mello, and David M. Studdert, *Liability, Patient Safety, and Defensive Medicine*, MEDICAL MALPRACTICE AND THE U.S. HEALTH CARE SYSTEM, (William M. Sage and Rogan Kersh eds.), 2006, 112.
[22] Michelle M. Mello and David M. Studdert, *The Medical Malpractice System: Structure and Performance*, MEDICAL MALPRACTICE AND THE U.S. HEALTH CARE SYSTEM, (William M. Sage and Rogan Kersh eds.), 2006, 24.
[23] Troyen A. Brennan, Michelle M. Mello, and David M. Studdert, *supra* note 20 at 109.
[24] Frank A. Sloan and Lindsey M. Chepke, MEDICAL MALPRACTICE, 2008, 14-15.
[25] Ibid at 17.
[26] Ibid at 71.
[27] Tom Baker, *Liability=Responsibility*, New York Times, July 11, 2009.
[28] Ken Bassett, Nitya Iyer, Arminee Kazanjian, "Defensive Medicine During Obstetrical Care: a By-Product of the Technological Age," Social Science and Medicine 51, 2000, as viewed in Baker, *The Medical Malpractice Myth*, 2005.
[29] *To Err Is Human: Building a Safer Health Care System*, Institute of Medicine, 1999.