



Improving Malpractice Prevention and Compensation Systems

An RWJF national program

SUMMARY

Improving Malpractice Prevention and Compensation Systems (IMPACS) was a national initiative of the Robert Wood Johnson Foundation (RWJF) to support promising new mechanisms to prevent negligent medical occurrences and to compensate patients injured by medical care.

Medical malpractice—how to identify it and compensate patients injured by it—has long been a difficult issue confronting American health care. The **tort system**, the traditional arena for resolving malpractice complaints, provides relief to relatively few.

IMPACS was intended to translate lessons learned from earlier studies of medical malpractice into demonstration projects that would test alternatives to the tort system and, thus, help move malpractice reform from the drawing board to the real world.

Key Results

In addition to demonstration projects, the national program supported evaluation studies of innovative malpractice reform systems.

The program funded the work of 11 grantee organizations. Five of the projects were demonstration projects and six were evaluation or research projects. See the [Project List](#) for reports on the projects.

- Of the five demonstrations initiated by the national program, only one—an intervention project Vanderbilt University Medical Center—was implemented. The other four did not progress beyond the planning stage.

As a result, the program's objective—to develop a new generation of mechanisms to prevent and compensate for medical malpractice—went largely unmet.

- *Improving Malpractice Prevention and Compensation Systems* produced solid research by respected scholars that may benefit policymakers and researchers when the next malpractice crisis or other development sparks a deeper interest in reform.

- A new system developed with national program funding has promise of reducing malpractice complaints and costs. The Vanderbilt demonstration—although still underway and not conclusive—shows significant potential for replication.
- *Improving Malpractice Prevention and Compensation Systems*-funded analysis was used to estimate the incidence of medical error in the nation's health system.

A 1999 Institute of Medicine report on the quality of care *To Err is Human: Building a Safer Health System* cited the findings generated by the program as one of two sources for an estimate that medical mistakes kill 44,000 to 98,000 people annually in American hospitals.

- The national program provided a forum for experts in the malpractice field to exchange and explore new ideas.

Program Management

The national program office was established at Georgetown University School of Medicine, [Institute for Health Care Research and Policy](#), Washington, in March 1994. The program's national advisory committee (see [Appendix 1](#) for a list of members) guided the selection of the 11 projects.

Funding

In October 1992, RWJF's Board of Trustees authorized spending up to \$5.5 million over four years to support the program.

THE PROBLEM

Medical malpractice—how to identify it and compensate patients injured by it—has long been a difficult issue confronting American health care.

The title of a 1986 US General Accounting Office report captures its intractability: *Medical Malpractice—No Agreement on Problems or Solutions*. From the perspective of patients, providers, and society as a whole, the tort-based system now used to resolve malpractice complaints has flaws.

Research shows that the current system provides relief to relatively few patients who sustain medical injuries. Even when successful, malpractice cases produce inconsistent monetary awards and can take years to resolve.

A 1991 Harvard Medical Practice Study showed that of the 30,000 patients studied in New York State, 1,133 suffered an unintended injury as a result of medical treatment; of those patients, 14 percent died of their injuries.

Extrapolated to the United States, researchers concluded that more than 1.3 million people are injured annually by adverse events, and some 180,000 die, at least in part because of these injuries.

Health care providers have their own set of complaints about the tort system. Many physicians view it as overly intrusive and contend that it turns patients into potential adversaries.

Out of concern for liability exposure, some doctors have given up their practices, limited the kinds of procedures they perform, or restricted the types of patients they see.

Evidence suggests this fear of court action is unwarranted. The same Harvard study concluded that doctors' perceived risk of suit was three times the actual risk. Nevertheless, the effects of the perception are real enough.

Defensive medicine—procedures initiated simply to avoid liability—is widely believed to be a factor in medical-cost inflation, although some observers dispute its significance in total health spending.

For society as a whole, one of the most obvious defects of the tort system is its high overhead. Research indicates that of every dollar paid by providers for malpractice insurance, claimants get only about 40 cents in compensation. The rest goes for legal fees, court costs, insurance company administration, and other expenditures.

Additionally, malpractice claims go through periodic escalations in frequency and severity that affect insurance affordability and availability. On occasion, these so-called malpractice crises threaten to interfere with the public's access to health care.

Finally, while the tort system imposes monetary penalties on some providers, studies of medical error show the system has not been a strong deterrent to substandard care.

A malpractice crisis in the mid-1970s and another in the 1980s prompted relatively minor changes in adjudication procedures at the state level. These included limits on both damage awards and plaintiffs' attorneys' contingency fees.

While these new restrictions reduced the cost of malpractice liability insurance, they failed to address the underlying problems discussed above. Also, the savings came disproportionately from restrictions on the most severely injured claimants, thus adding to what critics see as the inequity of the system.

Despite the many shortcomings of the malpractice tort system, fundamental reform has been stymied by lack of agreement on the exact nature of the malpractice problem and its solution and, to a considerable extent, by the strength of the interests vested in the status quo, most notably trial attorneys.

CONTEXT

In the 1980s, as malpractice insurance premiums were once again rising to the crisis point, the Robert Wood Johnson Foundation (RWJF) undertook its first significant effort to address the issue by initiating the *Medical Malpractice Program*.

The national program awarded 19 grants totaling \$4.5 million to:

- Develop and analyze data on malpractice and its impact.
- Propose new strategies for reducing medical injury and compensating injured patients.

Most of the grantees were universities, and the projects consisted primarily of studies intended to fill what RWJF saw as a gap in existing legal and policy literature.

The grants, which were awarded in 1987 and 1988, included partial support of the landmark Harvard Medical Practice Study cited above (Grant ID# 011215). (New York State was the principal funder of that research.)

