

# Caring For Patients In A Malpractice Crisis: Physician Satisfaction And Quality Of Care

Malpractice concerns could be harmful to the physician-patient relationship, especially among high-risk, “wounded” specialists.

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**ABSTRACT:** The rhetoric of malpractice reform is at fever pitch, but political advocacy does not necessarily reflect grassroots opinion. To determine whether the ongoing liability crisis has greatly reduced physicians’ professional satisfaction, we surveyed specialist physicians in Pennsylvania. We found widespread discontent among physicians practicing in high-liability environments, which seems to be compounded by other financial and administrative pressures. Opinion alone should not determine public policy, but physicians’ perceptions matter for two reasons. First, perceptions influence behavior with respect to practice environment and clinical decision making. Second, perceptions influence the physician-patient relationship and the interpersonal quality of care.

PHYSICIANS ACROSS THE COUNTRY have politically mobilized in response to dramatic increases in medical malpractice insurance premiums, particularly for high-risk specialists. By the American Medical Association’s (AMA’s) reckoning, about two-thirds of U.S. states are now in the midst of a “malpractice crisis” or showing signs of trouble.<sup>1</sup> Nowhere is the problem more acute than in Pennsylvania, where several insurers have exited the market and premiums for coverage through the remaining insurers have increased dramatically.<sup>2</sup>

To investigate the effects of the malpractice crisis on patient care, we conducted a series of key-informant interviews with representatives from Pennsylvania phy-

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sician groups, hospitals, and insurers, followed by a mail survey of 824 Pennsylvania physicians in high-risk specialties. This paper presents findings concerning the effects of the liability crisis on specialists' satisfaction and quality of care.

Physician satisfaction is often neglected or discounted as self-serving in policy debates. In this paper we outline a framework for understanding why physician satisfaction matters for patient care and what factors influence it. We then report on how the malpractice crisis appears to have affected satisfaction in Pennsylvania and explore the implications for quality of care. Our findings from Pennsylvania are not nationally generalizable, but they do provide a lens into the environment in states in severe malpractice crisis—a point at which several states have already arrived, and toward which many others appear to be headed.

### **Why Does Physician (Dis)Satisfaction Matter?**

Hard evidence is lacking for some of the irritants that cause grumbling among physicians, but professional dissatisfaction deserves policy attention if it has damaging consequences for patients.<sup>3</sup> Empirical studies have identified associations between physician satisfaction and a variety of measures of quality of care.<sup>4</sup> For example, patients of physicians with higher levels of job satisfaction have exhibited superior adherence to medical treatment.<sup>5</sup> Satisfied physicians tend to be more attentive to patients and to have higher levels of satisfaction among their patients.<sup>6</sup> Physician dissatisfaction, on the other hand, has been linked to riskier prescribing practices.<sup>7</sup> Dissatisfied physicians are also more likely to leave clinical practice or relocate, disrupting continuity of care and jeopardizing access to services in underserved regions.<sup>8</sup>

When financial stress is a source of dissatisfaction, physicians may change the insurance mix of their patients, increase patient volume, and reduce support services. Physicians dissatisfied with liability risks and costs may also take specific steps to reduce their exposure, such as restricting scope of practice, avoiding high-risk patients, and engaging in “defensive medicine.”

■ **Determinants of physician satisfaction.** Previous work has identified five domains of influence on physician satisfaction.<sup>9</sup> The domain of income is a function of both salary and overhead costs. Included in the domain of relationships are relations with patients, colleagues, nurses, and other staff. The domain of autonomy relates to a physician's sense of control over his or her work (including control over work hours) as well as his or her perceived ability to provide needed services to patients. The domain of practice environment consists of a constellation of factors including practice size, practice ownership, involvement with managed care, number of work hours and amount of personal time, and involvement with bureaucracies and administrative tasks. In the domain of the broader market environment, important dimensions include managed care penetration and the supply and organization of hospital and physician services in the area. Of these several factors, the strongest effects observed in previous studies have been for clinical autonomy, hours worked,

