Nursing Home Litigation and Tort Reform: A Case for Exceptionalism

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The medical malpractice crisis that is currently spreading across the United States bears many similarities to earlier crises. One novel aspect of the current crisis is the explicit inclusion of litigation against nursing homes as a target of reform. Encouraged by the nursing home industry, policymakers are considering the extension of conventional medical malpractice tort reforms to the nursing home sector. In this article, we caution against such an approach. Nursing home litigation has a number of distinctive features that raise serious questions about the wisdom of implementing reforms generically across the care continuum. Drawing on findings from our previous study of nursing home litigation, we outline these features and argue for careful attention to them as policymakers evaluate options for reform.

Key Words: Long-term care, Nursing homes, Medical malpractice, Lawsuits

The third medical malpractice crisis in recent history has arrived, bearing many of the hallmarks of its predecessors in the mid-1970s and mid-1980s (Mello, Studdert, & Brennan, 2003). To long-time observers of the tort system, the spiraling premiums for professional liability coverage, market pullouts by liability insurers, and scarcity of malpractice-insurance coverage facing providers in some states may seem like déjà vu all over again (U.S. Government Accounting Office, 2003). The policy responses under consideration will also look familiar: Legislators across the country are considering a range of “tort reforms”—legislative measures that seek to calm liability-insurance markets by shrinking the frequency and magnitude of claims. Caps on damages have emerged as the most visible and controversial of these reforms, receiving strong endorsement from the White House (Oppel, 2003).

One novel aspect of the current crisis is the explicit inclusion of lawsuits against nursing homes as a target of reform. This move will have escaped the notice of many in the broader health-policy community. The rancorous debate between trial lawyers and organized medicine is heavily focused on medical malpractice issues arising in the acute-care setting, and it tends to marginalize litigation in other areas. However, the move to broaden the reach of tort reforms beyond the acute-care sector has not escaped the notice of the nursing home industry. The industry has promoted and lauded such extensions, arguing that the rising tide of litigation against nursing homes threatens to erode a fragile compact between state and federal governments, residents, and long-term-care providers (American Health Care Association, 2003).

In a recent study of the scale of nursing home litigation in the United States, we found empirical support for claims that the litigation has reached epidemic levels, at least in Florida and Texas (Stevenson & Studdert, 2003). These findings have been interpreted by some as bolstering the case for importing conventional tort reforms into the nursing home sector (American Health Care Association, 2003; Kreiter, 2003). In this article, we caution against such a conclusion. Nursing home litigation...
has a number of distinctive features that raise serious questions about the wisdom of implementing a generic set of reforms across the care continuum.

Drawing on descriptive findings from our earlier study, we outline some distinctive features of nursing home litigation and argue for careful attention to them as policymakers evaluate options for addressing perceived problems with litigation in this area. Our focus is on tort reform, not on the policy response to nursing home litigation more generally. We acknowledge at the outset the arguments of some observers that tort reform as a policy move is a distraction, and that edge at the outset the arguments of some observers that tort reform as a policy move is a distraction, and that chief lesson of nursing home litigation is the need for redoubled attention to improving quality of care (Wright, 2003). Notwithstanding the force of such arguments, the reality is that debate over tort reform continues to rage in legislatures across the country.

**Key Characteristics of Personal Injury Litigation in Acute- and Long-Term-Care Settings**

To appreciate the dynamics of the litigation driving the wider tort reform debate today, we find it helpful to summarize some of the basic features of personal injury lawsuits arising in acute- and long-term-care settings. Of course, there is a degree of heterogeneity within every category of litigation, and, for every generalization, exceptions are readily identifiable. Our intention is to characterize broadly the respective bodies of litigation as a way of highlighting important differences between the “garden variety” claim against long-term-care providers and its acute-care counterpart.

**Acute-Care Litigation**

In a typical medical malpractice claim, the plaintiff is the patient. The allegation is that the provider in question failed to adhere to standards expected of a “reasonable” practitioner in similar circumstances and, as a result, the patient was injured. Such claims sound in general negligence law and are brought in state court. Traditionally, allegations of malpractice have centered on the negligent performance of procedures, especially surgical procedures. This is still a common type of claim. However, allegations of negligent diagnosis, such as missed myocardial infarction in the emergency department and delayed diagnosis of breast cancer, have become much more common in the past 20 years, as have allegations of medication errors (Physician Insurers’ Association of America, 2000).