The Harvard team's conclusions were reinforced by *Medical Malpractice Program*-funded researchers at the University of Chicago who measured medical error in three surgical units and found that only a small percentage of victims brought suit.

Other grantees explored such topics as:

- Problem-prone clinical processes.
- The effectiveness of hospital-based risk management programs.
- The validity of physicians' assumptions about likely malpractice claimants.

Still another group of grantees evaluated various tort reforms instituted since the late 1970s as well as alternatives to the tort system such as mediation and arbitration. (For a complete list of the 19 *Medical Malpractice Program* grants, see [Appendix 2](#).)

After the *Medical Malpractice Program* ended, RWJF awarded additional grants for malpractice research, including one to study Sweden's no-fault system for compensating medical error victims (ID# 018579). (See [Appendix 3](#) for a list of ad hoc grants.)

By the early 1990s—largely because of the more than 100 journal articles, monographs, and books produced by the *Medical Malpractice Program* projects—RWJF considered the malpractice problem well documented and believed the knowledge existed to develop effective solutions.

The most promising models for reform fell into three general categories:

- **Enterprise liability.** Under this approach, also termed enterprise responsibility and institutional liability, the liability for malpractice shifts from the individual practitioners to the hospital, medical group, or other provider institution.

The advantage is that responsibility for malpractice then lies at the level where institutional mechanisms can most effectively enforce accountability and implement preventive measures.

However, the feasibility of enterprise liability had not been determined. It was uncertain, for example, whether physicians and hospitals would accept the liability shift and, if they did, whether legislative changes would also be needed.

- **Alternative dispute resolution.** This category consists of administrative mechanisms that replace part or all of the existing tort system for determining compensation. By the early 1990s some states were already experimenting with alternative dispute resolution.

Some 15 states allowed arbitration to resolve medical malpractice claims, and North Carolina authorized court-ordered mediation in a few selected counties. Some physician groups wanted to go further and create state administrative boards to replace the courts altogether. The ability of alternative dispute resolution to replace courts had not been demonstrated.

- **No-fault plans.** Under no-fault a medically injured patient does not have to file a lawsuit and prove fault in order to be compensated. Instead, compensation is awarded administratively.

As a result, proponents argue, a much higher proportion of the medically injured receive compensation—and receive it quickly. Also, because litigation is eliminated, much of the money that now goes into overhead can go directly to the victim.

More feasible is the limited implementation of no-fault for selected injuries. In the late 1980s, Florida and Virginia enacted the nation's first selective no-fault systems. Both state programs restricted coverage to claims involving neurologically impaired newborn babies.

Given the history of a malpractice crisis about every 10 years, RWJF staff believed another crisis was likely in the 1990s. They also believed that a new upsurge in claims and premiums would generate increased interest in—and support for—changes in malpractice compensation such as those discussed above.

In addition, health care reform was becoming a major national issue, and it was believed that any comprehensive overhaul of the nation's health care structure would likely include changes in the malpractice component.

While aware of the strong and longstanding barriers to malpractice reform, RWJF considered circumstances ripe for stimulation of a new generation of malpractice compensation mechanisms.

PROGRAM DESIGN

In October 1992, the RWJF Board of Trustees authorized spending up to \$5.5 million over four years to support the demonstration and evaluation of promising new systems for preventing negligent medical occurrences and compensating persons injured by medical care.

The initiative—named *Improving Malpractice Prevention and Compensations Systems (IMPACS)*—was intended to translate the lessons learned from the *Medical Malpractice Program*-supported research into functioning demonstration projects and, thus, move malpractice reform from the drawing board to the real world.

The goal was to test reform models and develop a new generation of mechanisms to deal with malpractice cases.

IMPACS did not prescribe specific reform models for demonstration but instead set four areas in which projects were to seek significant improvement over the existing tort system. Projects were to:

- Provide more appropriate incentives to prevent medical injuries without inducing defensive medicine or adversarial provider-patient relationships.
- Incorporate malpractice risk management into health care organizations' quality-improvement initiatives.
- Achieve greater efficiency or lower overall cost in processing medical injury claims or compensating injured patients through non-adversarial systems.
- Provide benefits that are more consistent with actual damages for a greater proportion of injured patients.

RWJF was not interested in completely replacing the medical malpractice tort system but in stimulating innovations that had realistic potential for wider adaptation.

Demonstrations of enterprise liability, selective no-fault, and such alternative dispute resolution mechanisms as binding arbitration were the kinds of projects that RWJF sought to fund.

Projects could cover a state or other geographic area, or they could be limited to a specific health care organization, such as a multi-hospital system. They could test a new model or a new application of a previously developed model.

While demonstration projects were to be the principal focus of the national program, it also would fund evaluation studies of innovative systems. These could be systems already in operation or evaluations of demonstrations.

Grantee organizations funded to conduct demonstrations were expected to provide a 25 percent match for the project's implementation phase.

THE PROGRAM

National Program Office

The national program office was established in March 1994 at Georgetown University School of Medicine, [Institute for Health Care Research and Policy](#), Washington.

The national program director was Robert A. Berenson, M.D., a former health policy adviser in the Carter administration. In February 1998, Berenson left the program and took a position in the Clinton administration.

Deputy director Julia S. Howard oversaw the program until the national program office closed in September 1999. Thereafter, RWJF directly monitored the one project still in operation.

The national program office's principal role was to work closely with the national advisory committee to review proposals for projects and recommend the most promising to RWJF for funding.

The director also sought to bring together unrelated research teams when it appeared collaboration would enhance a project's results.

Additionally, the national program office:

- Developed project selection criteria.
- Conducted outreach to attract proposals.
- Identified and visited project sites.
- Monitored the progress of projects.
- Helped grantee organizations gain access to data belonging to health-related organizations.
- Organized meetings to explore malpractice issues and ideas.
- Promoted dissemination of articles written by *IMPACS*-funded researchers.
- Provided liaison with RWJF staff.