practice type, and income.<sup>10</sup>

■ **Liability pressures and physician satisfaction.** Somewhat surprisingly, malpractice has not previously been included in quantitative analyses of physician satisfaction, despite survey evidence showing that physicians have intense emotional reactions to malpractice litigation.<sup>11</sup> Malpractice pressures could lower physician satisfaction by affecting any of the five key domains. Because liability crises are infrequent but acute when they occur, malpractice concerns could potentiate other sources of dissatisfaction.

Physicians with high malpractice premiums may decide that they should reduce or eliminate high-risk services (autonomy) or that they should stop practicing altogether (market environment).<sup>12</sup> Physicians' net earnings may be severely affected by rising insurance premiums (income).<sup>13</sup> An atmosphere of high liability risk and costs may affect the physician-patient relationship, precluding mutual trust and hampering communication (relationships).<sup>14</sup> Finally, there is some evidence to suggest that physicians, especially those in small practices, may experience financial pressures during malpractice crises that push them into larger practices or direct employment by hospitals (practice environment).<sup>15</sup>

## Study Methods

■ **Key-informant interviews.** We conducted a series of in-depth interviews in fall 2002 with forty-one highly placed, knowledgeable people in the Pennsylvania health care community, including representatives from thirteen medical specialty societies and six county medical societies. Our methods are described elsewhere.<sup>16</sup> The interviews were semistructured, approximately forty-five minutes long, and conducted over the telephone or face to face. Three investigators coded and analyzed full-text transcripts of the interviews using thematic content analysis.

■ **Mail survey.** We designed a mail survey to gather information from a large sample of Pennsylvania physicians. Findings from the key-informant interviews prompted us to focus the survey on the six specialties identified by informants as most affected by the liability crisis: emergency medicine, general surgery, neurosurgery, obstetrics/gynecology, orthopedic surgery, and radiology.

A professional survey organization, Harris Interactive Inc., drew a stratified random sample of 1,333 physicians in these specialties from the AMA Physician Masterfile. One stratum consisted of the five counties identified by key informants as most affected by the crisis, and the other consisted of all other counties. We sampled physicians within each stratum who were active in patient care proportionately by specialty, except that we oversampled neurosurgeons to ensure adequate representation.

Following pilot testing and revision, the final survey questionnaire consisted of forty-one questions related to the perceived impact of the liability crisis. We administered the survey in May 2003 and received completed questionnaires from 824 physicians. The adjusted response rate, after exclusion of sixty-five non-

eligible physicians, was 65 percent. The margin of error was  $\pm 4$  percentage points.

We analyzed the data using the STATA 7.0 statistical package, incorporating appropriate adjustments for the complex survey design. Subgroup comparisons were performed using adjusted Wald and  $M^2$  tests for trend. Sampling weights were applied to ensure that survey responses reflected the distribution of Pennsylvania physicians in direct patient care in the selected specialties. Data were weighted first within each geographic stratum by specialty, sex, and length of time in practice, and then to make the data representative of all Pennsylvania physicians in each specialty.

■ **Population characteristics of the study sample.** Population descriptive statistics were derived by weighting data from our survey sample of 824 specialists (148 emergency medicine physicians, 155 general surgeons, 52 neurosurgeons, 187 obstetrician/gynecologists, 127 orthopedic surgeons, and 155 radiologists). Approximately two-thirds of these specialists were located in the five “high-risk” counties around Philadelphia. Nineteen percent were solo practitioners, 40 percent were in group practices, and 27 percent practiced in a hospital clinic.

Two-thirds of this group of specialists purchased primary-layer professional liability insurance directly from an insurance carrier; the remainder received coverage through a hospital. More than half had changed insurance carriers since the onset of the malpractice crisis in 2000; more than a third of those changes were made because the physician was dropped by his or her insurer.