The primary defendant in medical malpractice claims is the physician, although many claims also name hospitals, clinics, and other health care professionals as codefendants. Because physicians generally maintain a separate line of liability insurance from the institutions in which they work, separate defenses are mounted. The physician’s insurer retains counsel. If institutional defendants and other health care professionals are named, they will do the same, often together, because institutions’ liability insurance covers the nurses and ancillary providers they employ.

Fewer than 10% of malpractice claims reach trial (Danzon, 1985). The rest are settled with or without payment, or they are simply “dropped”—that is, they are never pursued beyond an initial demand for payment. Plaintiff “win” rates vary by state, but on average they appear to hover around 30% to 35% for both settlements and verdicts. Mean payments are very sensitive to geography (Danzon, 1985). On average, they are in the $200,000 to $250,000 range. Payment levels have been climbing steadily over the past decade (Smarr, 2003). However, means disguise a heavy right-skew to the distribution: Nearly 1 in 10 payouts total more than $1 million (Smarr, 2003; U.S. Government Accounting Office, 2003), a proportion that has doubled in the past five years (Thorpe, 2004).

Compensatory damages in civil litigation can be divided into two conceptually distinct components. Economic damages cover direct financial losses such as lost wage and health care costs; noneconomic damages compensate plaintiffs for pain, suffering, and other consequences of the injury that do not have a direct financial impact. In malpractice verdicts, noneconomic damages typically account for 30% to 40% of the award (American Law Institute Reporter’s Study, 1991; R. A. Bovbjerg, Sloan, & Blumstein, 1989; Vidmar, 1998). Punitive damages, a third component of damages, are not intended to compensate (although plaintiffs generally do receive these monies); rather, their purpose is to punish the defendant for egregious acts and to send a warning. Punitive damages are very rare in medical malpractice litigation. Although they are frequently requested, less than 1% of payouts in malpractice cases include punitive damages (Rustad, 1998; Studdert & Brennan, 2000).

**Nursing Home Litigation**

Personal injury claims against nursing homes are rarely initiated by the injured residents themselves. Almost 65% of these claims are initiated by residents’ children; another 20% are initiated by residents’ spouses. (All statistics are from our 2003 study, unless otherwise stated.) The allegations tend to center on abuse and neglect, rather than procedural mistakes and errors. The types of injuries most commonly alleged include death, pressure ulcers or bedsores, dehydration or weight loss, emotional distress, and falls. Although many nursing home claims are grounded in the common law, almost half are brought under state statutes such as residents’ rights and elder-abuse laws.

The primary defendant in nursing home claims is the nursing home itself, which is named in virtually every claim. Approximately two thirds of nursing home facilities in the United States are for profit (compared with fewer than one fifth of hospitals), and more than half are chain owned (Harrington, Carillo, Wellin, & Shemirani, 2002). One in five claims also name professional staff, such as medical and nursing directors. Full-time employees enjoy coverage from the nursing home’s liability-insurance policy, but medical directors,
attending physicians, or other contract staff usually rely on coverage from a separate source. Nursing homes have faced sharp increases in liability-insurance premiums over the past decade (Bourdon & Dubin, 2003; Hann, 2000; Insurance Services Office, 2002; Wright, 2003).

As with medical malpractice claims, fewer than 10% of nursing home claims reach trial. However, a much higher proportion of them result in some compensation to plaintiffs—nearly 9 out of every 10 claims. Average recoveries for nursing home claims nationwide (approximately $400,000) appear to be larger than the average medical malpractice payout. The composition of the payouts in nursing home claims also looks quite different from the medical malpractice compensation. Noneconomic damages figure much more prominently, different from the medical malpractice compensation. Noneconomic damages figure much more prominently, accounting for approximately 80% of the total on average—twice the share of noneconomic damages in medical malpractice payouts. In addition, punitive damages are more prevalent; approximately 18% of payouts in nursing home litigation include a punitive-damages component.

