Beyond MICRA

New Ideas for Liability Reform
Beyond MICRA: New Ideas for Liability Reform

American College of Physicians*

The existing medical liability system does not work. It does not deter negligence, provide timely compensation to injured persons, or resolve disputes fairly. Studies show that a large percentage of injured patients are not compensated and that physicians feel vulnerable to a lawsuit whether or not they practice high-quality medicine. The arbitrariness and inefficiency of the system disrupts the physician-patient relationship, increases health care costs, and, in some cases, hurts access to care. As a result, comprehensive changes to the liability system must be made. The American College of Physicians makes the following recommendations.

1. Congress should immediately pass the tort reforms contained in the California Medical Injury Compensation Reform Act (MICRA), particularly caps on noneconomic damages, as necessary short-term changes to a flawed system.

2. Federal legislation should be enacted that overturns recent court decisions that have relied on the Employee Retirement Income Security Act of 1974, a federal law that regulates pensions and other benefit plans, to bar plaintiffs from suing their health plan for negligence if the plan’s benefits or treatment decisions lead to an injury.

3. Demonstration projects should be created and funded to examine the feasibility of using a set of caps for noneconomic damage awards that are based on the severity of injury suffered and the injured party’s age. A set of caps could be seen as fairer to injured persons than flat caps but would still protect physicians from unlimited awards.

4. Demonstration projects should be authorized and funded to test enterprise liability and no-fault systems. These systems could take many forms, including administrative approaches; lists of accelerated compensation events; “early offer of settlement” approaches; and organizational liability for health plans, hospitals, or health systems. Such long-term reforms are consistent with trends in health care delivery and are necessary to promote quality of care, compensate injured persons, and protect physicians.

During the mid-1970s and 1980s, a series of reforms to the medical liability system was enacted by many states. An increase in medical liability insurance premiums due to an increase in claims had created a “crisis of availability,” and it was felt that policy changes were needed to protect physicians and ensure access to care. Although this type of malpractice insurance crisis does not exist now, it seems clear that our nation’s malpractice system does not work—for injured persons or physicians.

The tort system is designed to compensate persons injured by negligence, to deter negligent behavior, and to resolve disputes fairly. It performs poorly in all these areas. Punishment and enforcement under the system is unpredictable; lawsuits are time-consuming and expensive for both sides, and many victims of negligence do not receive timely and adequate awards. In addition, there is little evidence to suggest that the current liability system deters negligence.

The American College of Physicians has consistently voiced its skepticism about the tort system’s ability to assure quality care (1). Moreover, in the past several years, the College has embarked on a series of activities designed to improve the quality of care that patients receive. For example, the College has been committed to improving the competence of practitioners through writing practice guidelines (2) and developing criteria to establish skill levels for procedures (3).

Moreover, the College has consistently argued that the medical profession must take greater responsibility for monitoring itself and that licensing boards must have the resources and authority to enforce professional standards (4). We have also advocated the creation of a quality improvement system that focuses on outcomes and that requires physicians and other health practitioners to take greater responsibility for improving the quality of care they provide (5).

Studies have shown that in addition to not guaranteeing quality, the malpractice system does not adequately compensate injured persons. For example, the Harvard Medical Practice Study found that fewer than 3% of the negligently injured persons who have been identified file a malpractice claim and that only about half of those persons actually receive compensation (6). Moreover, even these so-called “winners” often must wait years before they collect their money as their lawsuit crawls through the legal system. The median time from injury to payment is 3 years, and data from New York indicate that the average delay between initial injury and payment is 6 years (6–9).

Today’s malpractice system is arbitrary, and the reasons physicians are sued are unclear. Recent studies confirm that no evidence shows a correlation between a physician’s experience with malpractice claims and quality of care (10, 11). Evidence also indicates that physicians are not usually sued when malpractice occurs and are often
sued when they are not at fault (6-9, 12). In fact, physicians are sometimes sued because their patients are unsatisfied with the interpersonal aspects of care rather than because of negligence (11). The results of this study (11) are consistent with those of a previous analysis that found that the key reasons potential plaintiffs consulted an attorney are general dissatisfaction with the health care system, especially the relationship with the physician before the alleged incident; whether the attorney advertises on television; and the claimant's financial circumstances (13).