Eighty-six percent of specialists had been named in a malpractice suit at least once during their careers, and 47 percent had been sued in the three years prior to the survey. Of particular interest is a subgroup (57 percent) of specialists who had been “wounded” by the current malpractice crisis: physicians who had been dropped by their insurer, sued in the past three years, or both.

## Study Results

■ **Overall satisfaction levels.** Nearly 40 percent of the Pennsylvania specialists we surveyed in 2003 were dissatisfied with the practice of medicine (Exhibit 1). OB/GYNs were most likely to report dissatisfaction, and emergency medicine physicians and radiologists the least likely. Solo practitioners were significantly more likely than specialists practicing in other settings to be very dissatisfied ( $p < .05$ ).

Career satisfaction among Pennsylvania high-risk specialists was much lower than that among two national samples of specialists surveyed as part of the Community Tracking Study (CTS)—one group in 1999, prior to the onset of the malpractice crisis, and one in 2001, when the crisis was beginning to affect some states.<sup>17</sup> The rate of dissatisfaction among the Pennsylvania specialists (39 percent) was twice as high as the rates in the 1999 and 2001 benchmark samples (19 percent and 1 percent, respectively;  $p < .01$  for both comparisons). The disparity was also present in subgroup analyses of surgical specialists and OB/GYNs ( $p < .01$  for all analyses).

**EXHIBIT 1**  
**Pennsylvania Specialist Physician Satisfaction (2003) Compared With National Benchmark, 1999 And 2001**

Satisfaction with overall career in medicine	PA sample, 2003 <sup>a</sup>	National sample	
		2001 <sup>b</sup>	1999
All specialists (number)	824	4,723	5,040
Very satisfied	24% <sup>c,d</sup>	42%	41%
Somewhat satisfied	36	39	38
Neither satisfied nor dissatisfied	2	1	1
Somewhat dissatisfied	24	14	15
Very dissatisfied	15	4	4
Surgical specialties (number) <sup>e</sup>	330	1,407	1,578
Very satisfied	28% <sup>d</sup>	40%	43%
Somewhat satisfied	30	39	36
Neither satisfied nor dissatisfied	2	1	1
Somewhat dissatisfied	23	15	15
Very dissatisfied	17	5	4
Obstetrician/gynecologists (number)	186	446	446
Very satisfied	15% <sup>d</sup>	34%	35%
Somewhat satisfied	33	38	38
Neither satisfied nor dissatisfied	3	1	<1
Somewhat dissatisfied	29	20	17
Very dissatisfied	20	6	9

**SOURCES:** See below.

**NOTES:** Weighted proportions of completed responses. Percentages may not sum to 100 because of rounding.

<sup>a</sup> Pennsylvania sample is from the authors' survey of physicians' views on malpractice and includes emergency medicine physicians, general surgeons, neurosurgeons, obstetrician/gynecologists, orthopedists, and radiologists.

<sup>b</sup> National samples are from the Community Tracking Study (CTS) Physician Survey and include all specialists except radiologists, anesthesiologists, and pathologists. B.E. Landon et al., "Changes in Career Satisfaction among Primary Care and Specialist Physicians, 1997–2001," *Journal of the American Medical Association* 289, no. 4 (2003): 442–449; Center for Studying Health System Change, Community Tracking Study Physician Survey, 2000–2001 (Washington: Center for Studying Health System Change, 2003); and HSC, Community Tracking Study Physician Survey, 1998–1999 (Washington: HSC, 2001).

<sup>c</sup> Significantly different ( $p < .01$ ) from 2001 national sample in  $M^2$  test for trend in ordinal data. See A. Agresti, *Introduction to Categorical Data Analysis* (New York: John Wiley and Sons, 1996), chap. 2.

<sup>d</sup> Significantly different ( $p < .01$ ) from 1999 national sample in  $M^2$  test for trend.

