Editor’s Introduction

In the mid-1970s, physicians became concerned about the difficulty of obtaining medical malpractice liability insurance and, where coverage was available, the high premiums. The medical malpractice "crisis" of the 1970s led to legislative changes in many states and to reforms within the insurance industry. Although these reforms seemed to alleviate the situation for a time, it worsened again in the 1980s, raising concern about a new crisis. Although nobody was certain about the extent or the causes of the problem, various legislative and regulatory solutions involving tort reform were proposed.

At the time, few funders were supporting research and demonstrations on medical malpractice insurance. In 1985, the Robert Wood Johnson Foundation began its support of a range of initiatives on the topic. The Foundation’s efforts represent a sustained attempt to understand the problems associated with malpractice and to help foster innovations in the way insurance issues are handled at the state level. Two national programs were supported: the first focused on research to document and explain the situation, and the second supported demonstrations and evaluations of actual reform efforts.

More than a hundred journal articles and reports have been written based on the research undertaken under the two national programs. In many ways, the efforts of those involved in the various projects supported by the Foundation defined a field of research directed at addressing a long-standing problem. In Chapter Six, key people involved in the initiatives synthesize the findings and examine the implications of the Foundation’s efforts.

The authors of this chapter were all involved in managing the Foundation’s investments in this area. Joel C. Cantor was director of evaluation research at the Foundation until January 1996 and is currently the director of the research division of the United Hospital Fund of New York. Robert A. Berenson, associate clinical professor of medicine at Georgetown University, directs the Foundation-supported Improving Malpractice Prevention and Compensation Systems (IMPACS) initiative. Julia S. Howard is the deputy director of the IMPACS project, and Walter Wadlington, the James Madison Professor of Law at the University of Virginia School of Law, directed the Foundation-supported Medical Malpractice Program.
Despite the press attention given to medical malpractice and the rising cost of malpractice insurance premiums, only recently have researchers focused on documenting the extent of the malpractice problem and finding solutions to it. In the face of firmly held conventional wisdom, many of the research findings are surprising. A Harvard University malpractice study, funded in part by the Robert Wood Johnson Foundation under the Medical Malpractice Program, found that 1 percent of hospital stays in New York state involved medical negligence and that only one in eight of the patients affected by this negligence actually brought a malpractice lawsuit. Moreover, the Harvard study found that the perceived risk of being sued in a given year was three times as great as the actual risk among physicians. Several other studies carried out under the program suggest that doctors' perceptions about their exposure to malpractice liability are simply inaccurate.

In 1985, after a decade of apprehension that harm to patients, and the system of compensation for such harm, could have a severe, adverse impact on physicians and health care institutions, the Robert Wood Johnson Foundation took steps to address these problems by initiating the Medical Malpractice Program (MMP). The program was designed to develop and analyze data on medical malpractice and its impact on health care delivery, and to develop strategies for reducing medical injury and adequately compensating medically injured persons. In 1994, the Foundation announced a second major program, Improving Malpractice Prevention and Compensation Systems, or IMPACS, which was intended to translate into action the lessons learned in the Malpractice Program by establishing models of malpractice prevention and compensation systems.

As the Foundation has done in many other areas, in medical malpractice it is attempting to effect a change in the system. Because of strong vested interests and systemic inertia, attempts to change a system carry a high risk of failure. If the Foundation's programs can bring about changes in social institutions, however, the potential payoff is enormous. The two malpractice programs were created to address the broad failures of current systems. In the view of those who framed the Foundation's malpractice work, the major problems were that:

