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SPECIAL REPORT

The State of Malpractice Liability Insurance

Who Bears the Responsibility?
What Are the Solutions?

FEATURING

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Peter B. Scanlan
Lawrence E. Smarr
Bruce H. Stern

The Physician Work Stoppage

A View from the Inside

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Donald F. Denny, MD



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The affordability of malpractice insurance has always been an issue, particularly for high-risk specialties such as obstetrics/gynecology, neurosurgery, and emergency medicine, among others. What is new is the outrage expressed by physicians, which in turn has led to walkouts and work stoppages in several states as well as other types of demonstrations, including refusal to cover trauma units or moving to new practice sites where the malpractice climate is considered friendlier.

Who bears responsibility for the problems faced by physicians and hospitals? The answer is not as clear as many would think. Is it the juries, who award escalating and often unmerited compensation? Is it plaintiffs' lawyers, who sometimes pursue cases with sympathy value as opposed to those marked by true medical malpractice? Is it the executives, who must ultimately answer for the investment and pricing performance of their malpractice insurance companies? What about the bureaucrats at Medicare and other insurance companies, who engineer declining reimbursements for physicians? Everyone seems to have a culprit—but not a solution—for the problem.

This year may bring the showdown (or the meltdown) in medical care that has been predicted for so long. Ultimately, good physicians want to provide quality medical care to their patients. Doctors do not want to strike, nor do they want to be second-guessed in court well after they had to make a medical decision, frequently urgently and under pressure to save a life. Society cannot afford an increase in defensive medicine, such as more cesarean sections brought about by concerns that any other decision will open a doctor's judgment to intense questioning in front of a jury. We need to find a solution, and if something is not done soon we are going to experience a crisis in care that no one—patients, families, and physicians alike—wants to endure.

In this *Medical Crossfire* Special Report, commentary from a range of experts has been collected in order to provide readers with a broad spectrum of insight. Additionally, *Medical Crossfire* spoke to a New Jersey radiologist who participated in an organized work stoppage in that state, giving a real-world view from the front lines. Finally, a listing of resources is included, providing information on how to access position papers and recent news releases from major organizations that are addressing malpractice liability insurance affordability. As always, we encourage you to participate in our Peer Exchange Process (see page 19). Reply with your opinions and experiences, and help *Medical Crossfire* to start an essential dialog between physicians on this very important issue.

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The State of Malpractice Liability Insurance

Who Bears the Responsibility? What Are the Solutions?

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EDITOR'S NOTE: In response to the many recent developments surrounding medical malpractice liability insurance, *Medical Crossfire* gathered eight national experts and asked them to provide their views on the evolving problem and to offer possible solutions. This commentary, listed here in alphabetical order by participant, includes the positions of representatives from the business, legal, insurance, and medical sides of this issue. We hope their opinions, suggestions, and insights will help you to develop the best possible understanding of this ongoing controversy. Please help to continue the discussion by submitting your own comments through our Peer Exchange Process (see page 19).



Richard Augustyn

Chief Executive Officer
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There are several factors behind this national crisis. First, in many states physicians are subjected to escalating and in some cases runaway jury awards. Second, insurers supplement premiums with investment income. Bond yields are now at a 40-year low, and with negative returns in the stock market, there is less investment income to offset underwriting losses. Third, in the 1990s many insurers decided to engage in bruising price wars to gain market share. They set rates based on the hope that optimistic projections for the future proved true. Clearly in hindsight they sold policies far below their cost for many years. This resulted in financial problems and catastrophic failures of more than one medical malpractice insurer.

Today's medical malpractice crisis differs from the past "hard market" of the late 1970s and '80s because of the creation of managed care. The price controls in place for provider services limit a physician's ability to recoup today's higher medical malpractice premiums through higher fees, resulting in a financial vise grip.

These individual developments and others have converged to create a crisis that many are calling a "perfect storm."

Obviously, true tort reform that enables physicians and their insurers to contain the steep rise in claim costs and more accurately project future costs is a very positive development. So, true reform that reduces the volatility of claim payments is one that most insurers would support.