The unpredictability of the liability system and its disassociation with quality of care has two major detrimental effects. First, the medical community does not believe that malpractice data are credible and therefore will not accept that data as a meaningful source of information about quality. Second, they diminish the system's ability to deter negligent medical care. Rather, they promote a feeling of vulnerability among physicians, thereby providing strong incentives not to reveal errors (14). It also causes them to believe they must do procedures to protect themselves from future legal action. In fact, a 1992 Gallup poll of physicians found that 84% of those surveyed said that the threat of medical liability suits causes them to order tests they might otherwise consider unnecessary (15). This risks harm to patients, causes the physician–patient relationship to suffer, adds to health care costs, and, in some instances, hurts access to care.

There is no agreement on the magnitude of costs from this so-called defensive medicine. A recent study by the U.S. Office of Technology Assessment concluded that it is impossible to accurately measure the total costs of defensive medicine. The investigators found that it was difficult to assess the motives for physicians' actions—there may be many reasons why a physician performed a particular service, including financial incentives, local standards of care, academic training, patient preferences, and requirements of hospitals or managed care organizations. In addition, many practices that were originally motivated by fear of liability have since been ingrained into medical practice and are no longer considered "defensive" (16).

Nonetheless, defensive medicine is a real phenomenon, and policymakers would be wise to enact programs that will reduce its occurrence and the associated costs, however measured.

For all these reasons, over the past several years, many organizations and individuals have argued that the malpractice system must be changed. Reforms to the system will provide relief to physicians who feel threatened and help to patients who have been injured. The College called for significant malpractice reform in its 1992 paper on comprehensive health care reform (4).

For internists, the need for liability reform is growing. Changes in the health care marketplace that emphasize the increasingly important role of the primary care physician could make these physicians more vulnerable to malpractice claims. In fact, "failure to diagnose" is the fastest growing category of malpractice claims.

Thus far, medical liability reform has revolved around a set of recommendations based on the provisions of the California Medical Injury Compensation Reform Act (MICRA). These include caps on noneconomic damages; elimination of joint and several liability to hold defendants liable in proportion to their degree of fault; offsets of awards from collateral sources; reasonable limits on statutes of limitations; and limits on attorney contingency fees.

These reforms have helped reduce the direct costs of medical malpractice. Malpractice premiums in California have decreased from 1976 to 1991. Moreover, if adopted nationally, these reforms could help improve the efficiency and predictability of the system and provide relief to physicians by imposing some limits on their liability.

Consequently, the College has consistently supported these principles as necessary reforms and has repeatedly called for their inclusion in any national health reform legislation (1). Nearly all the federal health reform proposals debated by the last Congress contain some or all of these provisions.

Despite the potential effectiveness of MICRA-type reforms, getting the Congress to enact them has been difficult. In particular, caps on noneconomic damages have historically not been supported by a majority in the Congress. Even though almost every medical group has been lobbying for these changes for years, the trial lawyers and consumer groups have effectively blocked any progress by arguing that these provisions will not reduce health system costs and will only serve to deny necessary compensation to injured patients.

Because caps on noneconomic damages have been such a divisive issue, some scholars have developed an alternative proposal. Under this plan, a set of multiple caps, graduated by the severity of injury suffered by the plaintiff and by age, would be established. This would simultaneously improve the fairness and predictability of awards while controlling their rate of growth (17). Although this approach had bipartisan support and was incorporated into health reform legislation sponsored in the last Congress by former Representative Jim Cooper (Democrat, Tennessee) and Senator Bob Dole (Republican, Kansas), it met resistance from the trial lawyers and some consumer organizations.