<sup>e</sup> Pennsylvania surgical specialties sample includes general surgeons, neurosurgeons, and orthopedists; CTS national sample includes all surgical specialties.

Seventy percent of specialists said that they would be very or somewhat likely to recommend their specialty to someone graduating from medical school today, but only 15 percent were willing to recommend practicing in Pennsylvania (Exhibit 2). Nearly half responded that they were not at all likely to recommend Pennsylvania, and specialists who had strong personal ties to the state (either grew up or attended medical school in Pennsylvania) were no more likely than those who did not to recommend practicing there. OB/GYNs and orthopedists were most dissatisfied with Pennsylvania (93 percent and 94 percent, respectively, unlikely to recommend). "Wounded" physicians were significantly less likely than other specialists to recommend Pennsylvania ( $p < .01$ ). Further analysis suggests that the low professional satisfaction observed among high-risk specialists in Pennsylv-

**EXHIBIT 2**  
**Pennsylvania Specialist Physicians' Recommendations To Physicians In Training, 2003**

Likelihood of recommending to someone graduating from medical school	Overall (%) (n = 824)	Liability insurance premium burden (%)			Professional liability experience (%)	
		Minor (n = 118)	Major (n = 373)	Extreme (n = 322)	"Wounded" physicians <sup>a</sup> (n = 464)	"Nonwounded" physicians (n = 326)
Practicing in specialty						
Very likely	38	45 <sup>b</sup>	41	31	39	36
Somewhat likely	32	39	31	30	31	32
Not very likely	21	12	22	22	21	21
Not at all likely	10	3	5	17	9	11
Practicing in PA						
Very likely	3	10 <sup>b</sup>	4	0	2 <sup>b</sup>	5
Somewhat likely	12	30	13	6	9	15
Not very likely	35	46	43	22	35	37
Not at all likely	49	14	40	73	54	43

**SOURCE:** Authors' survey of physicians' views on malpractice.

**NOTES:** Weighted proportion of completed responses. Percentages may not sum to 100 because of rounding.

<sup>a</sup> Physicians who have been sued, dropped by their liability insurer, or both within three years prior to the survey.

<sup>b</sup> *p* < .01 in adjusted Wald test for trend.

nia is related to several distinct effects of the malpractice crisis on the underlying determinants or domains of satisfaction.

■ **Effects on income.** Rising liability insurance premiums may affect physicians' incomes by raising the cost of doing business. Such an effect is especially plausible for physicians practicing in markets in which fees cannot easily be negotiated upward in response to increased overhead costs. Key informants reported that such conditions existed in Pennsylvania and that a major factor precluding the negotiation of higher rates was the market dominance of a single health plan in certain parts of the state.<sup>18</sup>

Informants described physicians as "getting it on both ends": Costs are rising while reimbursement remains static or declines. "The hospitals in Pennsylvania are paid at some of the best rates in the nation, but the physicians are paid some of the worst," one noted. Thus, said another,

I think if it were just the malpractice situation that added financial burden, it could be absorbed. We'd raise our rates to make up for that. But we have no way of passing on that extra cost to our consumers. And so, [reimbursement and insurance costs] both play a role.

The resulting income equation is not appealing to physicians. As an obstetrician explained,

I started alone in 1984, at which time my malpractice insurance was \$18,000 and most people were getting \$2,800 to deliver a baby. Today, the doctors are paying between \$100,000 and \$140,000 for malpractice [insurance], almost every patient is in an HMO, and we're getting \$1,600 to deliver babies.

This financial squeeze appears to be reflected in lower professional satisfaction.