- Malpractice lawsuits do not provide adequate incentives to correct the vast majority of medical injuries.
- The links between the institutions that address malpractice and the institutions intended to prevent injury and improve health care are weak at best.
- The system is inefficient; only about forty cents on the malpractice premium dollar compensates claimants; the rest goes for legal fees, court costs, and insurer costs.
- Periodically high cost and lack of availability of malpractice insurance have led to problems in
THE MEDICAL MALPRACTICE PROGRAM
In 1987 and 1988, through the Medical Malpractice Program, the Foundation awarded nineteen grants totaling $4.5 million. (Table 6.1 lists these grants and three others that the Foundation awarded through its ad hoc grant-making process during the late 1980s and early 1990s.) At the time that this first program was developed, malpractice premiums had risen to the point of creating a crisis, as they had done in roughly ten-year cycles, but the Foundation staff and consultants could find little in the legal or policy literature to explain these cycles or offer options for addressing the resultant problems. These observations led to the Medical Malpractice Program, which focused on understanding problems and identifying potential solutions.

The Extent of Medical Error and Malpractice
In the 1970s and 1980s, many states passed malpractice legislation even though the legislators had little or no reliable data about the extent of malpractice or the effectiveness of the tort system as a way to compensate victims of medical injury. Two studies supported under the program shed considerable light on this area. The most widely cited of these is the Harvard Medical Practice Study, which, we stated earlier, found that 1 percent of all hospital stays involved negligence and that only one in eight patients injured by negligence filed malpractice claims. This study, based on hospital records from New York state, also found that adverse events (whether or not they were caused by negligent conduct) occurred in 3.7 percent of hospital stays. These rates were similar to those recorded in a study of California hospitals ten years earlier, the basic methodology of which had been followed in the New York study.

The findings of the Harvard study were reinforced by researchers at the University of Chicago, who measured the incidence of error in patient care in three surgical units. Instead of focusing on medical records or insurance claims that had been closed, ethnographers observed hospital units and attended rounds and clinical meetings in which patient care was discussed. Although the purpose of the study was not simply to document the incidence of errors, one finding was that only a small percentage of the patients who were victims of medical error actually brought suit.

Physician and Hospital Practices
Clearly, the best way to prevent malpractice claims is to avoid or minimize the incidence of medical injury. If harm does occur, those responsible should try to mitigate it in a way that is acceptable to the
patient. One goal of the Medical Malpractice Program, therefore, was to have the health care and legal communities develop workable responses to medical injury.

Increasingly, health care professionals view the use of protocols, or practice guidelines, as viable tools for improving medical and hospital procedures. Some also see protocols as a means of clarifying the legal standard of care. One study examined the incidence of claims made by patients who went to an emergency room with chest pain or other symptoms but were not treated for myocardial infarction in a timely fashion. Protocols based on this information have been introduced in emergency rooms of military hospitals. Another team analyzed a ten-year database covering some five hundred California anesthesiologists insured by two physician-owned carriers and determined that insurer-introduced protocols had served to reduce claims and thus stabilize liability premiums.

Another study sought to understand whether certain practices or medical providers seemed to be prone to malpractice problems, so that strategies could be developed to reduce the number of events likely to lead to claims. Data on closed claims from a large New Jersey-based insurer were used to identify problem-prone clinical processes in four high-risk specialties: anesthesiology, general surgery, obstetrics and gynecology, and radiology. The investigators found that the claims histories of individual physicians were only modestly useful in predicting whether or not a claim might be filed and thus were of questionable help in targeting physicians for educational intervention or sanctions. On the other hand, the researchers concluded that for an entire system, malpractice data could be used to suggest interventions that might reduce negligence. They suggested that errors involving patients could be averted by such hospital practices as insuring the prompt delivery of test results to physicians.

The majority of malpractice claims stem from harm that occurs to the patient in the hospital. Therefore, risk management programs that are based in hospitals hold potential for limiting substandard care and preventing and controlling claims. Three studies addressed aspects of risk management practices. One grantee explored whether there was a factual basis for concluding that hospital-based risk management programs actually affected the number of claims filed. This study, of forty acute care general hospitals in Maryland during the early 1980s, provides the first large-scale evidence that risk management can help reduce malpractice claims.