With the new Republican majority elected to Congress in 1994, traditional tort reforms are a more distinct possibility. In fact, legal reform was a component of the "Contract with America" that Republicans have promised to enact during the 104th Congress. The College therefore challenges the new Congress to pass MICRA reforms, including caps on noneconomic damages, as soon as possible.

Even though the prospects for tort reform may be brighter than in past years, however, the opponents of reform remain strong. As a result, passage is still not guaranteed. Specifically, enacting caps on noneconomic damages will be a tough fight.

In addition, although traditional tort reforms may improve the existing liability system, they will not solve many of the problems that stem from its underlying flaws. For example, traditional tort reforms will have minimal effect on the practice of defensive medicine (16). In fact, evidence suggests that reforms that reduce the probability of being sued are more likely to effectively modify physician practice patterns than are proposals that only limit awards (18). Moreover, many experts argue that traditional tort reforms simply make it harder to sue—and will therefore not help victims of negligence receive compensation (19).
Finally, traditional reforms will not improve the liability system's ability to deter negligent care or to prevent injuries.

Thus, it is necessary to move the tort reform debate toward completely new proposals that will protect physicians but will also be seen by consumers as being in their own best interests.

**Practice Guidelines**

One possible approach is to expand the use of practice guidelines in tort litigation. The Health Security Act included a demonstration project that created an affirmative defense in a malpractice action for physicians who could show they followed an appropriate practice guideline (20). Proponents of this approach argue that the use of guidelines in the liability system will improve quality of care and reduce defensive medicine because physicians will know that they will be protected if they adhere to a previously defined standard of care.

Although this idea has merit, it is not without potential pitfalls. For example, a recent study commissioned by the U.S. Physician Payment Review Commission found that practice guidelines are about three times more likely to be used against physicians than in their defense. Moreover, the study found that conflicts over the relevance of various guidelines increased the need for expert witnesses during litigation and made physicians more vulnerable to malpractice claims (21).

**Administrative Fault-Based Approaches**

A few years ago, the American Medical Association—Specialty Society Medical Liability Project (AMA-SSMLP) developed a proposal for an alternative liability system in which an expert administrative agency would be used to resolve disputes. The proposal is designed to be fairer and more efficient than the existing system. It grants broad powers to an administrative agency—perhaps an existing medical disciplinary board—to adjudicate claims and monitor physician performance.

Under the plan, if a reviewer believed an injured person had a valid claim, the case would be heard by a Medical Board—hearing examiner who would have to render a decision within 90 days. In making his or her decision, the hearing examiner would determine if the provider is liable for the claimant’s injury and the size of the damage award. This decision would be subject to review by the Medical Board. In addition, the Board would investigate the practice patterns of physicians found liable, and physician credentialing activities would be expanded (22).

Although proponents of this approach argue that it is an efficient alternative to the current tort system, opponents have said the AMA-SSMLP plan does not remedy the existing system's inherent flaws. For example, because an individual physician can still be found negligent, the AMA-SSMLP approach will not reduce defensive medicine. In addition, like the current system, this approach would be an adversarial proceeding that hurts the physician—patient relationship. Moreover, because the entire claims resolution procedure—including the selection of the claimant's attorney, who is part of the office of the Board's general counsel—rests with the Medical Board, this plan could be seen as biased against injured patients and therefore politically unacceptable.

Consequently, many experts argue that to fix the existing system's flaws, it is necessary to develop proposals that will fundamentally change the liability system. These proposals must deter negligence, prevent injuries, compensate patients, and provide relief to physicians. Two types of long-term reforms that could accomplish these goals are no-fault liability approaches and enterprise liability.

