# Preliminary research on front end.

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## Overview

A few years ago, the Journal of Empirical Legal Studies published some (primarily) desriptive stats on changes in medmal claims.[1] The article looked at rates (usually relative to physicians), and noted general declines in payouts for medical malpractice. Explanations for changes in payouts/claims: (1) tort reform, (2) health care quality, (3) Rising litigation costs, (4) more hospital-employed physicians (hospitals pay instead of physicians, declining the amount of payments), (5) NPDB and settlement, (6) changes in personal injury claims in general.

I am interested in two concepts: improvements (or lack thereof) in health care quality and in defensive medicine. I can gloss these with medicalization concepts from the second year paper and add an aging component without too much trouble (initial thoughts are in the note entitled "Preliminary analysis and data" (prelim_code...)). This memo provides an overview of the legal research on these terms, primarily through the jumping point outlined in this JELS article.[2]

## Summary

### Health Care Quality

There are a number of errors in medical care, but most errors to not lead to claims.[3] However, most claims involve errors.

2. Improvements in Health-Care Quality If the rate of health-care errors drops, or the errors become more subtle and harder to recover damages

[1] Myungho Paik, Bernard Black & David A. Hyman, *The Receding Tide of Medical Malpractice Litigation: Part 1—National Trends*, 10 Journal of Empirical Legal Studies 612–638 (2013), http://onlinelibrary.wiley.com/doi/10.1111/jels.12021/abstract (last visited Apr 13, 2016).

[2] *Id.*

[3] Tom Baker, The Medical Malpractice Myth (2005).

for, the rate of malpractice claims should drop as well. Most errors do not lead to claims, but most claims do involve errors, and adverse event rates and malpractice rates are correlated.25 Unfortunately, although there have been improvements in healthcare quality in some areas (e.g., a decline in central-line-associated bloodstream infections in intensive care units), studies of error rates continue to show distressingly high rates, with no overall evidence of improvement.26 Thus, improvements in health-care quality are unlikely to explain our results.

3. Rising Litigation Costs The cost of defending med mal claims is rising over time. For example, in Texas, real defense costs roughly doubled from 1988 to 2004, even though payouts were roughly 25On most errors not leading to claims, see the review by Baker (2005). On most claims involving errors, often negligent errors, see Studdert et al. (2006). On the correlation between adverse patient safety events and malpractice claim rates, see Greenberg et al. (2010) and Black and Zabinski (2013). 26See, for example, Classen et al. (2011), Landrigan et al. (2010), and Farmer et al. (2013).