Another grantee, in Chicago, addressed ways of developing systems that would bring problems of medical injury to the attention of risk managers as quickly as possible, so that relevant information could
be gathered soon after any injury occurred. With this information, the risk managers might be able to resolve a dispute to the satisfaction of the patient without expensive and time-consuming legal proceedings. The project concluded that all hospital medical staff should be involved if reporting on incidence of medical injury is to be effective. This study also pointed to a need for a system that would function more effectively in passing along information about errors to risk managers, patient safety committees, or some part of the hospital administration.

Two other projects, in Oregon and Maryland, addressed the relationship between malpractice and medical credentialing, including state licensing procedures and the granting of hospital admitting privileges to physicians. The researchers in Oregon analyzed an eleven-year database from the state’s Board of Medical Examiners to identify physician characteristics and practices that were associated with disciplinary actions and malpractice claims, and the team in Maryland developed guidelines to help hospitals use background information about physicians appropriately and avoid its misuse in the credentialing process. The guidelines were important because Maryland, unlike other states, required reporting of certain malpractice claims and disciplinary proceedings against physicians. Subsequent to this project, the National Practitioner Data Bank, which changed the way information about individual physicians is used in hospital credentialing procedures, was started.

Beyond credentialing or practice protocols, some people have suggested that the perceptions of doctors about legal risk can serve to deter substandard conduct, but others claim that such perceptions can also lead to defensive procedures—diagnostic or treatment measures designed to protect a physician or a hospital from liability rather than to promote patient health. Moreover, several studies under the Medical Malpractice Program suggested that physicians' perceptions about liability exposure are inaccurate. The perceived risk of being sued in a given year was three times the actual risk among physicians studied in the Harvard Medical Practice Study. In a study in Florida, physicians' assumptions about likely malpractice claimants were shown to be unrealistic, and these assumptions varied according to the specialty involved. Three studies supported under the program refute the common assertion that Medicaid patients make malpractice claims more often than others. Studies in the states of Maryland, Washington, and New York revealed that the likelihood of claims from Medicaid patients was no greater than for non-Medicaid patients and in some instances was actually lower.

Whatever the basis for the fears of physicians, the potential result of those fears on doctor-patient relationships and on decisions that affect the cost of treatment or access to medical care can be
considerable. The study in Washington state focused first on whether some physicians stop practicing because of a concern about malpractice claims. It found that the attrition rate was small but, because of an already existing shortage of physicians, significant in impact. A further study adding Alaska, Montana, and Idaho found that despite tort reforms, the cost of liability insurance and a concern about the likelihood of being sued continued to limit the number of physicians engaging in obstetrical care.

Understanding and Refining the Legal System

Seven of the projects in the Medical Malpractice Program added significantly to understanding of the effects of conventional tort reforms since the late 1970s and of the functioning of malpractice dispute resolution in general. These projects include studies of the effectiveness of the existing tort system as well as evaluations of tort reforms.

Along with contingency fees and damages for pain and suffering, the civil jury system is among the components of the present compensation system criticized most widely by members of the health care establishment. But one program study found no support for assertions that juries are consistently pro-plaintiff, incompetent, or unjustifiably generous in their awards. The study did find, however, that jurors would like to have greater guidance from judges, particularly with regard to damages.

Fixing the amount of money to be awarded in a malpractice case can be especially controversial. Some critics point to the seeming inconsistency in damage awards, while other critics contend that awards are frequently too high. The distinction between economic and noneconomic loss is of particular importance. These issues were the subject of an extensive Florida study of closed claims for severe birth-related injuries to children and emergency room injuries to adults. In this study, claimants who actually recovered monetary damages received only about 80 percent of the costs that resulted from their medical injuries. The investigators also found that less seriously injured persons received proportionately greater compensation than severely injured persons. They sounded a cautionary note to the effect that the perception that the tort system works poorly may be unduly shaped by publicity about the relatively small number of claims that result in high damage awards.