In our mail survey, specialists who felt heavily financially burdened by malpractice insurance costs were least likely to report satisfaction with their practice. When asked to characterize their current professional liability insurance premium levels, 40 percent of specialists described their premiums as an “extreme burden,” 40 percent said that they were a “major burden,” 12 percent called them a “minor burden,” and 2 percent said that they were “not at all a burden.” There was a statistically significant, inverse relationship between premium burden ratings and overall satisfaction ( $p < .01$ ). There were also significant associations between premium burden and willingness to recommend specialty and Pennsylvania practice ( $p < .01$  for both, see Exhibit 2).

■ **Effects on relationships.** Liability pressures may affect physicians’ satisfaction and the quality of care by impinging upon the physician/patient relationship (Exhibit 3). Just over half of surveyed specialists denied that malpractice concerns made them less candid with their patients, but a sizable minority felt that they did. “Wounded” physicians and those with high premium burdens were significantly more likely to report such feelings ( $p < .05$  for “wounded” status and  $p < .01$  for premium burden). Three-fourths of specialists agreed with the statement, “Because of

### EXHIBIT 3 Effects Of Liability Pressures On Pennsylvania Specialists’ Interactions With Patients, 2003

	Geographic area (%)		Insurance premium burden (%)			Professional liability experience (%)	
	High-risk county (n = 296)	Low-risk county (n = 528)	Minor (n = 118)	Major (n = 373)	Extreme (n = 322)	“Wounded” physicians (n = 464)	“Nonwounded” physicians (n = 326)
Because of concerns about malpractice liability, I feel that I am less candid with my patients							
Agree	25	21	12 <sup>a</sup>	21	28	26 <sup>b</sup>	17
Neither agree nor disagree	22	24	27	22	23	22	24
Disagree	53	55	61	57	49	52	59
Because of concerns about malpractice liability, I view every patient as a potential malpractice lawsuit							
Agree	81	75	63 <sup>b</sup>	77	81	81 <sup>a</sup>	71
Neither agree nor disagree	9	9	13	9	8	9	9
Disagree	11	17	24	14	11	10	19
The malpractice system limits doctors’ ability to provide the highest-quality medical care							
A great deal	62 <sup>a</sup>	52	31 <sup>a</sup>	49	73	59	51
Somewhat	27	40	58	41	21	32	41
Not much/not at all	10	8	11	10	7	9	8

**SOURCE:** Authors’ survey of physicians’ views on malpractice.

**NOTES:** Weighted proportion of completed responses. Percentages may not sum to 100 because of rounding.

<sup>a</sup> $p < .01$  in adjusted Wald test for trend.

<sup>b</sup> $p < .05$  in adjusted Wald test for trend.

concerns about malpractice liability, I view every patient as a potential malpractice lawsuit.” Again, those with a high premium burden and those who had been sued or dropped by an insurer were significantly more likely to take this view ( $p < .05$  and  $p < .01$ , respectively).

These findings corroborate reports from the key-informant interviews. Interview participants noted that liability concerns had replaced doctors’ previously “warm, fuzzy relationship with patients” with hard-nosed scrutiny of the patient’s litigiousness and its potential impacts on quality. One respondent reported:

I heard a doctor say to a group of residents, “Every patient that comes in my office is a potential plaintiff, and that’s the way I look at it.” In my view, that’s much more devastating to the health care system than [physicians relocating out of state].

Another noted:

When you are constantly looking over your shoulder and thinking that any less-than-perfect outcome is going to result in a lawsuit, it’s not exactly the best psychological environment to try to concentrate on what you are doing with the patient

while a hospital executive remarked,

The doctors in this state are very sore, and this attitude affects how they deliver care. Unhappy doctors impact overall quality. In particular, communication between physicians and the [hospital] staff has deteriorated. A lot of these doctors are clinically depressed and aren’t able to communicate well.

■ **Effects on autonomy.** The malpractice crisis may also be affecting physicians’ satisfaction by eroding their sense of autonomy. Survey reports indicated that the liability environment impedes specialists’ perceived ability to deliver needed services in the way they would like. Ninety-one percent of specialists surveyed said that the malpractice system limits doctors’ ability to provide the highest-quality medical care (Exhibit 3). Specialists practicing in high-risk counties and those with heavy insurance premium burdens were significantly more likely than others to perceive that it limits quality “a great deal” ( $p < .01$  for both).

