I. ESSAY

Addressing The Malpractice Problem: The Robert Wood Johnson Foundation’s Programs

by Joel C. Cantor and Walter J. Wadlington

The Robert Wood Johnson Foundation (RWJF) Medical Malpractice Program was established in 1985 after a decade of fears that injuries to patients and the system of compensation for such injuries could have a severe, adverse impact on physicians and health institutions. Medical professionals’ frustration over rising costs and decreasing availability of liability insurance produced political pressures that led to legislative responses in many states—even though there was only limited understanding of the extent of malpractice, its underlying causes, and the potential effects of many responses on health care delivery and medically injured persons.

Addressing medical malpractice problems was a logical development for the foundation because the issue was consistent with its concerns about access to affordable, high-quality medical care. The objectives of the Medical Malpractice Program thus were to develop and analyze reliable data on the incidence and characteristics of medical malpractice and its impact on health care delivery, to evaluate responses, and to develop new or improved strategies for reducing medical injury and adequately compensating medically injured persons. This essay summarizes the accomplishments of the Medical Malpractice Program, points out some remaining gaps in the research literature, and describes a new RWJF initiative in this area.

Assessing The Accomplishments Of The Program

The most tangible result of the program was a body of research findings reflected in a collection of more than 100 articles, working papers, books, and reports. A bibliography, available from the authors, reflects a range of publications representing the legal, medical, economics, and health policy literatures. However, the success of a program should not be gauged simply

Joel Cantor is director of evaluation research at The Robert Wood Johnson Foundation in Princeton, New Jersey. Walter Wadlington is the James Madison Professor of Law at the University of Virginia in Charlottesville. He directed the foundation’s Medical Malpractice Program.
by a “head count” of publications, but rather by the value and impact of the research reflected in them. In this regard, it is significant that many of the studies provided cornerstones for policy debate; others are helping to shape new approaches in areas such as risk management and compensation for medical injury. Although difficult to quantify, another important accomplishment stemmed from the program’s role as a medium for interaction among investigators from disciplines with little or no prior contact. Much productive collaboration among program participants continues today.

**Scope of the research.** Proposals developed by researchers within the areas described in the program’s Call for Proposals were selected for funding on the basis of their feasibility and potential impact. The research findings selected for description below cover areas that are not easy to fit into a concise typology. Nevertheless, for convenience, we organize the major program results under four basic headings: dimensions of medical error and malpractice; physician and hospital practices; understanding and refining the legal system; and evolutionary and new compensation approaches.

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### Dimensions Of Medical Error And Malpractice

Many legislative responses to the malpractice “crisis” of the 1970s and 1980s were adopted with little or no reliable data about the dimensions of malpractice or the effectiveness of using the tort system as a mechanism for medical injury compensation. Two studies supported under the program shed considerable light on this area. The Harvard Medical Practice Study, using a representative cross-section of 1984 medical records from hospitals in New York State, found that adverse events (whether or not caused by negligence) occurred in 3.7 percent of hospital stays during the period studied. Of those stays, 27.6 percent (approximately 1 percent of all hospital stays) were determined to have involved negligence. The latter number, however, was eight times greater than the number of claims filed for the period. The ratios were very similar to those recorded in a study of California hospitals ten years earlier, the basic methodology of which had been followed in the New York study. Both studies had been undertaken in large measure to determine the economic feasibility of instituting some form of no-fault system. Factoring the costs under the tort system at the time of the California study, the researchers concluded that such a change at that time would not be financially viable. Because the costs of the system had escalated significantly in the decade between the studies, however, the Harvard researchers considered some type of no-fault system to be a realistic alternative that would provide a more fair and efficient approach than the tort system for medical injury compensation. The larger and more detailed New York study also provided researchers with a valuable database for
exploring other dimensions of medical malpractice, such as the extent to which the current tort system provides a deterrent to medical injury.

A much different approach was used by researchers from the University of Chicago, who measured the incidence of errors in patient care in three surgical units. Instead of focusing on medical records or closed claims, they conducted a prospective observational study in which trained ethnographers spent time in hospital units and attended rounds and clinical meetings in which patient care was discussed. The major goal of this study was to gain further understanding about the social and institutional context of error and the development of medical disputes by participants in the care process. Although the purpose of the study was not simply to document the incidence of errors, one finding was that only a small number of those patients whose health was seriously affected by discovered errors took steps indicating that they were dissatisfied with their care.