There are a significant number of remedies being discussed at both the state and federal

levels, and it is hard to signify which proposal would work the best to address this complex issue. But public debate is taking place around this issue, which is a healthy way to examine the problem. What are the root causes? How do they impact physicians, the larger health care system, and that system's costs that we all pay into? How should the rights of those who are injured as a result of medical malpractice be appropriately balanced, and how can the injured be compensated without overburdening the system with costs? It is a very difficult problem, but discussions like this help to identify all of the relevant issues and to develop durable solutions.

The New Jersey-based Coventus Inter-Insurance Exchange is one type of solution. Coventus is different than other insurers in that it is a nonprofit venture and is owned solely by member physicians. Its permanent mission, which is very different than that of commercial insurance companies, is to make coverage available to our members at cost without a profit incentive. Our members did not wake up one morning and decide to start an insurance company. Their backs were against the wall; they had a fear that when their malpractice insurance policies expired they would no longer be able to practice medicine. They took the initiative to ensure their own coverage. Physician-owned insurance companies represent one approach to innovative solutions for part of the problem. Public policy, private companies like Coventus, public insurance companies, and physicians themselves all have a role in the process of finding a suitable resolution to this crisis. ■



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At times like this it is very easy to point fingers. Some people like to say that runaway juries are behind rising medical liability premiums; others say the problem is greedy plaintiffs' attorneys who create cases where none exist. I would contend, however, that the trend toward rising premiums is a symptom of several underlying problems. One that has gotten a lot of press involves the failure on the part of insurance companies to accurately calculate their contingent risk in their malpractice insurance lines, which has resulted in artificially low premiums for a number of years. According to this theory, the current surge in premiums is merely a cyclical correction. While this may be true, I do not believe that it provides the entire answer.

A significant underlying risk factor contributing to the upward spiral in premiums is that the health care delivery system is failing to keep up with the increasingly complex demands of patient care. During the past several decades, we have seen a shift within the delivery system from acute intervention to the maintenance and monitoring of chronic diseases in an aging population. In addition, new knowledge and technologies are constantly affecting the standard of care. At the same time, the system remains fragmented and there is a lack of communication within it.

Physicians are caught in the middle. Many no longer run their own practices and have joined larger organizations. Increasingly, they are being impacted by the decisions of other health care entities and nonmedical personnel.

Any strategy to overcome the current dilemma must entail both long-term imple-

mentation of systemic change and short-term acceptance of individual responsibility. One long-term strategy, for example, is for individual practitioners to get involved with their state medical boards, medical staff organizations, and the management organizations of their integrated delivery systems. Through these relationships, physicians can encourage and participate in the integration of non-punitive quality assurance and risk-management techniques in ways that preserve their professional independence while integrating the responsibility for patient care into the larger health care delivery system. Examples of this process include the increased use of modern communication technologies such as personal digital assistants, as well as the risk-management systems hospitals are adopting to reduce medication errors.

The short-term picture is admittedly gloomy. Strategies a physician might pursue will depend on the laws of the state in which the physician practices. Some states absolutely mandate that physicians have malpractice insurance as a condition of licensure, while other states allow a little more flexibility. One option for large physician groups might be some level of self-insurance. In this way, physicians can accept some of the risk themselves, which would lower their premiums. Another solution may be mutual insurance companies or risk retention groups. Although joining such an organization is not necessarily going to control one's premiums, it may help to minimize the problem of having one's insurer pull out of the market. Finally, physicians should embrace the advances in communications

technology that would allow them to improve and to better coordinate their patients' care.

Physicians have inherited a system that lags behind other industries in incorporating modern risk-management systems and communications technologies. While short-term strategies are available to address the issue of rising medical liability premiums, the real long-term challenge lies in refocusing the

industry on the issues of quality assurance, risk management, and the management of patient care through more closely integrated systems. Such improved systems would focus on the free flow of information not only among physicians, but also between physicians and their patients and between physicians and the rapidly developing and overarching health care administrative bureaucracy. ■



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The medical liability system is broken. Awards continue to escalate, and there is no statistical correlation between the awards and negligence. Consequently, physicians are retiring early, limiting their practice, or moving to states with more-stable liability climates. America is acknowledged as having the best medical care in the world. Meanwhile, 12 states are in crisis, and patients are having difficulty finding a physician in their time of need. From the point of view of the American Medical Association (AMA), the biggest concern is patient access to care.