National Advisory Committee

A 12-member national advisory committee drawn largely from academia was formed to guide the selection of projects.

Walter J. Wadlington, L.L.B., of the University of Virginia School of Law and national program director of RWJF's earlier malpractice program, chaired the national advisory committee. (For the full committee membership, see [Appendix 1](#).)

The national advisory committee played a significant role in reviewing applications and recommending projects for funding. Several members made site visits to evaluate projects.

Project Selection

Eleven grantees received project funding under *Improving Malpractice Prevention and Compensation Systems*. With two exceptions the grantees were universities, university-related entities, or research organizations.

Initially, RWJF staff anticipated that projects would be identified without a formal solicitation. However, after meeting in March 1994 with malpractice experts on the program's needs and operations, the national program office developed a call for proposal.

The call for proposal—issued in July 1994 and directed at the fields of insurance, law, medicine, policy, government, and academia—scheduled two application due dates—October 14, 1994, and March 15, 1995.

As a result of the two cycles, the national program office and the national advisory committee recommended the following three demonstration projects and two evaluations to RWJF for funding.

Three Demonstration Projects

- Study and design of a no-fault administrative compensation plan for Colorado and phasedown of activities. Grantee: Copic Medical Foundation, Denver, Colo. (See [Program Results](#) on ID#s 022603 and 029969.)
- Study and design of a no-fault, enterprise liability compensation system to be tested at selected Utah hospitals. Grantee: Utah Alliance for Health Care, Salt Lake City, Utah. (See [Program Results](#) on ID# 023685.)
- Development of a system to identify and intervene with health care providers at high risk of malpractice claims and testing of the system at four community hospitals in Alabama. Grantee: Vanderbilt University Medical Center, Nashville, Tenn. (See [Program Results](#) on ID#s 028592 and 033572.)

Two Evaluation Projects

- Evaluation of the Florida and Virginia no-fault programs for birth-related neurological injuries. Grantee: Duke University Medical Center, Durham, N.C. (See [Program Results](#) on ID# 027070.)
- Evaluation of the use of court-ordered mediation for medical malpractice cases in several North Carolina counties and expansion of the study to include a control group of counties. Grantee: Wake Forest University School of Law, Winston-Salem, N.C. (See [Program Results](#) on ID#s 027071 and 032057.)

Challenges

Nevertheless, the response to the call for proposal was not what the national program office and the national advisory committee had hoped. While many applicants addressed research questions, there were few promising proposals for demonstration projects.

The national program office cited four reasons for the disappointing results:

- A lack of innovative models ready for demonstration in the area of risk management and reduction.
- Difficulty in promoting collaboration among the diverse disciplines—law, medicine, and health care administration—necessary to implement an alternative compensation system.
- Reluctance on the part of health-related organizations to participate as demonstration and evaluation sites. Two promising projects had to be scrubbed because health maintenance organizations (HMOs) would not agree to become demonstration sites.
- A shift in interest among legal scholars, consumer advocates, legislators, physicians, and health service researchers away from malpractice reform to issues generated by the increasing role of managed care—such as HMO corporate liability in coverage disputes and appeal rights for managed care subscribers. Additionally, the malpractice crisis that RWJF personnel had anticipated to fuel interest in comprehensive reform did not materialize; instead, the *IMPACS* program unfolded during a period of claim stability.

Second Call for Proposals

As part of an effort to identify new project opportunities, in April 1997, *IMPACS* issued a second call for proposal, this one directed at studies of the [National Practitioner Data Bank](#).

The National Practitioner Data Bank is an information repository created by Congress in 1986 to restrict the undisclosed movement of incompetent physicians from one state to another.

All physician malpractice payments and certain other adverse professional actions must be reported to the national data bank.

A number of unanswered questions about the national database's impact on malpractice issues were relevant to *IMPACS*. There was speculation, for example, that the reporting requirement might be dissuading physicians from settling suits and, thus, forcing more disputes to trial.

As a result of efforts to generate more proposals, the national program office and the national advisory committee recommended six additional grantees for funding by RWJF.

The following projects were added in the program's third and fourth years.

Two Demonstration Projects (Planning):

- Development of a court-ordered arbitration and mediation program in conjunction with the Philadelphia (Pa.) Court of Common Pleas. Grantee: Private Adjudication Center, Durham, N.C. (See [Program Results](#) on ID# 031124.)
- Development of a voluntary mediation model for resolving medical injury claims and publication of project findings. Grantee: Harvard School of Public Health (Boston, Mass.) (See [Program Results](#) on ID#s 031969 and 033629.)

Four Evaluation/Research Projects

- Continued analysis of Colorado and Utah medical injury data, and analysis of federal and state regulatory obstacles to no-fault and a comparison of the reliability of two record-review processes. Grantee: Brigham and Women's Hospital (Boston, Mass.). (See [Program Results](#) on ID#s 029907 and 032865.)
- Evaluation of the use of binding arbitration agreements by health care providers in California; grantee RAND Corporation, Santa Monica, Calif. (See [Program Results](#) on ID# 029968.)
- Research on the impact of NPDB reporting requirements on the resolution of malpractice claims. Grantee: Northwestern University, Evanston, Ill. (See [Program Results](#) on ID# 033494.)
- Study of enterprise liability in large, capitated physician organizations. Grantee: University of California, San Francisco, Institute for Health Policy Studies, San Francisco, Calif. (See [Program Results](#) on ID# 033501.)

Communications

IMPACS sponsored two conferences to explore malpractice issues. Experts representing a number of disciplines attended the conferences, which addressed the following:

- Emerging liability issues in managed care, October 1995 in Park City, Utah. Subsequently, the national program office produced a pamphlet for general dissemination highlighting information presented at the conference.