**Physician And Hospital Practices**

It is generally agreed that the best way to prevent malpractice claims is to avoid or minimize the incidence of medical injury. A further practical approach is to mitigate harm once it occurs in a manner that is accepted favorably by the patient. A fundamental goal of the Medical Malpractice Program was to develop workable responses to medical injury from the health care and legal communities; several such projects were supported.

**Modifying provider practices through protocols.** The use of protocols or practice guidelines is increasingly viewed as a viable means for improving medical and hospital procedures. Some also see protocols as a means of clarifying the legal standard of care. None of the program’s grantees focused specifically on the latter except to the extent that changing physician practices may redefine the standard, but several studies dealt with protocols designed to minimize injury caused by substandard care. Others sought to determine the extent to which physicians in different specialties had modified their practices because of concerns about liability.

One study examined the incidence of high-severity claims by patients who presented to an emergency room with chest pain or other symptoms but were not diagnosed or treated for myocardial infarction in a timely fashion. Protocols based on this information have been introduced in the emergency rooms of military hospitals. Another team analyzed a ten-year database on some 500 California anesthesiologists insured by two physician-owned carriers and determined that insurer-introduced protocols had served to reduce claims and thus to stabilize liability insurance premiums.

**Identifying problem-prone procedures or practitioners.** If particular practices or practitioners are identified as being prone to malpractice prob-
lems, strategies may be developed to minimize events that are likely to lead to claims. Many of the grantees touched on such issues as part of their larger projects, and several focused specifically on these issues. Closed claims data from a large New Jersey-based insurer were used to identify problem-prone clinical processes in four high-risk specialties (anesthesiology, general surgery, obstetrics and gynecology, and radiology). Among the categories of patient management, technical performance, and medical and nursing staff coordination, it was found that patient-management errors were cited most frequently for all four specialties and generally were associated with a greater frequency of serious injury and higher median payments. The investigators concluded that malpractice data could be used to suggest systems-level interventions that could reduce negligence. They suggest that patient-management errors could be averted by hospital practices such as ensuring prompt delivery of test results to physicians. The researchers also sought to determine the usefulness of malpractice claims data for identifying physicians in the four specialties who might be prone to errors caused by negligence. They found that such claims histories had only modestly predictive power and thus were of questionable use in targeting physicians for educational interventions or sanctions.

**Institutional risk management programs.** Some 78 percent of medical malpractice claims stem from hospital-based incidents, and hospital-based claims account for 87 percent of all malpractice payments. Hospital-based clinical risk management programs are thus considered to have the potential to limit substandard care and to prevent and control claims. Three studies addressed aspects of risk management practices.

One grantee explored whether there is a factual basis for concluding that hospital-based risk management programs actually affect malpractice claims experience. Defining hospital risk management as “a systematic program designed to reduce preventable injuries and accidents and minimize financial loss to the institution,” this retrospective study reviewed data from forty acute care general hospitals in Maryland in the early 1980s. The study provides the first evidence based on a relatively large number of hospitals that risk management can be associated with reduced malpractice claims.

Another team addressed ways of developing “early-warning” systems that would bring problems of significant medical injury to the attention of risk managers as early as possible, to allow for the gathering of relevant information while it is fresh to help define and mitigate damages and to offer the opportunity to resolve issues to the satisfaction of the patient without resorting to expensive and extended legal proceedings. The researchers describe a system that includes careful use of improved incident reports. The project concluded that active involvement of all hospital medical staff is a critical factor contributing to the effectiveness of incidence reporting.
This initial study is being expanded into a larger one to determine what further steps might be taken to make an early-warning system effective. The University of Chicago study of medical error, mentioned previously, also points to a need for a more effective hospital system to pass along information about errors to risk managers, patient safety committees, or some part of the hospital administration. It raises the additional question of whether physicians should be obliged to report such errors.

**Credentialing.** Two projects addressed medical credentialing and malpractice. Researchers in Oregon are developing predictive instruments to guide physician education programs and to increase the efficiency of disciplinary functions. The instruments are based on an analysis of an eleven-year database from the Oregon Board of Medical Examiners that identified physician characteristics and practices associated with disciplinary actions and malpractice claims. A team in Maryland developed guidelines to help hospitals use background information about physicians appropriately and avoid its misuse in the credentialing process. The guidelines were important because Maryland was one of the first states to require the reporting of certain malpractice claims and disciplinary proceedings against physicians. Subsequent to this project, the National Practitioner Data Bank was implemented to change the way in which information about individual physicians is used in hospitals’ credentialing procedures nationwide.