Indiana was in the forefront of states that enacted broad tort reforms for medical malpractice. Changes included a cap on damages and led to the creation of a patient compensation fund to pay all awards in excess of $100,000, financed by a surcharge on the medical providers’ basic liability premiums. Under this system, insurers accepting the first $100,000 of liability in a given case refer the rest of the claim to the compensation fund for settlement. Medical review panels were then created to determine the extent
of payment that would be made available under the fund. In an evaluation of the severe-claims experience under the Indiana system compared with that of neighboring states without damage caps, investigators found—to the surprise of some observers—that under the Indiana reforms only a small fraction of claims went before the medical review panels for their determination of liability and that large claims resulted in comparatively generous compensation. The investigators suggest that the Indiana cap may have inadvertently established what amounted to a no-fault system for large claims.

Some reformers have proposed that medically injured persons must submit their claims to an alternative dispute resolution process, at least initially, as one way to overcome common complaints about the trial system. There are many possible ways to resolve disputes, including arbitration and mediation. The suitability of various procedures in resolving malpractice disputes was examined in one study funded under the program. After analyzing procedural steps taken in malpractice cases that had been litigated in North Carolina, the investigators conducted demonstrations of several approaches, including mediation and arbitration of actual cases that were referred to them through the court system with the agreement of the parties. One innovative alternative was the use of a summary jury trial in specific cases in which the parties agreed to limit the number of factual issues in dispute, the number of expert witnesses, and the overall length of the trial. The parties also agreed to the imposition of a floor and a ceiling on damages. The investigators concluded that the cases most appropriate for summary trials were those in which liability was unclear but potential damages would be great if the recovery was granted.

Researchers in other projects developed or evaluated approaches that would award damages more fairly than the current system and better tailor damages to the needs of medically injured persons. These include development of a plan that would give damage awards precedence in future cases, payment for the future medical services an injured party needs through an insurance contract tailored to specific cases rather than as lump-sum payments, and the introduction of "scheduled" damages—specified compensation for specific injuries—for pain and suffering in medical malpractice awards.

**Evolutionary and New Compensation Approaches**

In addition to identifying problems that are posed by the way medical malpractice is handled in medical and legal systems and evaluating the major reforms of the 1970s, the program supported work intended to lead to alternatives to the existing systems. Three types of reforms were studied by Foundation grantees.
The idea of a liability system for medical injuries that would rapidly provide fair compensation for certain injuries without need to prove negligence is by no means new. However, past attempts to develop a workable system on such a basis have encountered difficulty in defining what constitutes an appropriate "compensable event." One such approach was developed using a large database of obstetrical injuries on which successful liability claims were founded.22 The investigators selected the new term **ACE (for accelerated compensable event)** to describe the triggering basis for recovery. Although compensation for an ACE would be awarded without proof that it was caused by negligent conduct, experts would generally agree that ACEs should seldom occur in standard medical practice.

ACEs are classes of medical injuries that are readily identifiable and relatively avoidable—in this study, preventable in at least 70 percent of those cases that receive good care. An accelerated compensable event system would not replace the tort system completely, because not all medical injuries would be covered under ACEs. However, the developers of the system estimate on the basis of past claims that between one-half and three-quarters of obstetrical claims would be covered. In concept, ACEs could be extended to much broader classes of medical injuries.

Another project supported by the Foundation examined an even broader reform proposal. The medical malpractice portion of the *Reporters' Study on Enterprise Liability and Personal Injury* for the American Law Institute included a proposal for shifting liability from individual physicians to hospitals or other health care institutions connected with incidents giving rise to claims, except in intentional torts.23 This approach, called "enterprise liability," would have much greater administrative efficiency than the current system in cases involving multiple defendants and would provide for more-even distribution of malpractice insurance costs that now vary greatly by specialty. Proponents also assert that enterprise liability appropriately reflects changes in the structure of medical practice today, and that it would shift legal responsibility for preventing injuries and improving quality to the institutions that are in the best position to do those things. Such incentives are appealing in light of the findings that the best prospect for reducing injuries is from changes in the system rather than from targeting individual physicians who are at high risk for committing errors.24 Some who are skeptical about or opposed to such an approach worry that it lessens the deterrent effect of the current tort system, or leads to limitations on physician autonomy.