Additionally, the national program commissioned a paper by one of the presenters, William Sage, that was published in *Health Affairs*.

- Developments in medical malpractice, September 1997 at Duke University, Durham, N.C. The presentations—the majority by *Improving Malpractice Prevention and Compensation Systems*-funded researchers—were published in the combined Winter & Spring 1997 issues of *Law and Contemporary Problems*, a publication of the university's School of Law.

Additionally, in November 1996 the national program cosponsored a briefing in Washington for congressional staff and journalists on new approaches to handling medical malpractice.

More than a hundred participants attended the half-day session, which was also sponsored by the American Academy of Actuaries and the Alliance for Health Reform.

The national program office also conducted meetings with outside experts to discuss the value of voluntary mediation and National Practitioner Data Bank research topics.

A paper describing the purpose and activities of the *Medical Malpractice Program* and *Improving Malpractice Prevention and Compensation Systems*—written by Cantor, Berenson, Howard, and Wadlington—was published as a chapter in the 1997 edition of *The Robert Wood Johnson Foundation Anthology*.

It was reprinted in the January 1998 issue of the *Journal of the Mississippi State Medical Association*. An earlier version of the article appeared in *Health Affairs*.

For additional details of these communications activities, see the National program office [Bibliography](#).

OVERALL PROGRAM RESULTS

- **Of the five demonstrations initiated by *Improving Malpractice Prevention and Compensation Systems*, only one—Vanderbilt University Medical Center's intervention project—was implemented;** the other four did not progress beyond the development or planning stage.

As a result, the program's objective—to develop a new generation of mechanisms to prevent and compensate for medical malpractice—went largely unmet.

The specific factors differed from project to project, but the program director attributed the outcome generally to the political and economic complexities of the

malpractice issue, including strong resistance from the plaintiffs' bar and other interests invested in the tort system.

- ***Improving Malpractice Prevention and Compensation Systems* produced solid research by respected scholars that can benefit policymakers and researchers in the future when another malpractice crisis or other development sparks a deeper interest in reform.** For example, journal articles stemming from the evaluation projects enhanced understanding of reform alternatives. The Colorado and Utah work is available to legislators in other states interested in the potential cost of—and barriers to—no-fault.

The National Practitioner Data Bank study could assist Congress in evaluating the strengths and weaknesses of that system.

Work conducted under the program in the mid-1990's was referenced at an Institute of Medicine meeting on malpractice in the spring of 2002.

Other research illuminated malpractice issues surrounding the growing area of managed care.

- **A new system developed with *Improving Malpractice Prevention and Compensation Systems* funding has promise of reducing malpractice complaints and costs.**

The Vanderbilt demonstration—although still underway and not conclusive—shows significant potential for replication.

Already, two hospitals unrelated to the national program have instituted the system, which tracks hospital patient complaints and provides informal counseling to physicians found to be at high risk of a malpractice claim.

- ***Improving Malpractice Prevention and Compensation Systems*-funded analysis was used to estimate the incidence of medical error in the nation's health system.** A 1999 Institute of Medicine report on the quality of care entitled *To Err is Human: Building a Safer Health System* cited the Colorado-Utah findings as one of two sources for an estimate that medical mistakes kill 44,000 to 98,000 people annually in American hospitals.

Even at the low end of the estimate, that would be more than die from highway accidents, breast cancer, or AIDS. The estimate focused national attention on the report, which set out a national agenda for improving patient safety.

- ***Improving Malpractice Prevention and Compensation Systems* provided a forum for experts in the malpractice field to exchange and explore new ideas.** While the program failed to attract as many new researchers and scholars into the field as the program director had hoped, sponsored conferences helped those who are active to keep up with emerging issues and reform possibilities.

LESSONS LEARNED

The program director and deputy program director cited the following as lessons to be learned from *Improving Malpractice Prevention and Compensation Systems* about work generally in the field of medical malpractice reform:

1. The political and economic interests invested in the current tort system make medical malpractice reform extremely difficult to achieve.

Before undertaking a reform project, funder and grantee should fully identify the obstacles to success and strategies for overcoming them. The barriers facing *Improving Malpractice Prevention and Compensation Systems* were not fully appreciated by RWJF, the national program office, and some grantees when the program started.

2. Grants alone will not reform the malpractice system; a compelling policy rationale and an active public relations campaign are also necessary in order to develop a committed constituency for reform. The most effective way to promote malpractice reform may be as a patient safety mechanism that can catch more medical errors than the current tort system.

IMPACS showed that, except for the small number of policy and health researchers working in the field, there is currently no strong constituency for malpractice reform. Certainly there are advocates for reform, but for many the issue is not a top priority. For many reform opponents, however, it is the number-one issue.

3. The medical malpractice issue has a "Catch-22" that reformers must overcome if they are to be successful. When no malpractice crisis exists, there is no interest in changing the system. And yet when a crisis does exist, the push is to limit monetary awards, not to make fundamental changes.

4. Persuading health care-related facilities and organizations to participate in medical malpractice projects is difficult. Even after getting a verbal agreement or letter of support, some grantees experienced difficulties when they arrived at a site to begin work.

Site access is facilitated by a fully developed plan that shows how the project will benefit the collaborating site.

AFTERWARD

The *IMPACS* national program office closed in 1996. Several of the individual projects continued past the closing of the NPO.

After the close of the *IMPACS* national program, RWJF continued to fund some projects related to malpractice reform. But RWJF also attempted to stimulate interest in the broader area of "medical liability," which focuses less on negligence and its legal

consequences, and more on creating transparency and accountability when undesired medical outcomes occur.

