The Truth About "Defensive Medicine"

"Defensive medicine" is myth that continues to be repeated by the hospital and doctor lobbies and groups funded by major conservative corporate interests like the American Tort Reform Association and American Legislative Exchange Council. Doctors, the story usually goes, are forced to order millions of unnecessary tests and procedures every year simply because they fear being sued. Take away the lawsuits, they say, and you stop a "leading" driver of health care costs.

Major studies find "defensive medicine" is a myth.

Studies by the Congressional Budget Office,[1] Government Accountability Office,[2] and Congressional Office of Technology Assessment cast doubt on the existence of any "defensive medicine" crisis:

> The 2008 Congressional Budget Office (CBO) report found that the evidence of "defensive medicine" *"is not conclusive."*[3]
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> The Government Accountability Office (GAO) found: *"[T]he overall prevalence and costs of [defensive medicine] have not been reliably measured. Studies designed to measure physicians' defensive medicine practices examined physician behavior in specific clinical situations, such as treating elderly Medicare patients with certain heart conditions. Given their limited scope, the study results cannot be generalized to estimate the extent and cost of defensive medicine practices across the health care system."*[4]
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> The Congressional Office of Technology Assessment (OTA) found that less than 8% of all diagnostic procedures were likely to be caused primarily by liability concerns.[5] The OTA found that most physicians who "order aggressive diagnostic procedures . . . do so primarily because they believe such procedures are medically indicated, not primarily because of concerns about liability."[6]

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[1] Congressional Budget Office (CBO), *Limiting Tort Liability for Medical Malpractice*, January 2004; *see also* CBO, *Budget Options, Volume I, Health Care,* at 21, December 2008.
[2] Government Accountability Office (GAO), *Medical Malpractice: Implications of Rising Premiums on Access to Health Care,* August 2003.
[3] CBO, *Budget Options, Volume I, Health Care,* Congressional Budget Office, December 2008, at 21.
[4] GAO, *Medical Malpractice: Implications of Rising Premiums on Access to Health Care*, August 2003.
[5] Office of Technology Assessment (OTA) U.S. Congress, Office of Technology Assessment, *Defensive Medicine and Medical Malpractice*, OTA-H--6O2 (1994), available at: http://biotech.law.lsu.edu/policy/9405.pdf
[6] *Id.* at 1.

In addition, a report by the National Bureau of Economic Research found: "The fact that we see very little evidence of widespread physician exodus or dramatic increases in the use of defensive medicine in response to increases in state malpractice premiums places the more dire predictions of malpractice alarmists in doubt."[7]

According to another study, doctors may not practice as "defensively" as even they believe. One government agency found that doctors chose not to order any tests or diagnostic procedures 95% of the time. Doctors who ordered tests almost always did so because of medical indications, and only one half of one percent of all cases involved doctors who ordered tests due solely to malpractice concerns.[8]

"Tort reform" would have no significant impact on how physicians practice medicine.

> A report by the National Bureau of Economic Research found: "The arguments that state tort reforms will avert local physician shortages or lead to greater efficiencies in care are not supported by our findings."[9]
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> The Congressional Office of Technology Assessment (OTA) found that the effects of "tort reform" on defensive medicine "are likely to be small."[10]

So-called "defensive medicine" is often motivated by the income it generates for physicians.

Multiple studies have concluded that so-called "defensive medicine" is frequently motivated by the income it generates for physicians:

> According to the CBO, "*some so-called defensive medicine may be motivated less by liability concerns than by the income it generates for physicians or by the positive (albeit small) benefits to patients. On the basis of existing studies and its own research, CBO believes that savings from reducing defensive medicine would be very small*."[11]

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[7] Katherine Baicker, Amitabh Chandra, *The Effect Of Malpractice Liability On The Delivery Of Health Care,* National Bureau of Economic Research, Working Paper 10709, August 2004, available at: http://escholarship.org/uc/item/7p61t3zh;jsessionid=0EA2539FF31288C837AF070039290FA1#page-6

[8] Alexee Deep Conroy, *Lessons Learned from the 'Laboratories of Democracy': A Critique of Federal Medical Liability Reform,"* CORNELL LAW REVIEW 1159, 1176 (2006).