**No-Fault and Quasi-No-Fault Systems**

Supporters of no-fault liability approaches argue that they are the best way to eliminate the major flaws of the tort system. They argue that a no-fault system is fairer to injured persons because it would compensate those who currently receive nothing from the system because they cannot establish the culpability of a physician. Proponents also say that a no-fault scheme would ultimately lower costs because it would reduce the tremendous time and money—nearly $0.60 of the malpractice insurance dollar and several years—that is currently spent litigating whether the physician was at fault (23). In addition, by eliminating the ability of patients to sue physicians, a no-fault approach could eliminate most defensive medicine costs (18).

Moreover, by imposing broad liability on the whole medical care system, a no-fault approach provides a powerful incentive for the system to develop innovative quality assurance and improvement techniques to prevent injuries (6–9). Thus, it coincides with the health delivery system's movement toward integration and the implementation of "continuous quality improvement" methods and practice pattern evaluation to monitor quality.

A no-fault system could take many forms. Their common feature is that a victim of an adverse medical outcome receives prompt compensation for the injury without the need to prove negligence. Rather, the victim need only prove that the injury was caused by or occurred during medical treatment. Often, there is a quid pro quo that no payment will be provided for noneconomic damages. Similar schemes are already used to compensate workers injured in workplace accidents and, in some states, in automobile accidents.

Advocates of no-fault systems point out that to be compensable, the injury must fall outside the range of expected or intended consequences from medical care. They add, however, that a patient has no automatic right to compensation simply because he or she was injured. After all, they say, some traumatic effects may be the inevitable byproduct of treatment that was in the patient's broader interests (6–9).

Another advantage of no-fault approaches is that they could be implemented by an administrative system. For example, because the only issue in dispute is whether the plaintiff sustained a compensable injury (and, if so, how large an award should be granted), this could be determined by an administrative body—either a hearing examiner or an expert panel (23). In contrast to the current liability system, an administrative scheme would resolve the dispute quickly. In addition, the use of experienced
adjudicators rather than lay juries would lead to more predictable and accurate results. Moreover, an administrative structure could accumulate system-wide data on quality problems and be better able than the tort system to identify problems and take corrective action.

Despite these benefits, no-fault approaches have some general potential drawbacks.

For example, what typically makes pure no-fault approaches unfeasible is the added costs that stem from compensating more patients for their injuries. Although a recent study found that a no-fault system might be no more expensive than the existing tort system (24), no-fault opponents argue that because about 4% of all hospitalized patients sustain an injury (6–9), a system that compensated all injured persons whether or not negligence was involved would be more costly.

In addition, despite little evidence that the tort system effectively prevents negligent medical behavior, critics of no-fault approaches say that these schemes may diminish the deterrent effect of the tort system because health providers will be forced to pay for all injuries, whether or not the injury was avoidable, and because the physician is disconnected from the consequences of his or her actions. Moreover, they argue, because the health system will compensate all injured persons, there might be a disincentive to treat a high-risk patient.

Opponents also argue that no-fault concepts are impractical in health care. Causation will be difficult to prove, they say, because many medical injuries and deaths are caused by the underlying condition, not the actual care received, whether negligent or not.

A no-fault system would also be unworkable with the current rules governing reports to the National Practitioner Data Bank. Without a change in current law, any physician involved in a dispute that results in compensation under a no-fault scheme could be reported to the Data Bank. Therefore, physicians would have a disincentive to help detect injuries and resolve disputes quickly. Thus, the goals of no-fault—dispute resolution and timely compensation—would be stymied.

Compensation Funds

Sweden has used a no-fault system to compensate persons for medical injuries for many years. A Special Patient Insurance Compensation Fund provides money to persons who suffer avoidable injuries from medical care. The right to compensation is based on the fact of an avoidable injury, not on a finding of fault or merely unfortunate results. Physicians often help their patients access the fund. After eligibility is initially determined, physicians and claim managers employed by the Fund apply specific eligibility criteria and make a final decision. The average report takes about 6 months (25).