"Errors happen," explained Nancy Barrant, RWJF program officer. "We need to get the errors out in the open so we can learn from them."

RWJF provided funding for these projects through individual grants issued outside of national programs, three grants under its national program *Changes in Health Care Financing and Organization* (HCFO) and one under its *Investigator Awards in Health Policy Research* national program. (See [Appendix 5](#) for a list of the 10 grants awarded as of May 2007.)

These projects fall into three main categories:

Increasing Disclosure and Transparency

Early evidence suggests that hospitals that have started to implement policies of disclosure and apology in the aftermath of medical errors are experiencing reductions in malpractice claims and malpractice premiums.

For example: after implementing a disclosure and apology policy, the [University of Michigan Health System](#) experienced a 60 percent decline in malpractice claims from 2001 to 2005 and a 50 percent decline in litigation costs.

Among the grants in this area:

- Researchers at the [Urban Institute](#) received funding under HCFO (Grant ID# 047939) to examine whether greater transparency in patient-provider relations can reduce medical fears and litigiousness, and improve participation in safety initiatives. RWJF awarded the grant through its *Changes in Health Care Financing and Organization* national program (for more information see [Program Results](#)).

The researchers planned to:

- Document existing models that promote increased transparency.
 - Examine their theoretical advantages and disadvantages.
 - Highlight the opportunities and obstacles to their implementation.
- RWJF awarded Grant ID# 058785 to Eve Shapiro Medical Writing to document the experience of early adopters of disclosure and apology policies.

The Costs of Defensive Medicine

Some policy advocates assert that fear of malpractice litigation continues to motivate physicians to practice "defensive medicine," ordering tests, procedures and/or medications of little benefit to patients, and adding billions to national health costs.

The practice of defensive medicine is generally agreed to exist, but its extent and costs remain subject to debate. Among the projects designed to address this issue:

- Investigators at the [Edmund S. Muskie School of Public Service at the University of Southern Maine](#) (Grant ID# 058347 under HCFO,) planned to build a dataset that would permit them to create a more accurate estimate of defensive medicine costs.

Their goals were to:

- Identify clinical conditions in which defensive medicine exists.
- Estimate the frequency and costs of defensive medicine in those conditions.
- Identify the sources of defensive medicine (e.g., type of tests, procedures and medications) in those conditions.

Alternatives to the Tort System

RWJF continues to fund the development of alternatives to the existing tort system. "Health Courts" are one area of particular promise. Health courts are specialized administrative courts designed to handle medical injury disputes.

As described in an article published in the *Milbank Quarterly* and available [online](#) at the RWJF website, health courts have five core features:

1. Injury compensation decisions are made outside the regular court system by specially trained judges.
2. Compensation decisions are based on a standard of care that is broader than the negligence standard.

To obtain compensation, claimants must show that the injury would not have occurred if best practices had been followed or an optimal system of care had been in place, but they need not show that care fell below the standard expected of a reasonable practitioner.

3. Compensation criteria are based on evidence, i.e., they are grounded in experts' interpretations of the leading scientific literature. To the maximum extent feasible, compensation decisions are guided by determinations about the preventability of common medical adverse events.

4. This knowledge, coupled with precedent, is converted to decision aids that allow fast-track compensation decisions for certain types of injury.
5. Guidelines also inform decisions about how much should be paid for economic and non-economic damages.

Among the grants in this area:

The [Common Good Institute](#) (Grant ID# 047032) held a forum that brought together experts in law, medicine and patient safety to weigh the effects of litigation on health care, and the potential solutions offered by health courts.

- Investigators at the [Harvard School of Public Health](#) (Grant ID# 051549) and the Common Good Institute (Grant ID#s 050659, 058662) collaborated on a project to design the health courts. Among the activities under these grants, Harvard and the Common Good Institute planned to:
 - Outline a menu of core features for health courts.
 - Formulate compensation criteria.
 - Analyze the activities' relationship to patient safety.
 - Work to advance initiatives underway in six states to implement health court systems.

Medical Malpractice Reform

RWJF continued to fund projects examining changes in the medical malpractice landscape. Among these:

- Investigators at the Duke University Center for Health Policy, Law and Management received funding under RWJF's *Investigator Awards in Health Policy Research* national program (Grant ID# 050449) to prepare a book, targeted at non-specialists about changes in medical malpractice.
- Investigators at the University of Alabama at Birmingham, Lister Hill Center for Health Policy received funding under HCFO (Grant ID# 050298) to examine the effect of medical malpractice reform on malpractice premiums and on consumer costs of health care.

Report prepared by: Michael H. Brown

Reviewed by: Robert Crum and Marian Bass

Program Officers: Joel C. Cantor, Beth A. Stevens and Judith Y. Whang

APPENDIX 1

IMPACS National Advisory Committee

(Current as of the time of the grant; provided by the grantee organization; not verified by RWJF.)

Walter J. Wadlington, L.L.B. (Chair)

James Madison Professor of Law
University of Virginia
Charlottesville, Va.

University of Pennsylvania
Philadelphia, Pa.

Laura-Mae Baldwin, M.D., M.P.H.

Associate Professor, Department of Family
Medicine
University of Washington
Seattle, Wash.

Thomas A. Massaro, M.D., Ph.D.

Harrison Foundation Professor of Law
Office of Medical Affairs
University of Virginia
Charlottesville, Va.

Joel Cantor, Sc.D.

Director, Division of Research
United Hospital Fund
New York, N.Y.

Alphonso O'Neill-White

Senior Vice President and General Counsel
Blue Cross & Blue Shield of Western New York
Buffalo, N.Y.

Daniel Creasey

President, Risk Management Foundation
Harvard Medical Institutions
Cambridge, Mass.

Sallyanne Payton, J.D.

Professor of Law
University of Michigan
Ann Arbor, Mich.