Tort Reform Characteristics

Tort reform is not the only policy response to sudden increases in malpractice claims and severity, but it is the one that has consistently captured the attention of legislators and policymakers during successive malpractice crises over the past 30 years (Studdert, Mello, & Brennan, 2004; Weiler, 1991). Other responses—for example, regulatory interventions in liability-insurance markets and experimentation with alternative approaches to compensation—are discussed periodically. Academic commentators have long championed more radical reform of the tort system (Abraham & Weiler, 2004; Havighurst & Tancredi, 1973; Jonson, Phillips, Orentlicher, & Hatlie, 1989). However, in the highly polarized policy debate that surrounds malpractice reform, forging consensus around fundamental change to the status quo has proven impossible, with only a few notable exceptions (R. A. Bovbjerg, Sloan, & Rankin, 1997). The politically feasible option has proved to be relatively modest tinkering with the system through so-called tort reform.

Conventional tort reforms divide roughly into three families (Studdert, Mello, & Brennan, 2004; Weiler, 1991). Reforms in the first family are characterized by measures that limit access to the courts. For example, laws shortening statutes of limitations or statutes of repose contract the time within which plaintiffs are permitted to lodge their claims. Screening panels and expert witness requirements may also be used to limit access by forcing the litigants to have the merits of their case scrutinized before they reach court.

A second family of reforms targets liability rules. For example, eliminating joint-and-several liability means that a plaintiff may recover from multiple defendants only in proportion to their respective contributions to causing the injury. Some legislatures also have introduced rules that change the standards for informed consent, expert witnesses, and the evidence required to prove negligence in certain circumstances.

The third family of reforms directly addresses the size of awards. Legislators have been particularly enthusiastic about this type of reform in the current crisis—a reaction that is no doubt due to the view (for which there is growing evidence) that large increases in damages awards, particularly the incidence of multimillion dollar awards, has fueled the current crisis (Bovbjerg & Bartow, 2003). Placing a limit or cap on damages is by far the most prominent member of this family of reforms. A few states have applied caps to the total award, but most focus on noneconomic or punitive damages. Caps permit insurers to better predict losses and stabilize premiums by setting limits and limiting exposure from case to case. Because personal injury lawyers are generally paid on a contingent fee basis, earning nothing if they lose and a share of the award if they win (typically, around 35%), caps also stifle volume by ensuring that fewer cases hold the promise of a favorable return.

Several other measures in this third family of reforms have formed part of recent tort reform packages. “Collateral source offset” rules reduce awards by denying plaintiffs compensation for losses that are recouped from other sources, such as health insurance. “Periodic payment” requirements mean that future losses are not available in a lump sum but must be collected in installments over many years.

Nursing Home Litigation and Tort Reform

Over the past 2 years, approximately a dozen states have considered or enacted tort reforms aimed at curbing the rise in nursing home litigation and the volatility of the liability-insurance markets for long-term-care facilities (Song, 2003). In March 2003, the West Virginia legislature lowered its cap on noneconomic damages to $250,000 and ensured that the new ceiling applied to both medical malpractice and nursing home litigation (H.B. 2122, 2003). Several months later, the Louisiana legislature signed into law a bill extending that state’s $500,000 cap on noneconomic damages to nursing home litigation (Act 479, 2003) and shortening the statute of limitations in health care litigation generally (Act 506, 2003). Ohio and Mississippi have amended recently enacted tort reform packages to bring nursing homes within their purview (S.B. 281, 2002; H.B. 2, 2002). In contrast, Arkansas lawmakers are considering legislation aimed directly at nursing homes that would limit punitive damages to the lesser of three times compensatory damages or $1 million; reform certain rules of evidence in nursing home litigation; and establish a liability-insurance pool to which nursing homes are required to contribute (H.B. 1213, 2003).

Two distinct approaches are evident in this frenetic tort reform activity. One approach to reform is generic: New legislative measures sweep across the care continuum, or nursing home litigation is brought into line with restrictions already in place for other types of personal injury litigation. A second approach is targeted: Reforms are tailored to perceived problems with nursing home litigation. The implicit rationale for
the targeted approach is that lawsuits against nursing homes present somewhat different policy challenges than those that arise from litigation in hospitals, physicians’ offices, and other clinical settings.

The best illustration of the divergence comes from recent legislative activity in Florida and Texas. Reform strategies pursued in these two states are especially noteworthy because of the central importance of these states in the landscape of nursing home litigation—approximately half of all lawsuits brought against nursing homes in the United States are initiated in Florida or Texas (Stevenson & Studdert, 2003).