In the United States, Florida and Virginia have established no-fault systems to compensate parents for birth-related injuries to infants. These systems were adopted in the mid-1980s in response to a liability insurance crisis for obstetricians. The states set up a fund that was paid for by assessments on participating hospitals and obstetrician-gynecologists. In addition, all other physicians must pay a small assessment each year into the fund. Claims are filed through the no-fault process if the physician involved is a program participant, if the injury to the child occurred during labor, and if the injury meets the program’s definition of a compensable injury. The claimants are eligible for payment for all medical expenses for the rest of the child’s life, with awards paid as expenses are incurred. The parents are not allowed to bring suit in tort.

These programs have shown promise. Insurance rates for obstetricians and other physicians have stabilized, and injured children have received compensation quickly—often within 90 days. Observers have noted that these programs show that no-fault programs can be designed effectively (26).

Avoidable Classes of Events

Another type of no-fault system, advocated by Bovbjerg and Tancredi (27), uses lists of avoidable classes of events. Unlike a “true” no-fault system, this system targets classes of adverse outcomes that are agreed in advance to be avoidable. Avoidable classes of events require the creation of a set of bad medical outcomes that generally would not occur if a patient received good care. These lists would be created by medical experts on the basis of their clinical experience and epidemiologic evidence. A qualified administrative body could determine whether they apply in a particular dispute.

Proponents of this approach point out that such lists have already been created for obstetrics and general and orthopedic surgery. Studies have shown that these lists cover a large proportion of the serious cases that are typically litigated (23).

Because this system involves applying expertise in advance rather than by a retrospective case-by-case review, it is more predictable and efficient than the current system. In addition, more accurate information about injuries would be acquired, and clinicians would have better feedback. Simplified processes could replace costly and complex litigation, allowing claimants to be compensated faster. Defensiveness could be reduced because these lists would be professionally validated, and taking defensive measures that did not cut injury rates would not help practitioners.

However, there are concerns about the practicality and complexity of this approach. It is unclear whether accurate and fair lists of events could be developed. In addition, there would probably be concerns about the list development process. For example, disputes could arise about who made the decisions and on whose advice. Moreover, equity concerns are raised if certain injured persons receive levels of compensation different from what others receive simply because their injury was included in the list.

Early Offer of Settlement

Another model is called neo-no-fault or “early offer of settlement.” Under this program, physicians and other health providers can offer an injured person, within 90 days, payment for all future economic losses (excluding payments from other sources). In return, the plaintiff gives up his or her right to sue for damages. In one version of this idea, the defendant can come forward only after receiving notice of a lawsuit by the plaintiff. In
another iteration, the defendant must make the offer immediately after learning of the patient’s injury.

By encouraging settlement offers to most of the patients not now helped, this model allows injured persons to recover—and recover faster—when they otherwise would not. In addition, providers can resolve their disputes quickly without having to pay litigation costs and can avoid payments for pain and suffering.

Opponents of this plan argue that it is unduly coercive on patients. Moreover, they claim, the immediate payment version of the idea relies on provider willingness to accept responsibility in more cases. In addition, like other no-fault remedies, it might work “too well,” and large numbers of cases would have to be paid.

Enterprise Liability

Another proposed reform that focuses on compensation for the injured party and promotes injury prevention is enterprise liability (or organizational liability). This theory recognizes the increasingly organizational character of the health care system and attempts to reconcile the legal standard of care with the changing circumstances of the practice of medicine.

The original version of this idea envisioned a hospital as the “enterprise” that is the focus of liability and is responsible for quality monitoring. More recently, however, system reformers have attempted to apply enterprise liability concepts to health plans or other health care organizations.

Under enterprise liability, a hospital (or health plan or another health care organization) would bear the exclusive liability for medical malpractice by affiliated health care providers, whether or not these providers were employees of the organization. The only exception would be for an injury resulting from intentional misconduct, in which case the individual provider would still be liable (28).