Physicians are united on this issue, and we know that the public agrees as well. A recent survey by the Health Care Liability Alliance¹ showed that 78% of Americans are concerned about diminished access to care if doctors were to leave their practices because of rising liability costs. Seventy-three percent support reasonable limits on pain and suffering awards and non-economic damages. The American

public is in favor of fixing the system. The House of Representatives is in favor of fixing the system. Department of Health and Human Services Secretary Tommy G. Thompson is in favor, and so is President Bush.

The AMA has conducted an extensive investigation and has listened to arguments by the opponents of medical liability reform. For example, some claim that the insurance companies suffered heavy losses in the stock market, leading to a need to increase their rates. However, medical liability companies are bound by law to allocate 85% to 90% of their investments into very stable bonds or government securities. According to AM Best, a group that rates and evaluates insurance companies, during the past five years the investment return of insurance companies has been stable, between 5% and 5.5%.

Opponents also claim that caps on non-economic damages will not work, but they have used flawed methodology to come to

this inappropriate conclusion. Based on the Foreman study for the Pennsylvania Medical Society² and the Tillinghast study for the Medical Society of New Jersey,³ a \$250,000 fixed cap on non-economic damages would work to reduce liability insurance rates.

There is a treatment that works. The California Medical Injury Compensation Reform Act (MICRA), passed in 1975, took California from having one of the highest medical liability rates in 1975 to having a stable level. MICRA enacted a \$250,000 cap on non-economic damages, mandatory periodic payments of future damages, and a sliding scale for plaintiff attorneys' contingency fees. This California law was ruled constitutional by the California Supreme Court.

The AMA has not found merit in any arguments against a national treatment similar to California's MICRA. What has been found is a very strong incentive to keep the present system on the part of those who profit greatly from it. In our continuing investigation, every time we debunk one of the opponents' statements they simply develop another theory.

What is needed is a reasonable debate, involving all pertinent parties, based on the facts. If a medical researcher claims to have found the cure for cancer, he has an obligation to provide confirmatory data and to allow an independent investigator to attempt to reproduce his results. The scientific method also should apply to treating the medical liability crisis. Unfortunately, opponents of reform are providing hyperboles and sound bites. We need to get to the facts, because the health of America depends on it. This system is melting down before our very eyes. ■

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The lawsuit lottery is having a devastating effect on the health care system on a number of levels. First are the raw numbers, the increased costs. But the issue of increased costs is not a clinical or academic discussion; it has devastating effects on real people. For every 1% that health care costs increase,

300,000 people nationwide lose their coverage. Second, the current litigation environment compromises quality. Physicians order unnecessary tests and procedures based not on their best medical judgment but on their fear of lawsuits. This practice of defensive medicine impairs quality of care and adds billions of

dollars to this country's health care bill every year. Third, litigation is compromising access. Physicians are closing their practices, retiring early, or moving to areas of the country where they can afford malpractice insurance. Physicians are threatening walkouts. We have never seen a phenomenon like this before. Furthermore, this issue is not concentrated in just one state but is affecting a broad swath of the country. Finally, in the area of patient safety, litigation has been a roadblock to making progress on the reporting of medical errors. There is a great fear that anyone who reports an error will be the focus of a lawsuit.

The American Association of Health Plans (AAHP) is supportive of reform and believes that President Bush's proposals are a step in the right direction. Such improvements

would include caps on non-economic damages, the allocation of liability according to fault, qualifications for expert witnesses in court, and time limits on filing suits.