In 2001, the Florida legislature passed S.B. 1202 (Polivka, Salmon, Hyer, Johnson, & Hedgecock, 2003). The bill contained provisions mandating nurse staffing levels, quality monitoring and audits, adverse-incident reporting, and other measures directed at quality of care. The bill also introduced a range of tort reforms to the nursing home sector, including limits on punitive damages, a shorter statute of limitations, a statutory formulation of the negligence standard, mandatory mediation, and restrictions on attorneys’ fees in certain circumstances. Notably, compensatory damages were not capped. In August 2003, when the legislature enacted malpractice reforms that included caps, it declined to include long-term-care facilities among the entities covered by the reforms, despite intense lobbying by the nursing home industry for lawmakers to do so (Florida Health Care Association, press release, 2003).

Texas provides an interesting contrast. The Texas legislature passed sweeping changes to the tort system in 2003 that apply uniformly to medical malpractice and nursing home claims. The bill, H.B. 4, places a $250,000 cap on noneconomic damages, increasable to $500,000 in claims involving multiple providers (H.B. 4, 2003). In addition, H.B. 4 extends a previously enacted cap on punitive damages to nursing home lawsuits, reversing exceptions that had previously applied to claims involving injuries to children, elderly adults, and disabled individuals.

### Key Points of Difference

Whether policymakers choose to address perceived problems with nursing home litigation separately from or in concert with broader tort reforms, several distinctive features of nursing home litigation are critical to evaluating the potential impact of reforms in this sector. Our subsequent discussion focuses on four such features: (a) noneconomic damages; (b) punitive damages; (c) the nature of claims; and (d) the nature of injuries.

#### Noneconomic Damages

Critiques of excessive medical malpractice verdicts distill largely into concerns about noneconomic damages. The inherent subjectivity of noneconomic damages, the fact that juries are given little or no guidance in determining them, and their significant contribution to award totals feed perceptions that this part of the system is out of control (Howard, 2002). Critics blame trial lawyers and juries for exploiting the intangibility of this type of loss to inflate payouts, an argument that legislators seem particularly receptive to during times of crisis. Hence, more than any other tort reform measure, caps on noneconomic damages have emerged as the favored policy strategy for “containing” the malpractice crisis.

In the context of nursing home litigation, this type of cap can be expected to have a disproportionately large impact on plaintiffs’ awards because of the distinctive nature of the plaintiffs and the losses involved. Few elderly people have ongoing sources of income that would be diminished by physical injury. Consequently, the balance between economic and noneconomic damages is quite different from other types of medical malpractice litigation: Economic damages tend to constitute a relatively small portion of the award, and noneconomic damages constitute a relatively large portion. Our survey results indicate that noneconomic damages account for approximately 80% of residents’ awards nationwide—roughly double the proportion in medical malpractice awards (see Table 1).

To illustrate the sensitivity of total compensation under a cap to the underlying balance between economic and noneconomic losses, consider the treatment of a million-dollar verdict under a $250,000 cap on noneconomic damages. For an average iatrogenic injury, noneconomic damages in a verdict of this size would total approximately $350,000, and imposition of the award would reduce the overall award by $100,000, or 10%, to $900,000. In the nursing home setting, noneconomic damages would constitute approximately $800,000 of a million-dollar award, and the cap on non-

### Table 1. Breakdown of Damages for Nursing Home and Medical Malpractice Claims

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<thead>
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<th>Damages</th>
<th>Nursing Home Litigation</th>
<th>Medical Malpractice</th>
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<tr>
<td></td>
<td>Florida</td>
<td>Texas</td>
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<tr>
<td>Noneconomic damages as proportion of total compensatory damages (%)</td>
<td>81</td>
<td>74</td>
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<tr>
<td>Economic damages as proportion of total compensatory damages (%)</td>
<td>19</td>
<td>26</td>
</tr>
<tr>
<td>Paid claims with punitive damages (%)</td>
<td>13</td>
<td>30</td>
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Notes: Nursing home litigation estimates are from a national survey of attorneys, weighted by number of claims. See Stevenson and Studdert (2003) for more detail on methods and results. Sources for medical malpractice noneconomic–economic breakdown are R. A. Bovbjerg, Sloan, and Blumstein (1989); Vidmar (1998); and the American Law Institute Reporter’s Study (1991). Sources for medical malpractice percentage with punitive damages are Studdert and Brennan (2000) and Rustad (1998).
economic damages would reduce the award by $550,000, or 55%, to $450,000. In terms of both absolute and proportional reductions, the nursing home claim faces a much more significant burden under the cap.