**Physicians’ perceptions about liability exposure.** Physicians’ perceptions about legal risk can serve to deter substandard conduct, but they also can lead to defensive procedures, best defined as diagnostic or treatment measures designed to protect a physician or hospital from liability rather than to promote patients’ health. Several studies suggest that physicians’ perceptions about liability exposure are inaccurate. The perceived risk of being sued in a given year was three times the actual risk among physicians studied in the Harvard Medical Practice Study.\(^{11}\) In a study in Florida, physicians’ assumptions about the profile of the likely malpractice claimant were shown to be unrealistic, and these varied according to specialty.\(^ {12}\) Three studies supported under the program refute the common assertion that Medicaid patients make malpractice claims more often than others do. Studies in Maryland, Washington, and New York revealed that the likelihood of claims from Medicaid patients was no greater, and in some instances was actually lower, than for non-Medicaid patients.\(^ {13}\)

Whatever the basis for physicians’ fears, their potential impact on doctor/patient relationships and decisions affecting cost of and access to treatment can be considerable. A study in Washington State focused first on whether obstetricians are influenced to stop practicing because of concern about malpractice claims. The study found that the obstetrician attrition rate was small but significant in impact because of an already existing
shortage of physicians in obstetrics. A further study adding Alaska, Montana, and Idaho found that despite tort reforms, the cost of liability insurance and concern about the likelihood of being sued continued to limit the number of physicians practicing obstetrics.

**Understanding And Refining The Legal System**

Several projects added significantly to the understanding of the effects of conventional tort reforms since the late 1970s and the functioning of malpractice dispute resolution in general.

**The Indiana experience.** Indiana was one of the first states to enact broad medical malpractice tort reforms. These changes included a cap on damages and creation of a patient compensation fund (PCF) to pay all awards in excess of $100,000, which is financed by a surcharge on medical providers’ basic liability premiums. Under the system, insurers accepting the first $100,000 of liability in a particular instance refer the rest of the claim for settlement to the PCF. Medical review panels were then created to determine the extent of payment to be made available under the PCF. In an evaluation of the severe claims experience in Indiana compared with that of neighboring states without damage caps, investigators found that under the Indiana reforms only a small fraction of claims went before medical review panels for their determination of liability and that large claims resulted in comparatively generous compensation. These results surprised some observers. The investigators suggested that the Indiana cap may have inadvertently verged on a no-fault system for large claims.

**The jury system.** Along with contingent fees and damages for pain and suffering, the civil jury system is among the components of the present compensation system criticized most widely by members of the health care establishment. However, an empirical study found no support for assertions that juries are consistently proplaintiff, incompetent, or unjustifiably generous in their awards. The study did find, however, that jurors would like to have greater guidance from judges, particularly with regard to damages. This study did not address the common criticisms of the current trial system—that it is unnecessarily costly and creates uncertainties and delays, matters that affect both plaintiffs and defendants.

**Alternative dispute resolution.** A common reform proposal is that medically injured persons be required to submit their claims to an alternative dispute resolution (ADR) process, at least initially. There are many possible models of ADR, including arbitration and mediation. The suitability of various ADR procedures in resolving medical malpractice disputes was examined in one study funded under the program. After analyzing procedural steps taken in malpractice cases that had been litigated in North
Carolina, investigators conducted demonstrations of several approaches, including mediation and arbitration of actual cases under dispute that were referred to them by the court system with voluntary agreement of the parties involved. One innovative alternative was the use of a summary jury trial in specific cases in which the parties agreed to limit the number of factual issues in dispute, the number of expert witnesses, and the overall length of the trial. The parties also agreed to the imposition of a floor and ceiling on damages. Cases most appropriate for summary trials are those in which liability is unclear but potential damages are great if recovery is granted. Because the decision cannot be appealed, summary jury trials have the same effect as binding arbitration in avoiding protracted appeals. These trials also can substantially shorten the time required to close a case.

**Damages.** Determining the amount of money to be awarded in a malpractice case can be especially controversial. A major criticism is the seeming inconsistency of damages awarded. Other critics contend that awards are consistently too high. The distinction between economic and noneconomic loss is of particular importance, with the latter including compensation for pain and suffering, which is sometimes thought to serve as payment for plaintiffs’ legal fees. These issues were examined in an extensive study of closed claims for severe birth-related injuries to children and emergency room injuries to adults in Florida. In this study, claimants who actually recovered monetary damages received only about 80 percent of the costs induced by their medical injuries. The investigators also found that less seriously injured persons received proportionately higher compensation than severely injured persons. The researchers sounded a cautionary note that the perception that the tort system works poorly may be unduly shaped by publicity about the relatively small number of claims that result in very high damage awards.