When patients pay their health care premiums, they want to know that as many of these dollars as possible are going toward care provided in an examining room or an operating room and not for an infinite number of disputes in the courtroom. The problem of malpractice liability has become more and more insidious, and we are still desperately looking for ways to fund basic care for all Americans. Public support for malpractice reform is increasing as patients become concerned about litigation causing the liability insurance crisis to limit access to health care when they need it. ■



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When looking at the issue of rising medical liability insurance premiums, it is important to consider the historical context. During the past 30 or 40 years, premiums have fluctuated. These cycles reflect the investment economy more than current trends in malpractice activity. This is because insurance companies pay claims with the income derived from investing the premiums, not so much with the premiums themselves. When the investment economy takes a downturn, premiums are increased to make up for lower returns.

A key determinant of whether individual physicians perceive the current situation as a

crisis is their last premium notice. If the premium is high, then the perception is that we are in the midst of a crisis; if it is similar to or lower than last year's premium, then there is typically less concern.

Beyond the perception of the individual physician, however, are alarming regional and general trends. There are certain areas—for example, Miami and the delta area of Mississippi—where suit frequency and severity have risen dramatically and without apparent explanation. In Nevada and West Virginia, where the major medical malpractice carriers have departed the state, doctors do face a

crisis. Clearly, concerns about the viability of the current system are not unfounded.

Doctors and lawyers view the world very differently and thus tend to communicate poorly. I say this as someone who has trained in both worlds. Physicians, for example, are trained in absolute truths. They are taught that learning the right things and applying them correctly will achieve a good result. Lawyers, on the other hand, are taught that there are no absolute truths, only relative truths. All the truths in their world are established by judges, juries, and legislatures. For this reason, lawyers have a hard time understanding the intensity of sentiment among physicians when medical liability issues are discussed.

In truth, part of what makes a physician effective is the need to be connected to patients and to have their trust. When a patient has a bad outcome, a malpractice suit adds salt to the wound. In the lawyer's view, however, a malpractice suit is a practical means to redress the patient's wrongs so that he can get on with his life. Under tort law, such a medical liability suit has three goals: to punish the person who has made the mistake; to make the plaintiff whole again—or to at least compensate him

financially; and to prevent this kind of error in the future. The question becomes, how well does this system achieve these three goals? The answer is, not very. And the dilemma is that we do not seem to have a better alternative.

Physicians can lessen the likelihood that they will be the defendant in a malpractice suit. One important step is to build good relationships with their patients. The better the relationship a physician has with a patient, the less the chance of a suit. Another important issue is documentation. Physicians probably lose 40% to 50% of malpractice cases because of poor documentation in patients' medical records. Physicians also need to redefine their definition of informed consent. True informed consent requires a dialogue, during which the physician addresses the patient's questions, concerns, and fears. Finally, the medical community needs to develop a more systematic approach to care. Many malpractice cases result from patients being passed from one physician to another with little communication between physicians. Better communication among physicians, as well as between physician and patient, can go a long way toward improving the quality of care and lowering the risk of a lawsuit. ■



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There is no question that there has been an increase in frequency of severe medical malpractice losses in the past several years. From a reinsurance perspective, this results in

claims accelerating into reinsurance contracts at a pace not contemplated by the original pricing assumptions. Reasons for the rising severity include the ability of insurance company

adjusters to investigate and recognize serious cases at a faster pace, an attempt by judges in many jurisdictions to accelerate the litigation process and reduce dockets, the availability of large insurance policy limits, and the increased skill of plaintiffs' attorneys to argue for more damages and compensation for claimants. All of the previous reasons are further compounded by lower interest rates that limit the investment income reinsurers had expected to earn on malpractice premiums. The result is that companies that provide medical liability reinsurance are facing challenges that did not exist a few years ago. They are reassessing pricing models and need to increase premiums to their insurance carrier clients now and over the next few years. Such increases will no doubt impact the cost to the medical profession and ultimately to consumers.