One objection to these calculations is that the noneconomic losses are not equivalent across the two calculations, and therefore the comparison is not fair. In other words, the fact that older plaintiffs do not incur significant economic losses has nothing to do with the cap, so it would be inappropriate to use this underlying reality to attribute regressiveness to the cap. The comparison can be modified to deal with this objection: A nursing home claim that attracted $350,000 in noneconomic losses (i.e., the same amount as the iatrogenic-injury scenario just given) would attract, on average, $85,500 in economic damages. Imposition of the cap would reduce the overall award by $100,000, or 23%, to $335,500. In absolute terms, the impact of the cap is identical for the two types of claims. However, as a proportion of the overall award, the cap’s effect on the nursing home claim remains more than twice that of the medical malpractice claim.

Hardened skeptics of noneconomic damages will still not be persuaded. They will point to the arbitrariness of the noneconomic award, and they will argue that $800,000, $350,000, or any payment of such magnitude is excessive compensation for this type of loss, making the reduction reasonable. This argument is not compelling from the perspective of a compensation policy that prizes equity across different types of injury. However, as a narrower argument about the socially appropriate valuation of noneconomic losses associated with injuries in the nursing home, it may be more convincing. Consideration of what is the appropriate valuation for pain and suffering experienced by injured residents, however, should recognize that a significant portion of nursing home lawsuits involve serious injury (Stevenson & Studdert, 2003). For cases in which such injury is conceded or judged to be due to negligence, will society be content to limit nursing home residents’ total recovery to a level only slightly higher than the dollar amount of the cap? The paucity of economic damages in nursing home claims virtually ensures this outcome, except for instances in which punitive damages play a significant role in boosting the award.

**Punitive Damages**

Another distinctive feature of nursing home litigation is the role of punitive damages in awards. Although punitive damages play a negligible role in medical malpractice litigation (<1% of awards), they appear to be quite common in nursing home litigation, figuring in nearly one in five payments nationally and one in three payments in Texas (Table 1).

Plausible explanations for the discrepancy are not difficult to find. The high prevalence of abuse, neglect, and other “dignitary” harms in nursing home claims presents the types of scenarios that are likely to incense juries to award punitive damages. In addition, previous research shows that punitive damages are more likely to be awarded in cases against corporations than individuals (Eisenberg, Goerdt, Ostrum, Rottman, & Wells, 1997; Peterson, Sarma, & Shanley, 1987); a related point is that the incidence of punitive damages appears to be positively correlated with the wealth of defendants (Rustad, 1998). Both of these defendant characteristics elevate the probability of punitive-damage awards in nursing home litigation, where institutional defendants abound, and where many of them are large, for-profit corporations (Harrington et al., 2002). By comparison, primary defendants in medical malpractice claims are individual physicians, whom juries tend to perceive as human beings capable of committing regrettable but not repeated errors or oversights (Studdert & Brennan, 2001).

What significance does the distinctive prominence of punitive damages in nursing home litigation have for tort reform? For policymakers interested in options for controlling high-end verdicts, punitive damages present a potentially attractive and effective target in the nursing home sector that does not exist for medical malpractice claims. Placing limits on this component of awards instead of noneconomic damages would ward off the charge that the cap is interfering with plaintiffs’ ability to be made “whole” for their losses. At the same time, the prevalence of punitive damages in nursing home litigation means that such limits could still have a meaningful impact on the overall costs of litigation—but there are trade-offs. Though punitive damages are not designed to compensate plaintiffs, they do serve other purposes, namely, punishing the defendant and deterring repetition of the conduct in question. Hence, in theory, switching the target of caps from non-economic to punitive damages privileges the tort system’s compensation goals over its goals of punishment and deterrence.

**Nature of Claims**

Applying a medical malpractice framework to nursing home claims raises a number of questions of “fit.” The legal bases of nursing home litigation are relatively heterogeneous. In many states, tort litigation is just one avenue among several for residents who seek redress for harm. For the majority of plaintiffs in Florida, for instance, the state’s residents’ rights statute is the primary basis for their claim (Stevenson & Studdert, 2003). Significant opportunities to recover through statutory causes of action also exist in Arkansas, Georgia, Louisiana, Maine, Ohio, and Texas.