Physicians’ financial responses to rising liability costs may play a role in constraining their ability to provide high levels of service to patients. Three quarters of specialists reported that because of liability costs, the practice or hospital where they saw most of their patients was likely, within the next two years, to increase the volume of patients seen (Exhibit 4). Specialists practicing in the five-county “high-risk” area around Philadelphia were significantly more likely ( $p < .01$ ) than others to be trying to increase volume.

In interviews, physician-informants described the difficult choices being made:

Physician overhead is going up, reimbursement is going down, and doctors need to figure out how to make up this difference—by either working longer hours, buying fewer medical supplies, or cutting down on certain high-risk procedures to reduce malpractice rates.

Increasing the number of patients seen was a commonly reported strategy.

#### EXHIBIT 4 Effects Of Rising Liability Costs On Pennsylvania Specialists' Practice Environment, 2003

Likelihood of practice or hospital where physician sees most patients taking the following steps within next two years because of liability costs	Overall (%)	High-risk county (%)	Low-risk county (%)
Increasing the volume of patients seen			
Definitely will (already decided to)	13	13 <sup>a</sup>	13
Very likely	33	42	28
Somewhat likely	30	26	32
Not likely/definitely will not	24	2	27
Reducing the number of clinical staff			
Definitely will (already decided to)	13	14	13
Very likely	22	27	19
Somewhat likely	28	24	31
Not likely/definitely will not	36	35	37
Reducing the number of administrative staff			
Definitely will (already decided to)	16	18	14
Very likely	24	25	24
Somewhat likely	33	32	33
Not likely/definitely will not	28	25	29
Canceling or delaying capital improvements			
Definitely will (already decided to)	18	23 <sup>a</sup>	15
Very likely	29	33	27
Somewhat likely	30	23	34
Not likely/definitely will not	23	22	25

**SOURCE:** Authors' survey of physicians' views on malpractice.

**NOTES:** Weighted proportion of completed responses. Percentages may not sum to 100 because of rounding. Sample sizes are in Exhibit 3.

<sup>a</sup>  $p < .01$  in adjusted Wald test for trend.

“Doctors are delivering more babies per month than they should be,” one head of a specialty society said. “They have to do it in order to generate enough money to maintain something of a lifestyle—not their old lifestyle, but to just stay alive.” By boosting gross revenue, this measure helped physicians keep their practice doors open, but at a price:

The more business [physicians] do, the more opportunity they have to pay their premiums. So access is going to be a very late victim. The first victim is going to be quality of care, in terms of how many patients you see an hour, the amount of time you give them.

The extent to which the asserted relationship between volume and quality actually manifests itself depends in part on the physician's baseline volume. Practices that had been operating below capacity may be able to absorb more patients, while those with a full patient load may have difficulty adding patients without compromising quality.

■ **Effects on practice environment.** In addition to attempting to boost revenue through higher volume, many specialists in the mail survey reported that their prac-

tice or hospital was taking steps to reduce overhead costs (Exhibit 4). Nearly two-thirds reported that their practice or hospital would likely reduce the number of clinical staff over the next two years because of liability costs. Nearly three-fourths indicated that their practice or hospital would likely reduce the number of administrative staff, and a similar percentage reported that their practice or hospital would cancel or delay capital improvements because of liability costs. The overall picture of patient care in Pennsylvania, as one key informant put it, is one of doctors “trying to do more with less.”