While the United States' health care system remains the best in the world, it has undergone a significant cultural shift during the past decade. The advances that were made during the past 10 years have been tremendous, but along with these advances came exponential growth in patient expectations. Patients today expect that their physicians have an answer for everything. In the past, many claims related to failure-to-diagnose issues were limited to certain medical specialties. But today we are also seeing the same types of claims increasingly being made against primary-care physicians who are expected, with all the technology available to them, to catch everything right away. When physicians do miss a diagnosis or do not have the immediate answer to a problem, patients too often assume that malpractice has occurred. This attitude places an incredible burden on doctors.

The present health care system contains too many competing interests. It has the air of trying to combine capitalism with socialism, leaving all parties ultimately dissatisfied, disenfranchised, and disenfranchised. There has

been little progress in the past decade and, some could argue, the system is worse today than yesterday. In an effort to curb escalating medical costs, pressure was placed on the doctors to change their method of care and find ways to cut back on procedures such as hospitalization. To enforce this objective the large health care organizations (HMOs and PPOs) that provide individuals with health insurance leveraged their position with doctors through their control of the patient population. The medical community was pressured to accept less compensation for their procedures in exchange for an increased flow of patients. This development forced doctors, now faced with less income per patient, to streamline their operations while other costs of doing business—such as medical malpractice premiums, support staff salaries, and administrative compliance costs—were rising. At odds with this formula was the fear arising from a litigious environment with escalating malpractice claims. This fear caused doctors to increase the recommendation for additional test procedures as a safeguard against suits, which, although not a bad outcome, substantially increases the overall cost of the system.

At Carvill America, Inc., we advise insurance companies on managing and measuring medical malpractice risk exposure. From our perspective, one of the best things physicians can do is to work with their insurance carriers to identify emerging problem areas and develop techniques for better control of risk. Many insurance companies will reduce physicians' premiums if they have a good risk-management system in place. Good risk management includes techniques for a better physician-client relationship and a patient load that is not overburdened. But the issues associated with medical liability are complex and there is no simple solution. As medicine and technology continue to improve, patients will expect an even higher standard of care that comes only at an ever-increasing cost. Physicians are certainly

aware of this. Their medical liability premiums reflect the risk and complexities. I therefore think this issue will remain volatile for at least the next five or six years. During this time, there must be an increasing dialogue between health insurance carriers, health care providers, medical malpractice insurance carriers, legislators, and the public to address the situation. I do not have an easy answer as to how we can fix the system, but I believe we will find ways to improve it over time.

If we are looking for a culprit for the current state of health care affairs, there are numerous contributors. Our society as a whole must acknowledge its part in creating a system that permits windfall financial gain through a justice system that is not always fair, for health care providers whose financial reward is not always deemed equitable, and for a country whose citizens have developed expectations often beyond the realm of reality. ■



Lawrence E. Smarr

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Physician Insurers Association of America
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The medical malpractice crisis is real, and it is beginning to hurt American health care consumers. It has been a long time coming and will need a long-term, not a short-term, solution. Insurance is not magic; as long as there are unlimited jury awards, there will be unlimited insurance premiums needed to pay for them. The debate rages on as the trial lawyers try to protect the current system, in which 70% of all medical malpractice claims filed are resolved without a single cent paid to the plaintiff. Of those cases that do go to trial, judges and juries find 80% to be without merit and no payment is made. However, the lawyers do not have to win very often, because when they do win they win big.

The Physician Insurers Association of America (PIAA) is a trade association of insurance companies that are owned and/or operated by the health care professionals and

the entities they insure: doctors, dentists, and hospitals. PIAA companies insure more than 60% of all physicians in America.

This issue should be characterized as a medical liability crisis and not a medical liability insurance crisis. The situation we are in today is a crisis of affordability and availability of insurance for health care providers, and, more importantly, a growing crisis of access to the health care system for patients across the country. Dramatic increases in medical malpractice claim costs, on the rise for more than three decades, have finally reached a level at which doctors and hospitals can no longer afford the premiums insurers must charge to meet these costs. The average paid claim has risen almost three times as fast as the level of inflation over the past 10 years, and the percentage of claims paid at \$1 million or greater doubled over the four-year period between 1997 and 2001.¹ Doctors are no

longer able to pass these cost increases along to health care consumers as payment for health care increasingly comes from federal government, state government, and managed care. Many physicians caught in this financial squeeze have no choice but to move to less litigious locations or to leave the practice of medicine altogether, leaving patients fewer and fewer choices in their health care providers.