In seeking to control litigation, policymakers must decide whether to extend restrictions on access and damages to claims brought through such alternative causes of action. Some policymakers may embrace tort reform but balk at the notion of interfering with the scope of a residents’ rights statute. However, the potential of reforms to curb litigation may be significantly undercut by the availability of alternative bases of suit, especially if enactment of the reforms triggers a “compensating” increase in the usage of these alternatives.

A range of other issues of fit arise in shifting malpractice tort reforms to the nursing home context.
Consider the abridgement of statutes of limitations, for example. Though residents’ family members tend to be the prime movers in litigation, some residents have little or no personal support outside the nursing home. Courts and legislators may be reluctant to run the clock down on nursing home residents who are slow to identify and act upon harms, especially in the context of problematic and highly variable state regulatory and enforcement mechanisms. Although survey inspections and complaint investigations ideally provide protection and recourse for nursing home residents over and above their access to the courts, numerous shortcomings have been identified in these processes in recent years (Harrington, Mullan, & Carrillo, 2004; U.S. Office of the Inspector General, 1999; Zimmerman, Hawes, Stegemann, & Bowers, 2003).

Collateral source rules, historically a popular item in tort reform packages, present another example of tension. These rules aim to prevent plaintiffs from “double dipping” by recovering for losses for which the plaintiff has already been remunerated through other sources of payment. In practice, one of the main items against which damages are offset is health care expenditures; thus, in effect, collateral source rules force health insurers to shoulder medical costs associated with negligent injury. In the nursing home sector, Medicaid is a major payment source. Eager as legislators may be to relieve nursing homes of financial responsibility for the health care costs of successful claimants, it seems unlikely that many will be prepared to have their own cash-strapped Medicaid programs take on these costs. Moreover, recent litigation shows that Medicaid is not content to assume the role of first payer when there are negligent actors involved (Arkansas Department of Human Services v. Estate of Ferrell, 1999; Roberts v. Total Health Care, Inc., 1998).

**Nature of Injuries**

The heterogeneity in types of nursing home claims outlined herein stems partly from the nature of the injuries that drive this litigation. The injury profile, in turn, reflects the peculiarities of the long-term-care environment and the special vulnerabilities of its residents. The amount of medical care received by most residents is quite low; support of personal needs and the maintenance of functioning are the core services. In this relatively low-tech environment, the usual stimulus for malpractice lawsuits, such as missed diagnoses and surgical errors, gives way to allegations of neglected bedsores, malnutrition, and emotional abuse. More than half of claims against nursing homes involve deaths, compared with less than one fifth of malpractice claims (Waters et al., 2003).

Will lawmakers and courts be willing to enforce the conventional armory of tort reform measures when confronted with specific types of harm that befal residents? Congress’s recent consideration of damages caps in H.R. 5 should raise some doubts. The case of Jessica Santillan, a 17-year-old transplant patient who died after receiving a heart–lung transplant of the wrong blood type, unfolded during Congressional deliberations over H.R. 5. Eventually, even the bill’s Republican backers joined the chorus of legislators who declared the importance of establishing exceptions for egregious cases (Stolberg, 2003). The nature of alleged injuries in the nursing home setting may produce a ready supply of exceptions.

California is currently grappling with this very issue. Tort reforms passed in that state in 1975 capped noneconomic damages awards in medical malpractice verdicts at $250,000. However, the limit does not apply when plaintiffs can show that the defendants’ behavior consisted of egregious acts of abuse involving “recklessness, oppression, fraud, or malice.” The debate in California centers on whether the state’s (more permissive) elder-abuse statute preempts the application of this cap in the case of nursing home claims.

**Tort Reform and Compensation System Performance: A Broader Perspective**

There is reasonable evidence that some tort reform measures, in particular caps on damages and collateral source offset rules, control payouts in malpractice litigation (Studdert, Mello, & Brennan, 2004). The impact of tort reforms on liability-insurance markets is less clear. Although some research suggests that they help to contain premiums in the medium term, study findings on this point have been quite mixed (Zuckerman, Bovbjerg, & Sloan, 1990). From a broader perspective, however, tort reforms’ attractiveness must be evaluated by their capacity to advance key functional objectives of injury-compensation systems: (a) delivery of compensation to individuals who are injured by substandard care; and (b) deterrence of unsafe practices (Keeton, Dobbs, Keeton, & Owens, 1984). How is tort reform in the nursing home sector likely to fare on these fronts?