■ **Effects on market environment.** Elsewhere we have reported on several effects that the liability crisis is having on broader features of the Pennsylvania health care market.<sup>19</sup> First, many specialists are entering into direct employment relationships with hospitals to obtain affordable insurance under the hospital’s policy. Second, the financial burden of liability coverage is compounding existing forces pushing solo physicians into larger group practices. Third, to cut their insurance bill, many group practices are reducing the number of members who perform high-risk procedures. All of these changes in the organization of health care services may affect specialists’ professional satisfaction.

## Conclusion

In a severe malpractice crisis, rising liability expenses may well involve costs for patients. The costs may be economic—state governments may divert tax dollars toward subsidies for malpractice insurance premiums, and health insurance costs may increase if provider reimbursement is raised in response to increased overhead. Alternatively, the cost to patients may come in the form of lower quality and availability of health services.<sup>20</sup> As the conduit for such effects, physicians’ behavior is a critical policy focus. This behavior, in turn, is often rooted in physicians’ anxieties and discontent.

Our findings suggest that the malpractice crisis in Pennsylvania is decreasing specialist physicians’ satisfaction with medical practice in ways that may affect the quality of care. Our data do not permit us to describe the interplay between liability stressors and other factors that may erode satisfaction, such as reimbursement climate and general administrative burden.<sup>21</sup> The relationship may be cumulative, with an acute malpractice crisis acting as a “last straw” among the physicians who are most affected by it.

We cannot gauge the extent to which misinformation or exaggerated perceptions of litigation risk feed physicians’ unhappiness. Previous research suggests that physicians may overestimate their probability of being sued, even at the height of tort crises.<sup>22</sup> On the other hand, the high rate of suit among physicians in our sample suggests that these physicians’ fear of lawsuits may be well-founded.

State-to-state variations in the liability environment mean that our data are not necessarily generalizable. Pennsylvania is among the three or four states hit hardest by rising liability costs, but all indicators point toward a deepening of the mal-

practice crisis in other states. The high-risk specialties we surveyed also are not necessarily representative of physicians generally.<sup>23</sup> However, severe stress to these specialties might well compromise the health care system as a whole.

The debate in state legislatures over appropriate policy responses to the malpractice crisis is focused on three strategies: insurance subsidies, stricter insurance regulation, and reforms to the tort liability system. Insurance subsidies may take the form of direct state payments to providers for primary-layer insurance or relief from contributions to state-run patient compensation funds. Stricter rate regulation by state departments of insurance is a straightforward way to stabilize premiums, but it may prompt insurers to exit the market. Providers have lobbied strongly for caps on noneconomic damages and other tort reforms to stabilize claims costs. The evidence about the effects of caps is somewhat mixed, but several studies have linked them with improvements in the liability environment.<sup>24</sup>

Overall, these reform strategies are responsive to physician dissatisfaction, but their efficacy as a cure for the tort crisis and a prophylactic against recurrences is questionable. The core objective of such reforms should not be to restore physicians' job satisfaction, but to improve the malpractice system's performance in compensating patients and promoting high-quality care.<sup>25</sup> If a byproduct of reform is higher professional satisfaction, however, this may amplify the gains to patients.

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#### NOTES

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16. Mello et al., "Hospitals' Behavior in a Tort Crisis."
17. Landon et al., "Changes in Career Satisfaction." The CTS and Pennsylvania samples of specialists were not identical; see Exhibit 1 for details.
18. Mello et al., "Hospitals' Behavior in a Tort Crisis."
19. *Ibid.*
20. A related point is that some policy responses to the malpractice crisis, such as damages caps, may shift more of the costs of malpractice-related injuries to patients by limiting providers' liability. It is also possible that at least one of the effects of the liability crisis on the market—the movement of physicians into more integrated practice arrangements—may actually improve quality and efficiency.
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22. A.G. Lawthers et al., "Physicians' Perceptions of the Risk of Being Sued," *Journal of Health Politics, Policy and Law* 17, no. 3 (1992): 463–482.
23. Additionally, our sample excluded some specialties that were included in the CTS sample, precluding a precise comparison of satisfaction levels.
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