The popular myth that stock market losses are the cause of insurers' premium increases is altogether untrue. Only 10% of PIAA member companies' assets are invested in equities. Eighty percent of their assets are invested in high-grade corporate and government bonds. While it is certainly true that declining interest rates have made it harder for insurance companies to keep premiums as low as they have been in the past, such declines account for a relatively small amount of the need to increase rates.² The overriding factor in increased premiums has been the dramatic increase in the cost of paying claims.

Legislators are now challenged with finding a solution to a problem long in coming that has truly reached the crisis stage. It is time for Congress to put an end to the wastefulness and inequities of our tort legal system, in which the average lawsuit takes

five years to work its way through the system and only 50 cents of every dollar available to pay claims finds its way into the hands of the patient. The other 50 cents goes to the lawyers. The system works fine for the legal profession, which is why trial lawyers and others fight so hard to maintain the status quo.

Federal tort reform is the only answer to this crisis. Many state reforms, once enacted, have proven to be all too easily overturned by state court systems swayed by the influential trial bar. The California MICRA reforms, in place for more than two decades, have proven to be effective. A solution is before us—it is the California model, and it works. Congress must move in a bipartisan effort to support President Bush and pass similar reforms on a federal level to assure that all Americans will have access to affordable health care and that doctors can afford to pay their insurance premiums and stay in practice. ■

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Bruce H. Stern

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The malpractice insurance problem has been caused by three factors that combined to devalue the portfolios of the medical malpractice insurance companies: poor

investment choices, the 9/11 tragedy, and the difficulties in the reinsurance market. Now these companies are trying to recoup their losses through higher premiums for doctors in

states like New Jersey, an area of the country that is being hit particularly hard.

Despite physicians' allegations that this is a universal crisis, statistics released by Holly Bakke, New Jersey Commissioner of Banking and Insurance, show that it is not as widespread as doctors claim. The Department of Banking and Insurance report demonstrated that statewide only 8% of the state's physicians saw increases in excess of 30%. The Association of Trial Lawyers of America–New Jersey (ATLA–NJ) does recognize that obstetricians and gynecologists (OB/GYNs) are certainly the hardest-hit subgroup of all the medical specialties. These physicians are getting hit at both ends. Anecdotally, one local OB/GYN has made the assertion that these specialists receive the reimbursement of a family doctor while having the risk classification of a neurosurgeon. The shame in this debate is that the OB/GYNs have not joined ATLA–NJ in our call for legislation to require better reimbursement for work performed.

Physicians and their advocates claim that the problem is due to excessive verdicts, but they have presented no proof of excessive verdicts that are directly causing the problem. I have teamed with state legislators in numerous conversations with New Jersey physicians, their lobbyists, and with the members of the New Jersey Council of Teaching Hospitals. We have challenged them, we have asked them to produce such data, and for the past year they have been unable to respond. Recently, the New Jersey Administrative Office of the Courts released figures that showed that only 200 cases went to verdict, with plaintiffs winning or obtaining a verdict in 54 cases. The average award was \$300,000 for both economic and non-economic damages.

When we speak to physicians, we ask, What do you consider to be an excessive verdict? They do not know. Then, How many excessive verdicts have there been? They do

not know. They will offer an anecdote, and we respond, How much of that verdict was non-economic and how much was economic? They do not know. They do not know what the damages were, or what happened to the victim in that case. They simply continue to cite “excessive verdicts.” It is a myth that these excessive verdicts exist. There is a system in place to prevent excessive verdicts. For example, recently there was a \$9 million medical malpractice verdict in Bergen County, New Jersey. In response, doctors held a protest on the steps of the Bergen County courthouse. Shortly afterwards, Judge Joseph L. Yannotti concluded that the verdict was excessive, and he reduced it to \$1.8 million.