Finally, no-fault compensation would eliminate one of the most difficult and troubling steps in the present tort system, the finding of fault. Under a no-fault scheme, medically induced injuries are
compensable regardless of a finding of negligence. Proponents of a no-fault approach contend that a properly structured plan can provide fair compensation for a greater number of injured parties because of substantial reductions in administrative and other costs. Expenses might be lowered if damages for some types of noneconomic loss were reduced or eliminated. Some suggest that the deterrent effect of the current tort system on substandard care can be (and perhaps has been) substantially replaced by other controls, and that a no-fault system could provide the incentive to reduce all medical injuries. The Harvard Medical Practice Study\(^2\) estimated that a comprehensive no-fault approach would cost no more than the current system but would distribute compensation more broadly and equitably.

**Accomplishments and Unmet Aspirations**

The most tangible result of the program was a body of research findings: a collection of more than one hundred articles, working papers, books, and reports from the legal, medical, economics, and health policy fields. The success of a program should not be gauged simply by a count of publications, however, but rather by the value and impact of the research reflected in them. In this regard, it is significant that many of the studies provided cornerstones for the current debate among policy-makers;\(^2\) others are helping shape new approaches in areas such as risk management and compensation for medical injury (including some with the support of the Foundation-funded IMPACS initiative). Another important accomplishment, although it is a difficult one to quantify, was that the program came to serve as a liaison among researchers from different disciplines—people who had little or no prior contact. In many cases, productive collaboration among program participants continues today.

The program contributed significantly to what is known about the dimensions of medical error, how medical providers view and respond to the current malpractice system, and how the problems of the current system may be overcome. But even the substantial body of research amassed does not address all the important questions raised by policy makers, health care managers, and medical practitioners. Nevertheless, several generalizations can be made from the studies supported under the program:

- Provisions in the health care and legal systems to identify, prevent, and compensate medical injuries are seriously flawed; indeed, the great majority of injuries go unidentified by those suffering them.
- Various stakeholders may view malpractice-related problems differently. Medical providers see the system as arbitrary, for example, while policy analysts emphasize lost opportunities for stronger incentives to prevent injuries and to compensate injured parties fairly.
- Risk management and related mechanisms can be effective, but they are not now sufficiently broad-based and active enough to make a significant contribution to reducing the problem of medical malpractice.
- The best opportunities to prevent medical injuries are in changes to the organization of care rather than in targeting "bad apple" providers.
Current methods of claims adjudication operate more fairly than many have suggested, but they are slow, expensive, and adversarial and thus compound dissatisfaction in the malpractice arena. Alternative dispute resolution techniques have not been widely adopted.

There exist promising new approaches to malpractice problems that are ready to be adopted, at least on a demonstration basis.

The most significant obstacle that surfaced early in the Medical Malpractice Program was that many researchers found themselves confronted with unanticipated and often unexplained barriers to data sources, even though the owners of the data had assured them access. In the malpractice arena, more than in other areas of health services, assertions by data providers about confidentiality and potential liability are barriers to research. Generally, claims-related research is limited to closed cases; even so, some malpractice insurers and health care organizations are reluctant to share information. Further research on malpractice requires that keepers of data be willing to open their books.

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

**IMPROVING MALPRACTICE PREVENTION AND COMPENSATION SYSTEMS (IMPACS)**

As the findings of the research supported under the Medical Malpractice Program came to light, the Foundation shifted its emphasis to applying possible solutions to the problems of malpractice-related systems. In July 1994, the Foundation launched IMPACS, a program that made as much as $6 million available for recipients to prepare, implement, and evaluate demonstration projects. Resources could also be used to evaluate policy changes and demonstration projects that are not funded by the Robert Wood Johnson Foundation. The Foundation, through an external program office and advisory committee, used a combination of two rounds of competitive applications and solicited projects on specific topics that were supported under IMPACS.