[9] Katherine Baicker, Amitabh Chandra, *The Effect Of Malpractice Liability On The Delivery Of Health Care,* National Bureau of Economic Research, Working Paper 10709, August 2004, available at: http://escholarship.org/uc/item/7p61t3zh;jsessionid=0EA2539FF31288C837AF070039290FA1#page-6

[10] *Id.*

[11] CBO, *Limiting Tort Liability for Medical Malpractice*, January 2004.

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

Health care economists -- and some physicians -- have urged structural reforms that move physician compensation from "fee-for-service" to salary to help reduce the incentive to engage in so-called "defensive medicine."

"Defensive medicine" provides even bigger profits for physicians who self-refer.

"Defensive medicine" earns even bigger profits for physicians who self-refer tests on equipment or at facilities in which they have a financial stake:

> In a CNN report, a doctor admitted that the doctors order additional medical tests to generate more income: "*doctors are able to profit not just from being physicians like we have traditionally but by ordering tests on equipment that they own or x-rays on equipment that they own or sending patients to facilities that they own or have a financial interest in.*"[14]
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> The Inspector General's Office of the Department of Health and Human Services reports that physicians cherry-pick patients and self-refer profitable procedures and insured patients to their own hospitals.[15]
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> In a study by Professor Jean Mitchell, she looked at private insurance reimbursement trends across California for use of MRI, CT, and PET scans between 2000 and 2004. Mitchell found that use of MRI, CT, PET, and RMPI scans was one of the fastest-growing components of medical spending in the United States. During the period she studied, Mitchell found that use of PET scans utilization increased by almost 400%, and use of MRI and CT scans increased by over 50%.[16] Mitchell asserted that the dramatic increase in use of these scanning technologies was linked to "self-referral arrangements and independent diagnostic testing facilities,"[17] meaning "physicians referring patients

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[12] GAO, *Medical Malpractice: Implications of Rising Premiums on Access to Health Care,* August 2003.
[13] CBO, *Limiting Tort Liability for Medical Malpractice*, January 2004.
[14] CNN, *Doctor vs. Doctors*, September 18, 2009, available at: http://www.cnn.com/video/?/video/bestoftv/2009/09/18/tuchman.doc.vs.docs.cnn.
[15] Office of the Inspector General, U.S. Department of Health and Human Services, *Physician-Owned Specialty Hospitals' Ability to Manage Medical Emergencies*, January 2008.
[16] Jean M. Mitchell, Utilization Trends for Advanced Imaging Procedures: Evidence From Individuals With Private Insurance Coverage in California, Medical Care, May 2008 - Volume 46 - Issue 5 - pp 460-466.
[17] *Id.*

for ancillary services to their medical facility, or one in which a financial interest is held."[18]

Mitchell explained: "Physician self-referrals are a response to financial incentive….Everyone responds to that. If you were in their shoes and getting pay cuts, which is essentially what's happened, you would try to make up that lost income. The easiest way to do it, in specialties that need imaging, is to expand the scope of practice in order to bill for the imaging. That is what's happening."

Self-referral has become such a concern that even doctors are moving to ban the practice. The American Hospital Association (AHA) is debating a policy that would ban doctors from referring patients to hospitals in which they have a financial stake.[19] The AHA found that self-referral *behaviors "may damage the health care system at large by adding costs and by weakening the health care safety net as community hospitals see their mix of patients becoming more complex and less well financed*."[20]

[18] Amy Lillard, *Imaging Economics*, July 2008, available at: http://www.imagingeconomics.com/issues/articles/2008-07_01.asp

[19] Gary Jacobson, *Cost of Care: Doctor-Owned Hospitals a Lucrative Practice, Though Opinions Split on Benefits*, Dallas Morning News, September 21, 2009.

[20] American Hospital Association, *Physician Ownership and Self-Referral in Hospitals: Research on Negative Effects Grows*, Trendwatch, April 2008.