Under the original proposal that envisioned hospitals as the liable enterprise, the hospital would accept liability for malpractice by an affiliated provider as long as the claimant was subsequently treated for the same underlying medical condition, regardless of where the malpractice, or the resulting injury, took place. Consequently, if the claimant was subsequently hospitalized after malpractice occurred in a physician’s office, that hospital would be liable. Individual providers would be relieved of liability but would be required to pay the hospital an annual surcharge to reimburse it for the increased costs of accepting liability (Abraham KS, Weiler PC. Organizational Liability for Medical Malpractice: An Alternative to Individual Health Care Provider Liability for Hospital-Related Malpractice. Unpublished manuscript; March 1993).

Although this may seem like a new idea, some institutions, such as the Federation of Jewish Philanthropies and the Risk Management Foundation of the Harvard Medical Institutions, are already operating programs using these concepts. At the Federation of Jewish Philanthropies, for example, the same insurer provides coverage to several Federation hospitals and to many of the individual physicians who admit most of their patients to these hospitals. If a physician is sued over an event occurring at the hospital, the hospital insurer manages a joint defense.

Moreover, in the United Kingdom, the National Health Service Management Executive recently instituted an administrative change similar to enterprise liability. In general, the National Health Service agreed to indemnify clinical staff in hospitals for their negligence, thus relieving physicians of their obligation to purchase malpractice insurance (29).

In addition, many areas of tort law have moved away from personally blaming particular individuals for accidental injury resulting from the activity of an organization. For example, when an airplane crashes, the airline is potentially liable, not the pilot.

Health care law is also moving in this direction. Many health maintenance organizations have been held responsible for the malpractice committed by staff physicians. Hospitals are also liable under “vicarious liability” for the malpractice committed by their employees. As the health care delivery system becomes more organized and integrated, it is likely that courts will hold health care organizations responsible for the actions of affiliated health providers, including physicians.

Although the courts are beginning to hold hospitals and health plans liable in some circumstances, current law will not relieve individual physicians of liability. Thus, the problems in the current tort system will not be resolved merely by expanding liability to health plans, hospitals, or other entities. Enterprise liability is designed to take the law one step further by removing individual physicians as defendants.

Proponents of enterprise liability argue that it will improve care, reduce costs, and promote insurance stability. They also argue that it is a more appropriate legal response to the changing health care delivery system. Improvement in the quality of care will stem from making organizations liable because they are the entities best able to develop injury prevention and quality monitoring programs (30).

Hospital quality assurance programs, continuous quality improvement techniques, and practice pattern analysis are all examples of the growing trend of improving care through aggregating data rather than through reviewing individual cases. By examining the health care system from an epidemiologic perspective, hospitals or integrated provider networks will be able to identify risks and prevent injuries. Institutional liability could continue this trend by encouraging collective, institution-wide monitoring and quality feedback.

In addition, care could improve because of the improvement in the provider patient relationship. Physicians cite litigation as a major source of tension in the their relationships with patients (25). Proponents of enterprise liability argue that as the threat of suits against physicians disappears, the negative effects on the physician-patient relationship, including mistrust and the practice of defensive medicine, should disappear (Abraham KS, Weiler PC. Organizational Liability for Medical Malpractice: An Alternative to Individual Health Care Provider Liability for Hospital-Related Malpractice. Unpublished manuscript, March 1993).

Costs would be decreased by the reduction in defensive medicine, as well as by the reduced administrative burden from malpractice litigation with only one defendant (Abraham KS, Weiler PC. Organizational Liability for Medical Malpractice: An Alternative to Individual Health Care
Provider Liability for Hospital-Related Malpractice. Unpublished manuscript; March 1993). These reductions could be passed on to physicians. At the Federation of Jewish Philanthropies, the physicians participating in the "channeling" program pay liability insurance premiums that are as much as 25% less than those charged by other insurers for similar coverage (Federation of Jewish Philanthropies Report. Voluntary Attending Physicians Professional Liability Insurance Program).