Nancy Neveloff Dubler, L.L.B.

Director, Division of Bioethics, Department of
Epidemiology and Social Medicine
Montefiore Medical Center
Bronx, N.Y.

J. Douglas Peters

Shareholder
Charfoos & Christensen, P.C.
Detroit, Mich.

Jack Hadley, Ph.D.

Institute for Health Care Research and Policy
Georgetown University
Washington, D.C.

Frank A. Sloan, Ph.D.

J. Alexander McMahon Professor of Health
Policy and Management and Professor of
Economics
Center for Health Policy Research and
Education
Duke University
Durham, N.C.

A. Russell Localio, J.D., M.S., M.P.H.

Center of Clinical Epidemiology and
Biostatistics

APPENDIX 2

Grants Awarded under the *Medical Malpractice Program 1987–1988*

(Current as of the time of the grant; provided by the grantee organization; not verified by RWJF.)

- American Registry of Pathology: Prospective study of risk management and practice protocols in hospital emergency departments, \$192,094 (ID# 012406).
- Amherst College: Evaluation of the effect of malpractice reform laws of the 1970s on the number, size, and disposition of claims, \$95,579 (ID# 012410).
- University of California, San Francisco: Study of the potential use of risk-adjusted liability insurance premiums for hospitals, \$166,529 (ID# 012413).
- Harvard University, School of Public Health: Study of the incidence of iatrogenic injuries, economic losses, and relationship to malpractice litigation, \$273,939 (ID# 012415).
- Indiana University Foundation: Evaluation of Indiana's malpractice tort and insurance reforms of 1975, \$260,093 (ID# 012416).
- Institute for Medical Risk Studies: Study of the feasibility and effectiveness of "early warning" systems for malpractice claims, \$231,060 (ID# 012417).
- Johns Hopkins University, School of Hygiene and Public Health: Evaluation of Maryland's 1986 law mandating reporting to a central database of physician disciplinary and tort actions, \$285,131 (ID# 012418).
- Johns Hopkins University, School of Hygiene and Public Health: Study of early risk factors for malpractice involvement of 1948–1964 medical graduates from Johns Hopkins Medical School, \$207,702 (ID# 012419).
- University of Minnesota: Study of high-risk pregnancies and development of medical-error risk-reduction education for physicians, \$296,027 (ID# 012407).
- University of Pennsylvania: Study of the economic impact of potential changes in systems of malpractice compensation on physicians and consumers, \$224,650 (ID# 012408).
- Private Adjudication Center, Duke University: Development of a pilot study of alternative dispute resolution (ADR) procedures in malpractice disputes, \$284,421 (ID# 012414).
- Stanford University: Study of the impact of anesthesiology practice standards on medical outcomes and malpractice claim risk, \$200,865 (ID# 012409).

- University of Texas, Health Science Center: Study of the feasibility of using a list of "accelerated compensable events" as part of a no-fault insurance approach, \$300,000 (ID# 012411).
- Vanderbilt University, Institute for Public Policy Studies: Study of the feasibility of using "damage scheduling" and experience-rated premiums in malpractice insurance, \$225,659 (ID# 012412).
- University of Chicago, Department of Surgery: Study of factors that influence patient malpractice-claiming behavior, \$290,470 (ID# 014041).
- Maryland Department of Health and Mental Hygiene: Study of the relative risk of malpractice claims in low-income versus other populations, \$87,498 (ID# 014042).
- Oregon Foundation for Medical Excellence: Development of a predictive tool to help identify physicians at high risk of malpractice claims or disciplinary actions, \$293,072 (ID# 014044).
- Vanderbilt University, Institute for Public Policy Studies: Study of malpractice-claiming behavior and economic outcomes of claims, \$299,393 (ID# 014045).
- University of Washington, Department of Family Medicine: Study of the impact of malpractice systems on access to obstetrical care for poor and rural mothers, \$295,093 (ID# 014046).

APPENDIX 3

Additional RWJF ad hoc grants in support of malpractice research

(Current as of the time of the grant; provided by the grantee organization; not verified by RWJF.)

- The Urban Institute: Special Journal Issue on Medical Malpractice Reform: Journal of Law and Contemporary Problems special issue: "Medical Malpractice, Lessons for Reform," \$25,996 (ID# 017040).
- The University of Pennsylvania/The Wharton School: Analysis of Medical Injury Compensation in Sweden and New Zealand, \$49,993 (ID# 018579).
- Harvard University School of Public Health: Research on Medical Injury and on Compensation and Deterrence Alternatives, \$150,119 (ID# 017095).
- American Law Institute: Study of medical malpractice and tort law, \$159,772 (ID# 012009).
- Preparation and Distribution of the Proceedings from the *Medical Malpractice Program* Annual Meeting, \$99,488, (CP 031).
- University of Washington School of Medicine: Research on Defensive Medicine in Obstetrics, \$20,380 (ID# 020588).

- University of Virginia Law School Foundation: Feasibility of organizational liability approach for medical malpractice, \$170,351 (ID# 019892).
- George Washington University: Dissemination of a "Policymaker's Guide to Medical Malpractice," \$8,350 (ID# 026736).

APPENDIX 4

Glossary

Adverse event: an injury caused by medical management and resulting in either a prolonged hospital stay or disability at time of discharge.

Confidence score: a number; very high numbers indicate high confidence in the answer.

Disability prerequisite: the length of time a person must have a physical or mental condition that prevents the performance of one or more occupational duties short-term (temporarily), long-term, or permanently (total disability), before becoming eligible for benefits.