Researchers in other projects developed or evaluated approaches that would award damages more fairly than the current system does and better tailor damages to the special needs of medically injured persons. These include development of a “common law” scheme through the reporting of damage awards that could have precedential value in future cases; payment for future medical services of an injured party through an insurance contract tailored to specific cases rather than through lump-sum payments; and introduction of “scheduled damages” (specified compensation amounts for specific injuries) for pain and suffering in medical malpractice awards.

**Evolutionary And New Compensation Approaches**

In addition to identifying problems in how medical malpractice is now handled in medical and legal systems, the program supported development...
tal activities intended to lead to alternatives to existing systems.

**Accelerated compensable events.** The idea of a liability system for medical injuries that would rapidly provide fair compensation for certain injuries without need to prove negligence is by no means new. However, past attempts to develop a workable system on such a basis have encountered difficulty in defining what constitutes an appropriate “compensable event.” One such approach was developed using a large database of obstetrical injuries on which successful liability claims were based. The investigators selected the new term *accelerated compensable event*, or ACE, to describe the triggering basis for recovery. Although compensation for an ACE would be awarded without proof of negligence, experts generally agree that ACES should seldom occur in the course of standard medical practice.

ACES are classes of medical injuries that are readily identifiable, relatively avoidable (in this study, preventable in at least 70 percent of those cases that receive good care), and not likely to cause distortions in medical decision making—that is, not encouraging a practitioner to use a more dangerous or less effective alternative because it would be less likely to produce an ACE. An ACE system would not replace the tort system completely because not all medical injuries would be covered under ACES. However, the developers of the system estimate on the basis of past claims that between one-half and three-quarters of obstetrical claims would be covered. In concept, ACES could be extended to much broader classes of medical injuries.

**Enterprise liability.** The medical malpractice portion of the Reporters’ Study: Enterprise Responsibility for Personal Injury of the American Law Institute included a proposal for shifting liability from individual physicians to hospitals or other health care institutions connected with incidents giving rise to claims, except in intentional torts. This approach would have much greater administrative efficiency than the current system does in cases involving multiple defendants and would provide for more even distribution of malpractice insurance costs that now vary greatly by specialty. Proponents also assert that enterprise liability appropriately reflects changes in the structure of medical practice today and that it would shift legal responsibility for preventing injuries and improving quality to institutions that are in the best position to do so. Such incentives are appealing in light of the findings cited above that the best prospect for reducing injuries is “systems” changes rather than targeting individual physicians at high risk for errors. Some who are skeptical about or opposed to such an approach worry that it will lessen the deterrent effect of the current tort system, or that it could lead to limitations on physician autonomy.

**No-fault alternatives.** No-fault compensation would eliminate one of the most difficult and troubling steps in the present tort system: the finding
of fault. Under a no-fault scheme, medically induced injuries are compensable regardless of a finding of negligence. Proponents of a no-fault approach contend that a properly crafted scheme can provide fair compensation for a greater number of injured parties because of substantial reductions in administrative and other transaction costs. Expenses might be reduced if damages for some types of noneconomic loss are reduced or eliminated. Some suggest that the current tort system’s deterrent effect on substandard care can be (and perhaps has been) substantially replaced by other controls as a means for assuring quality, and that a no-fault system could provide the incentive to reduce all medical injuries. The Harvard Medical Practice Study estimated that a comprehensive no-fault approach would cost no more than the current system but would distribute compensation more broadly and equitably. Another researcher studied no-fault compensation approaches in Sweden and New Zealand but found that they may not provide direct lessons for the United States because of their integration with the broad social insurance programs of those countries. Others have proposed more limited approaches to no fault. The ACE approach can be regarded as a selective no-fault system because there would be no fixing of specific blameworthiness or fault, although the number of injuries covered would be much fewer than could be expected in a broad no-fault system.