Proponents also argue that enterprise liability is in keeping with trends in the health care delivery system. Traditional medical malpractice law is built on a delivery system model that is becoming more and more rare—one in which individual physicians have the sole authority to define appropriate health outcomes and are obligated to do so without considering system resources. The realities of health care today and in the future, however, are that system and health plan cost-containment strategies require physicians to ration care according to cost-effectiveness. Thus, physicians are put in a double bind—not having the power or resources to maintain the standard of care but being legally responsible for failing to meet it (31).

Moreover, health plans have been able to use the Employee Retirement Income Security Act (ERISA), a federal law governing health benefits plans, to avoid liability regarding their benefits decisions. The courts have ruled that ERISA preempts all state laws and regulations, including tort claims against the health plan. The courts have upheld the ERISA preemption even when they have recognized that insurers are making medical decisions through their utilization review processes (32). Thus, even when patients and their physicians are overridden by a health plan regarding a treatment decision, the plan cannot be sued for negligence. The College calls for federal legislation to remedy this problem by allowing an injured person to sue a health plan for damages.

Unlike the health plan, the physician does not receive special legal protection and therefore remains liable. Enterprise liability will help relieve this pressure and protect physicians because it recognizes the diffusion of medical decision-making responsibility. When physicians have a monopoly on the power to define medical outcomes, they have responsibility for negligent medical decisions. But the separation between providers and payers is blurring, and payers in the managed care context influence medical decisions. Thus, it seems reasonable that health care organizations assume liability.

For these reasons, many observers have advocated that enterprise liability concepts be expanded to health plans. For example, the ability of health plans to monitor quality and develop information on injury prevention was one of the key reasons an advisory group to the Clinton administration proposed extending enterprise liability to health plans (33).

Nevertheless, there are several potential drawbacks to transferring liability to a hospital, health plan, or health care organization. For example, there are questions about whether it can work in practice. For enterprise liability to be effective, physicians have to be employees of the organization or there has to be sufficient integration so that the health plan and physicians are working together on the necessary quality assurance and injury prevention programs. In the current delivery system, this may only be true in certain health maintenance organizations.

Furthermore, practitioners belonging to many health plans or with privileges at many hospitals with different rules pose a problem, as do solo practitioners. Other implementation issues must be addressed, such as how to apply these concepts to "out of network" providers and in markets where fee-for-service still dominates. If current market trends continue, however, the delivery system structure necessary to support enterprise liability models should soon be in place in many areas (30).

In addition, as with a no-fault program, implementation of an enterprise liability scheme would require modification of the National Practitioner Data Bank reporting rules. It would be unfair for hospitals or health plans that are managing the legal defense to settle a case and report the physician to the Data Bank if he or she had no part in the decision to settle the claim. Moreover, because the individual physician is removed as the focus of liability, reporting an individual physician to the Data Bank in an enterprise liability system seems illogical.

Another potential problem is that, as the now legally responsible entity, institutions and health plans may have an incentive to conceal injuries or bad outcomes rather than taking steps to prevent them (19). They also may have an incentive to avoid treating high-risk patients or trying innovative procedures. In addition, it is possible that juries in lawsuits against an entity will view it as a deep-pocket corporation and less deserving of sympathy than an individual physician. Damage awards could thus increase, mitigating any cost savings. This makes it particularly important that College-endorsed caps on damages be enacted. Moreover, in a fault-based system, enterprise liability may not reduce defensive medicine because incentives to do extra procedures will exist.

Skeptics of enterprise liability also say it may not be an overall gain for participating physicians. For example, they argue that it is unclear whether physicians will benefit from the tradeoff of no personal liability if they are subject to more control by a hospital or health plan. Many physicians already feel that managed care organizations have stripped them of their clinical autonomy. Although enterprise liability advocates say that these trends argue for a liability system that shields physicians, opponents believe that an enterprise liability system will exacerbate the problem. Moreover, opponents argue that by shifting the duty of care, enterprise liability could dilute the role of the medical profession as a patient advocate and blur the distinction between physicians and other providers.