IOM (Institute of Medicine): established in 1970, conducts studies of policy issues related to health and medicine; issues position statements on these issues; cooperates with the major scientific and professional societies in the field; identifies qualified individuals to serve on study groups in other organizational units; and disseminates information to the public and the relevant professions. The IOM is a part of the National Academy of Sciences, a private, non-profit, self-perpetuating society of scholars engaged in scientific and engineering research, dedicated to the furtherance of science and technology and to their use for the general welfare. Upon the authority of the charter granted to it by the Congress in 1863, the academy has a mandate that requires it to advise the federal government on scientific and technical matters.

Medical malpractice: any act or failure to act by a member of the medical profession that results in harm, injury, distress, prolonged physical or mental suffering, or death to a patient while that patient is under the care of that medical professional.

Stratified random sample: a sample obtained by taking random samples from each stratum or subgroup of a population under study.

Tort: a civil wrong or breach of a duty to another person, as outlined by law; a civil wrong other than breach of contract. It is a private or civil wrong that arises from a breach of duty that exists by virtue of society's expectations of one another. A tort occurs when: (1) a defendant has a duty to a plaintiff (e.g., to ensure that a product is safe for use); (2) the defendant has breached that duty (e.g., the product is in fact unsafe); and (3)

the breach is the proximate cause of an injury (e.g., the unsafe product directly causes an injury).

APPENDIX 5

Related RWJF Grants Awarded After the Program

(Current as of the time of the grant; provided by the grantee organization; not verified by RWJF.)

(All grants listed below were made outside of RWJF's national programs unless otherwise indicated.)

Increasing Disclosure and Transparency

ID# 047939 (HCFO)

Research on Liability Problems and Transparent Disclosure to Patients on a Solution
Urban Institute (Washington, D.C.)
\$99,142 (March 2003 to August 2004)

ID# 058785

Background Paper on Hospital Experience with Apology after Medical Errors and the
Reduction in Medical Malpractice Claims
Eve Shapiro Medical Writing (Bethesda, Md.)
\$10,326 (September 2006 to June 2007)

Costs of Defensive Medicine

ID# 058347 (HCFO)

Defensive Medicine as a Response to Medical Malpractice Liability in the United
States
University of Southern Maine, Edmund S. Muskie School of Public Service
(Portland, Maine)
\$264,111 (September 2006 to September 2007)

Alternatives to the Tort System

ID# 047032

Forum on Building a New System of Medical Justice
Common Good Institute (New York, N.Y.)
\$50,000 (October 2002 to December 2002)

ID# 050659

Designing a Reliable System of Medical Justice
Common Good Institute (New York, N.Y.)

\$715,710 (December 2004 to November 2007)

ID# 051549

Designing a Reliable System of Medical Justice

Harvard University School of Public Health (Boston, Mass.)

\$760,540 (December 2004 to November 2007)

ID# 058662

Designing a Reliable System of Medical Justice

Common Good Institute Inc. (New York, N.Y.)

\$994,560 (February 2007 to February 2009)

Medical Malpractice Reform

ID# 050449 (Investigator Awards in Health Policy Research)

Preparation of a Book about Changes in Medical Malpractice

Duke University Center for Health Policy, Law and Management (Durham, N.C.)

\$274,903 (March 2004 to June 2007)

ID# 050298 (HCFO)

Examining the Effect of Medical Malpractice Reform on Malpractice Premiums and on Consumer Costs of Health Care

University of Alabama at Birmingham, Lister Hill Center for Health Policy (Birmingham, Ala.)

\$204,220 (February 2004 to July 2005)

Other Grants

ID# 046686

Advancing State Regulatory Frameworks for Mandatory Reporting of Medical Errors

Center for Health Policy Development (Portland, Maine)

\$199,998 (December 2002 to December 2003)

BIBLIOGRAPHY

(Current as of date of the report; as provided by the grantee organization; not verified by RWJF; items not available from RWJF.)

Book Chapters

Cantor JC, Berenson RA, Howard JS and Wadlington W. "Addressing the Problem of Medical Malpractice." In *To Improve Health and Health Care 1997: The Robert Wood Johnson Foundation Anthology*, Stephen I. Isaacs and James R. Knickman (eds). San Francisco: Jossey-Bass, 1997. Also appears [online](#) and was reprinted in the *Journal of the Mississippi State Medical Association*. An earlier version was published in *Health Affairs*.

Articles

Cantor JC and Wadlington WJ. "Essay: Addressing the Malpractice Problem: The Robert Wood Johnson Foundation's Programs." *Health Affairs*, 13(5): 229–240, 1994. A later version of this essay was published as a chapter in *To Improve Health and Health Care 1997: The Robert Wood Johnson Foundation Anthology* and was reprinted in the *Journal of the Mississippi State Medical Association*.

Cantor JC, Berenson RA, Howard JS and Wadlington W. "Addressing the Problem of Medical Malpractice." *Journal of the Mississippi State Medical Association*, 39(1): 10–20, 1998. This article was a reprint of a chapter in *To Improve Health and Health Care 1997: The Robert Wood Johnson Foundation Anthology*.

Mello MM, Studdert DM, Kachalia AB and Brennan TA. "'Health Courts' and Accountability for Patient Safety." *Milbank Quarterly*, 84(3): 459–492, 2006. Available [online](#).

Sage W. "'Health Law 2000': The Legal System and the Changing Health Care Market." *Health Affairs*, 15(3): 9–27, 1996. Available [online](#).

Reports

Gillespie K. *Perspectives: Malpractice Law Evolves Under Managed Care*. Princeton, NJ: The Robert Wood Johnson Foundation, 1996. This pamphlet was produced for general dissemination and reported highlights of the conference on "Emergency Liability Issues in Managed Care" held by *IMPACS* October 6–7, 1995 in Park City, UT.