As a result of the knowledge gained in the Medical Malpractice Program, the Foundation and its advisers felt that the timing was right for a demonstration initiative such as IMPACS. The history of ten-year
cycles in malpractice claims suggested than another crisis period could be expected to begin in the mid-1990s. As in the past, an upsurge in malpractice claims and insurance premiums could be expected to generate considerable interest and political will for reform. It was believed that an interest in reform would spur support for broad demonstration projects.

The Foundation was looking for projects in four broad areas:

1. Providing more appropriate incentives for preventing medical injuries, without giving rise to costly defensive medicine or adversarial provider-patient relationships
2. Incorporating malpractice risk management into quality improvement initiatives of health care organizations
3. Achieving greater efficiency or lower overall cost in processing medical injury claims or compensating injured patients by nonadversarial systems
4. Providing benefits that are more consistent with actual damages for a significantly greater proportion of injured patients

Through the mid-1990s, no new upsurge in malpractice claims or premiums has occurred, and consequently no groundswell of interest in reform projects has emerged. Nevertheless, serious interest does exist, and IMPACS has attracted and is funding a wide range of significant projects.

**IMPACS Projects Supported So Far**

Table 6.2 lists the projects supported through IMPACS to date. The first two involve planning and feasibility analysis for comprehensive reforms in how malpractice claims are handled in Colorado and Utah. In both projects, members of the Harvard Medical Practice Study team are conducting local versions of the New York study. In both cases, estimates of the incidence of adverse events and malpractice claims are to be made and the costs of the alternative compensation system are to be compared with those of the existing tort system. The design and implementation plans for these two demonstrations also differ in important ways.

In Colorado, staff at the Copic Medical Foundation, the not-for-profit arm of the major doctor-owned medical malpractice insurer in the state, are working to develop an alternative to the tort system. The alternative channels all known cases of medical injury into an administrative system that determines whether a medically related injury took place, and what level of compensation should be granted to injured parties. The system would not require proof of fault before compensation was awarded. The Copic reform model has several advantages over the current fault-based system, at least in theory. First, it provides compensation to a broader range of injured patients and families, and more quickly than the existing tort system does. Second, it is linked to systems of quality improvement and medical discipline,
thereby giving clearer and stronger signals for the prevention of future medical injuries. Moreover, such signals reflect medical injuries of all kinds, not just those that result from negligence. Finally, the system is designed to cost no more than the existing tort system, but significant administration and adjudication costs are redirected into patient compensation.

Copic is creating a detailed design for a model administrative/no-fault system, studying the cost of the reform model, and working with interested parties to refine the model. A number of difficult issues must be resolved as part of the planning process. For instance, how would levels of compensation be determined for specific injuries? What appeals processes would be allowed? And how would the compensation system be coordinated with other sources of funding for medical care and disability, including Medicaid, Medicare, the workers compensation system, and employer-based health insurance? After the model is completed, the proposed reform will probably require state legislation before it can be put into place.

The Utah project is designing a broad-based reform by studying the incidence of medical injury and claims and comparing the costs of a new system with those of the status quo. The model of reform in Utah is different from the Colorado project in several important ways. The former is building on work done under the Medical Malpractice Program, which developed the concept of enterprise liability or responsibility in medical malpractice. In this model, individual doctors are relieved of legal responsibility for medical error, and institutions—most likely hospitals—take on full responsibility. One important advantage of this proposal is that responsibility for preventing medical errors is at a level where systemic interventions can be used. Also in the Utah project, systems for identification of and compensation for medical injury are aligned with quality improvement programs at hospitals. Unlike the Colorado project, the Utah Alliance for Health Care plans to conduct a demonstration of its concept in certain Utah hospitals. As in Colorado, a number of important issues have to be resolved before the demonstration can go forward, such as how to obtain informed consent for patients in demonstration hospitals.