Conclusion

Over the years, the College has consistently supported traditional tort reforms, such as those contained in MICRA, to provide immediate relief to physicians and improve a poor system. We reiterate our support for these concepts. Moreover, a federal law should be enacted that allows plaintiffs to sue their health plan for negligence if the plan's benefits or treatment decisions lead to an injury. Both of these policies are necessary short-term changes to the tort system. We also want to support further study of creating caps for noneconomic
damage awards that are graduated for the severity of the injury sustained.

Nevertheless, it seems clear that in the long term, fundamental reform is necessary to eliminate the system’s inherent flaws. A new structure will be better able to accomplish the goals of preventing and detecting injuries, compensating patients, and reducing defensive medicine costs. Alternative liability approaches are also necessary because the existing system does not adequately protect physicians, who are faced with differing practice arrangements and an increasingly complicated clinical decision-making environment.

Although expanded use of practice guidelines could streamline the existing system, they clearly still leave physicians vulnerable. The administrative approach designed by the AMA-SSMLP does not accomplish the goals of liability system reform and does not seem politically feasible.

In contrast, enterprise liability shows promise. Whereas the existing tort system was built on a health care delivery system that is becoming rare, enterprise liability reflects the realities of a more integrated delivery system. We caution, however, that it is premature to endorse a national policy that mandates immediate implementation of enterprise liability throughout the health care system.

Thus, the American College of Physicians expresses support for demonstration projects to determine the feasibility of enterprise liability. If an entity—hospital, health plan, or organization—can show that it can develop injury prevention programs and effectively monitor quality of care, and if its affiliated physicians agree to participate, it should be allowed to develop an enterprise liability system.

The College also believes that no-fault concepts should be tested. Although some observers have argued that pure no-fault systems may be too costly, others have said that a no-fault system may not be more expensive than the existing tort system. One model worthy of closer examination is an administrative compensation system governed by a medical expert panel, which would be responsible for using a previously established list to determine if an injury is compensable and the amount of damages that should be awarded. Under this scheme, awards for noneconomic damages would be prohibited. Should a claimant be dissatisfied with the decision of the panel, certain appeal procedures would be available.

We urge the U.S. Congress to pass legislation authorizing the Secretary of the Department of Health and Human Services to provide grants to develop no-fault and enterprise liability projects. To be eligible to receive federal money, a grantee would have to show that its system meets the following criteria.

1. It would resolve disputes quickly and fairly.
2. It would provide timely compensation to injured persons.
3. It would improve the quality of care.
4. It is supported by participating physicians. This will ensure that physicians are involved in all phases of the project’s development and implementation, including development of risk management systems, quality monitoring, and injury prevention.
5. It has policies in place guaranteeing certain “due process” protections (5) for physicians.
6. It has physician advisory panels to oversee liability claims management for health plans and organizations so that physicians are protected from undue micromanagement.

In addition, as part of these demonstrations, the rules regarding the National Practitioner Data Bank must be changed to permit nonreporting of individual physicians participating in the projects where appropriate.

These are not overly burdensome criteria. For example, at the Federation of Jewish Philanthropies, participating physicians work regularly with the Risk Management Department, and policies have been established to give a panel of physicians the opportunity to review malpractice claims before the hospital insurer makes a settlement.

It is important to note that demonstration projects can use enterprise liability and no-fault concepts simultaneously. An entity could replace an individual as the focus of liability, and no-fault principles could be used to lower system costs and improve compensation to patients. A good example is a hospital that creates an enterprise liability plan with its physicians but also has its physicians develop a list of avoidable classes of events. A similar scheme is about to be implemented in Utah.

Demonstrations will provide policymakers with sufficient information for determining future courses of action. We hope this will ultimately lead to true liability reform that will compensate injured patients, prevent injuries, and relieve physicians of the burdens the current system imposes.

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