Sponsored Conferences

"Emerging Liability Issues in Managed Care," October 6–7, 1995, Park City, UT. Attended by approximately 50 people. In addition to *IMPACS* project directors and *IMPACS* National Advisory Committee members, the registrants included representatives of the Utah Medical Association, National Practitioners Data Bank, Humana, Inc., American Medical Association's Department of Professional Liability and Insurance, Kaiser Foundation Health Plan, and several universities. Eight presentations.

Presentations

- Randall Bovbjerg, The Urban Institute (Washington), "An Overview of Policy Issues in Liability for Managed Care."
- Sallyanne Payton, University of Michigan Law School (Ann Arbor, MI), "ERISA's Potential Application to Medical Malpractice."
- Trischa O'Hanlon, Kaiser Foundation Health Plan. (Pasadena, CA), "Current Issues Regarding Arbitration of Malpractice Claims."
- Clark Havighurst, Duke University School of Law (Durham, NC), "The Unexpected Path to Health Care Reform."
- Brent James, Intermountain Health Care (Salt Lake City, UT), "The Quality Improvement Paradigm and Individual Culpability."
- Alice Gosfield, Gosfield & Associates (Philadelphia.), "Legal Concerns in Quality Improvement."
- James Robinson, University of California (Berkeley, CA), "Organizational and Contractual Relationships in the Changing Medical Marketplace."
- William Sage, Columbia University School of Law (New York), "Health Law 2000: The Future of the Marketplace."

"IMPACS/Duke Medical Malpractice Conference," September 12–13, 1997, Durham, NC. Attended by approximately 40 people, including the *IMPACS* project directors; professors of law, medicine, and business; and members of various health care-related groups. Universities and organizations represented included Indiana University, Stanford University, University of Alabama, Vanderbilt University, Wake Forest University, American College of Obstetricians and Gynecologists, American College of Physicians, and the Physician Insurers Association of America. Four panels.

Panels

- "Understanding the Evolving Reality of Malpractice Litigation," Daniel Kessler, Stanford University (Stanford, CA); Mark McClellan, Stanford University (Stanford, CA); William Sage, Columbia University School of Law (New York).
- "Dispute Resolution and Malpractice," Thomas Metzloff, Duke University School of Law (Durham, NC); Ralph Peeples, Wake Forest University School of Law (Winston-Salem, NC); Catherine Harris, Wake Forest University (Winston-Salem, NC); John Rolph, University of Southern California (Los Angeles); Elizabeth Rolph, RAND (Santa Monica, CA); Edward Dauer, University of Denver College of Law (Denver); Leonard Marcus, Harvard School of Public Health, Boston.
- "Learning from Malpractice: How Malpractice Relates to Discipline, Risk Management, and Quality Assurance," Frances Miller, Boston University (Boston);

Larry Smarr, Physician Insurers Association of America (Rockville, MD); Gerald B. Hickson, Vanderbilt University Medical Center (Nashville, TN).

- "Assessing the No-Fault Potential in Medical Malpractice," Randall Bovbjerg, The Urban Institute (Washington); Frank Sloan, Duke University (Durham, NC); Troyen Brennan, Harvard University (Cambridge, MA); David Studdert, Harvard School of Public Health (Boston).

The panelists' presentations, most of which focused on *IMPACS*-funded projects, served as the bases for articles later published in the combined Winter & Spring 1997 issues of *Law and Contemporary Problems*, a quarterly publication of the Duke University School of Law.

Sponsored Workshops

"Medical Practice Mediation," March 29, 1996, Washington. Attended by stakeholders in the medical malpractice issue and experts in mediation to discuss the use of voluntary mediation to resolve malpractice claims.

"*IMPACS* Meeting on the National Practitioner Data Bank," November 7, 1996, Washington. Attended by 21 NPDB officials, risk-management experts, *IMPACS* National Advisory Committee members, and RWJF staff.

"Patients, Providers, Insurers: Who's the Injured Party? A Briefing on Making the Medical Malpractice System More Equitable," November 22, 1996, Washington. Attended by approximately 100 congressional staff members, journalists, and representatives of various health care industry interest groups. Cosponsored by *IMPACS* with the American Academy of Actuaries and the Alliance for Health Reform.

Print Coverage

"Medical Malpractice Reform: Finding a Better Way—New Research Shows No Fault, Arbitration and Mediation Each Holds Promise—and Pitfalls," in *ACP Observer*, November, 1997. Available [online](#).

PROJECT LIST

Reports on the projects managed under this National Program are listed below. Click on a project's title to see the complete report, which typically includes a summary, description of the project's objectives, its results or findings, post grant activities and a list of key products.

Colorado (Copic Medical Foundation) and Utah (Utah Alliance for Healthcare)

- [Researchers Evaluate the Feasibility of a No-Fault System for Medically Injured Patients in Utah and Colorado](#) (September 2006)

Duke University Medical Center

- Can the No-Fault Approach Contain Malpractice Insurance Costs? (September 2002)

Harvard School of Public Health

- A Plan of Voluntary Mediation as Alternative for Malpractice Claims Doesn't Make It to the Demonstration Phase (September 2002)

Northwestern University

- Number of Malpractice Suits Being Challenged in Court Increases (September 2006)

Private Adjudication Center

- Obstacles Block Testing New Ways to Resolve Medical Malpractice Cases (September 2002)

RAND Corporation

- Researchers Study the Trend of Using Arbitration to Resolve Health Care Delivery Problems (September 2002)

University of California, San Francisco, Institute for Health Policy Studies

- Large Group Purchasers Have Power to Drive Improvements in Patient Safety (September 2006)

Vanderbilt University Medical Center

- Counseling of Physicians at High Risk of Malpractice Claims Lowers the Level of Patient Complaints (September 2002)

Wake Forest University School of Law

- Does Mediation Work Better Than Trial for Settling Medical Malpractice Cases? (September 2002)