Three other IMPACS projects are evaluations of policies already in place at the state level, and a fourth involves a rigorous study of a new intervention in the Philadelphia area. Frank Sloan and his colleagues at Duke University are evaluating no-fault compensation systems for birth-related neurological injuries in Florida and Virginia. Birth-related injuries are relatively infrequent, but when they do occur they are expensive, and they have been at the center of malpractice concerns in obstetrics nationwide. Florida and Virginia have established funds to compensate families of injured infants without resorting to the tort
system. These are currently the only no-fault systems operating in the malpractice arena in the United States, and the evaluators will learn lessons for the broader application of this concept.

A second evaluation project, being conducted at the Wake Forest School of Law, is studying North Carolina’s program for court-ordered mediation of malpractice cases. This evaluation compares the program’s performance with respect to settlement rates, disposition time, and cost with the performance of the traditional court system.

A third evaluation project, to be run by RAND, is a descriptive case study of the use of alternative dispute resolution, or ADR, for malpractice and coverage disputes in managed care organizations; it is to develop measures of the cost-effectiveness of these programs. The investigators are designing and testing a way to gauge provider attitudes about ADR. The use of ADR in managed care coverage disputes and malpractice allegations may be a way to avoid costly and lengthy lawsuits while still allowing for the fair resolution of claims.

Another ADR effort, to be carried out by the Private Adjudication Center of Duke University Law School, is developing, implementing, and evaluating a court-ordered arbitration model for use in medical malpractice cases. In concert with the state court system of Pennsylvania, the investigators will develop a rigorous examination of the costs and benefits of this type of ADR.

One other project now supported by IMPACS combines demonstration and evaluation. In this project, investigators at Vanderbilt University Children’s Hospital are collecting data from multiple sources to identify physicians and clinical situations that receive a high volume of complaints. Prior research by these investigators demonstrated that the volume of general complaints about a physician is associated with an elevated risk of malpractice claims. The information is to be used to develop methods of correcting poor practices. The evaluation will then determine if the program leads to a reduced incidence of malpractice and related claims.

The Future of IMPACS
None of the projects supported to date under IMPACS is far enough along to declare success, or even to generate significant lessons. The researchers are expected to complete their findings in 1997 and 1998. Some of the projects may receive renewal grants for follow-up activities or broadening their work, and there are still several proposals being reviewed that could lead to new IMPACS grants.
CONCLUSION
Within the American health care system, the problem of medical malpractice is not high on the agenda of policy makers; nor is it high among the priorities of those who manage private health care organizations, except for those who must deal with the problem directly. It is natural to ask, then, whether the relatively modest efforts of a private foundation can make a significant difference in this area. Part of the answer is coming as the IMPACS projects play out. Ultimately, though, an answer may not come until a widely perceived malpractice crisis creates the demand for reform. At the very least, much more is known today about the causes and the consequences of malpractice and the functioning of systems for identifying, compensating, and preventing medical injury than was known before the Robert Wood Johnson Foundation launched its initiatives.

Notes
1 For a good overview of problems in the system for identifying and compensating medical malpractice, see Medical Malpractice: Problems and Reforms (Washington, D.C.: The Urban Institute and Intergovernmental Health Policy Project, September 1995).


8 Harvard Medical Practice Study (1990).


26 For example, the President's Task Force on Health Care Reform proposed, but later abandoned, enterprise liability—a concept developed in part under a grant to the American Law Institute—as the cornerstone of malpractice-related changes under comprehensive health care reform.

**TABLES**

6.1 Grants in the Field of Malpractice Made by the Foundation, 1987–1993
6.2 Grants Made Through Improving Malpractice Prevention and Compensation Systems, 1994 to Present