Summary

The Robert Wood Johnson Foundation’s Medical Malpractice Program has contributed significantly to what is known about the dimensions of medical error, how medical providers perceive and respond to the current malpractice system, and the ways in which the problems of the current system may be overcome. Even this substantial body of research, however, does not answer all of the important questions raised by policymakers, health care managers, and medical practitioners. Nevertheless, several generalizations can be made from the studies supported under the Medical Malpractice Program: (1) Provisions in the health care and legal systems to identify, prevent, and compensate for medical injuries are seriously flawed; indeed, the great majority of injuries go unidentified. (2) Various stakeholders may perceive malpractice-related problems differently. For example, medical providers see the system as arbitrary, while policy analysts emphasize lost opportunities for stronger incentives to prevent injuries and to compensate injured parties fairly. (3) Risk management and related mechanisms can be effective, but they are not broad-based and active enough to make a significant contribution to reducing medical malpractice. (4) The best opportunities to prevent medical injuries are in changes to the organization of care rather than in targeting “bad-apple” providers. (5)
Current methods of claims adjudication operate more fairly than many have suggested, but the system is slow, expensive, and adversarial, which compounds dissatisfaction with the system. Alternative dispute resolution techniques have not been adopted widely. 

Need for further research. The most significant obstacle that surfaced early in the Medical Malpractice Program was that many researchers encountered unanticipated-and often unexplained-barriers to data sources even though they had been assured access by the owners of the data. More than in other areas of health services research, assertions by data providers about confidentiality and potential liability are barriers to research in the malpractice arena. Generally, claims-related research is limited to closed cases; even so, some malpractice insurers and health care organizations are reluctant to share information. Further research on malpractice will require that keepers of data be willing to “open their books.”

One area still in need of substantial research is the phenomenon of “claiming behavior” a special concern given our knowledge about the relatively small percentage of negligently injured persons who file claims or instigate lawsuits. Also in need of detailed focus is defensive medicine, thus far discussed largely in broad generalizations and a few careful but narrow studies. Other research topics include problems associated with increasing ambulatory care and expanded autonomy of allied health care professionals, the effects of changing practice structures and of managed care on fixing liability, special issues of rural practice, the potential impact of outcomes research, and the effects of introducing or withholding new technology or complex procedures on standards for determining liability.

A next step: demonstrations. As findings of research supported under the Medical Malpractice Program are coming to light, RWJF is shifting its emphasis to the field application of possible solutions to the problems of existing malpractice-related systems. Through a new initiative titled Improving Malpractice Prevention and Compensation Systems (IMPACS), the foundation plans to fund the development of demonstration activities and the evaluation of new or existing innovations. Demonstration and evaluation projects from government agencies or health care organizations are sought. Those selected for funding will hold promise for significant improvements over the current system by providing more appropriate incentives for preventing medical injuries without inducing costly defensive medicine or adversarial doctor/patient relationships; incorporating malpractice risk management activities into health care organizations’ quality improvement initiatives; achieving greater efficiency or lower overall cost in processing medical injury claims or compensating injured patients by
Epilogue

The Robert Wood Johnson Foundation Medical Malpractice Program was initiated less than ten years ago. Since then a sizable body of research findings and proposals has come from foundation grantees. Other entities, both governmental and private, also have contributed to this body of material. Some new actions have been based on the growing understanding of medical malpractice, but overall movement toward change in responding more fairly and efficiently to problems of medical injury has been slow. Much emphasis has been placed on fine-tuning previous responses to malpractice crises, some of which have had little effect, rather than on developing or instituting innovative approaches. One reason for this relative inaction was a stabilizing of the incidence (though not the severity) of claims, with a concomitant stabilization or even lowering of some medical liability insurance premium rates. In short, the pressure for change had abated. Recently, though, insurance rates have begun to rise again in some jurisdictions. New pressures and fears of crisis will encourage development of new approaches building on our expanded knowledge. There is little time to waste on the road to demonstration and, ultimately, system reform.

The views expressed in this essay are solely those of the authors, and no endorsement by The Robert Wood Johnson Foundation or the University of Virginia is intended or should be inferred. The authors thank Erika Miles for research assistance.

NOTES

2. President Bill Clinton’s task force on health care reform proposed, but later abandoned, enterprise liability—a concept developed in part under a grant to the American Law Institute (discussed further below) as the cornerstone of malpractice-related changes under comprehensive health care reform. Also, the U.S. Congress Office of Technology Assessment wrote a summary drawing upon a number of projects supported under the program. U.S. Congress Office of Technology Assessment, Defensive Medicine and Medical Malpractice (Washington: U.S. Government Printing Office, July 1994).


23. Rolph et al., “Malpractice Claims Data as a Quality Improvement Tool.”


26. OTA, *Defensive Medicine and Medical Malpractice*. 