There are multiple dimensions to sound compensation performance, principally, accuracy, adequacy, vertical equity, and horizontal equity (Mehlman, 2003). Accuracy demands that meritorious cases receive damages whereas nonmeritorious cases do not. Adequacy of compensation means that total damages received by winning plaintiffs meet, and do not exceed, societal expectations about what constitutes reasonable compensation for the injury in question. The notion of vertical equity captures the expectation that more severe injuries receive higher compensation than less severe ones, and vice versa; horizontal equity refers to the idea that injuries of similar severity will attract similar levels of compensation.

Implicit in our earlier analysis of differences between litigation in the acute-care and long-term-care sectors is the argument that, in the event tort reforms are pursued, a so-called exceptionalist approach to nursing home litigation would position states for better performance against compensation ideals. For example, attention to the distinctive importance of noneconomic damages in claims brought by elderly adults would help ensure the adequacy of compensation for this class of litigants; it also may promote vertical and horizontal equity relative to other classes of litigants. Similarly, acknowledging the prominence of abuse and neglect among nursing home claims, and the relative paucity of medical
treatment injuries, would help craft compensation policies capable of placing socially appropriate levels of damages in the right hands (adequacy and accuracy). In summary, the formulation of just approaches to compensation hinges, to some extent, on recognition of unique aspects of nursing home litigation.

The connection between tort reform and deterrence is murkier, and arguably less significant. Tort law’s role in ensuring safety and quality in health care has long been the subject of fierce debate (Stevenson & Studdert, 2003; Troyer & Thompson, 2004). The trial bar and some consumer-advocacy organizations insist that unfettered access to litigation is critical to ensuring high-quality care; in the nursing home setting, the steady flow of anecdotal reports of poor care is used to bolster this argument. Providers and defense attorneys counter that lawsuits are haphazard and that their principal impact on quality is negative, draining resources in a fiscally strained system that could otherwise be directed toward improving resident care. Thus, the battle over deterrence is joined.

In fact, evidence that litigation promotes quality is limited at best (R. A. Bovbjerg & Sloan, 1998; Schwartz, 1994). A number of well-designed studies of medical malpractice have investigated the connection between exposure to liability risk and improved health outcomes and have found none (Entman et al., 1994; Mello & Brennan, 2002). In the long-term-care setting, where litigation plays a complementary role alongside relatively elaborate regulatory oversight, the potential for deterrence to have a productive impact may be further diminished.

However, the critical point about deterrence in the context of current tort reform debates is that the two bear surprisingly little relationship to one another. Conventional tort reforms largely bypass quality-improvement concerns. Their mission is to rein in the frequency and costs of litigation in order to alleviate the burden of liability-insurance premiums and stabilize liability-insurance markets. Despite some rhetoric to the contrary, connections to quality improvement are incidental. Indeed, the schism between several popular tort reforms, such as caps on damages, and patient-safety imperatives has drawn criticism from a number of commentators in the recent policy debates (Sage, 2003; Studdert, Mello, & Brennan, 2004). Consequently, controversial as the tort-quality relationship may be, tort reform’s impact on the performance of compensation goals is a more salient issue.

Conclusions

Litigation “crises” in the nursing home and acute-care sectors share much in common. Providers in both sectors cite surges in claims and rising payouts as important causes and are clamoring for legislative relief. Visible consequences include rising liability premiums, difficulties in obtaining coverage, and concerns among policymakers about threats to quality and access for consumers. As policymakers move to address these threats and calm liability-insurance markets, the prospect of generic interventions is alluring.

However, significant differences in the underlying characteristics of the litigation should be recognized, and their implications treated seriously. The preponderance of noneconomic damages associated with residents’ losses, the prevalence of punitive damages in nursing home litigation, and the distinctive nature of claims and injuries in the long-term-care setting all deserve attention in the design of a policy response. Ironically, insufficient sensitivity to these distinctions is likely to cause stress for both of the major stakeholders in nursing home litigation—the negligently injured residents and their families, whose ability to obtain reasonable compensation for meritorious claims would be inappropriately obstructed, and nursing homes themselves, for whom ineffective reforms would fail to alleviate the burden of litigation.

References


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