Of course, there is not always a legislative solution for every problem, but there are some things the legislature can do. When this debate began, one of the biggest complaints from doctors was that after being named in a suit it would be determined that they should not have been a party to the complaint. Often all the attorneys get is a hospital chart, and it is not clear who played what part in the patient's care. It is the attorney's responsibility to name all of the physicians on that chart in the case. So doctors were being sued, later they would be released from the case, and despite the fact that they were not liable, their premiums would be affected. That is clearly wrong. ATLA–NJ supports provisions for pre-trial discovery to weed out doctors who have no place in the lawsuit. Honestly, the last thing an attorney who is arguing a medical malpractice case wants is seven or eight defendants with seven or eight defense attorneys.

Additionally, regulation of the medical malpractice insurance companies is necessary. Many people involved in this debate are fond of pointing to California, with its restrictive MICRA legislation, as an example of effective reform. But what they fail to note is that California's Proposition 103, passed in 1988, enacted widespread insurance regulations on

carriers and therefore prevented rate increases. California's current status is not due to MICRA alone.

Finally, it is important to remember that medical malpractice starts with medical malpractice. More reporting requirements need to be in place. It is amazing to hear that some physicians believe that patients should not be

told when a medical mistake is made because they do not want to be held accountable. That is mind-boggling. A report issued by Public Citizen revealed that 3% to 5% of physicians are responsible for 50% to 60% of medical malpractice claims. Stronger disciplinary measures are needed to discipline and weed out the bad doctors. ■

JOIN THE EXCHANGE

- ▶ Were you involved in a work stoppage or other protest?
- ▶ Have increased insurance premiums affected your practice?
- ▶ Do you want to respond to a participant's commentary?

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The Physician Work Stoppage

A View from the Inside

In the largest protest action by physicians to date, thousands of New Jersey doctors participated in a work stoppage that began February 3 and lasted between one day and one week, depending on the practice. The state is one of a dozen identified by the American Medical Association as suffering a liability insurance crisis, with increased premiums causing physicians to stop providing high-risk services, move out of state, or, in some cases, choose early retirement. On February 3, an estimated 70% of New Jersey's nearly 22,000 physicians closed their practices or limited the number of patient visits. On February 4, physicians held a rally at the New Jersey State House in Trenton to voice their concerns about the affordability of malpractice liability insurance to state legislators. *Medical Crossfire* spoke with a participating physician—Donald F. Denny, MD, an attending radiologist at The Medical Center at Princeton—for a view from the inside of this protest action.

Medical Crossfire: What message were New Jersey physicians trying to send through the work stoppage, and to whom was this message directed?

Dr. Denny: We hoped to emphasize that physicians, as a group, are so concerned about malpractice liability issues that we were able to organize a concerted effort. That is unusual in itself; physicians, by nature, do not necessarily all see eye to eye. We also hoped that the public would realize that this problem is seriously affecting not only physicians but also patients and their access to medical care. Ideally, we wanted to reach two audiences. The first includes the legislators and the governor. New Jersey doctors are concerned that our lawmakers are not taking this issue seriously. The second audience is, of course, our patients. We wanted to wake

them up to the facts that practitioners are leaving the state and the problem is likely to accelerate.

Medical Crossfire: How was the work stoppage organized?

Dr. Denny: It was a grassroots movement that started in the northern part of the state. New Jersey Citizens United for Healthcare Access (NJCUHA) held a forum and invited representatives from the medical specialty societies in New Jersey. I attended as a representative of the Radiological Society of New Jersey. At the forum, a number of specialty societies chose to support the work stoppage, as did the Medical Society of New Jersey.

On an institutional level, the administration of The Medical Center at Princeton

took the position that as long as essential medical services were covered, physicians were on staff to attend hospitalized patients, and patients entering the hospital were properly cared for, it would support the physicians.

Medical Crossfire: What concessions were made for patient care?

Dr. Denny: Concessions for patient care and length of participation varied from practice to practice. In my radiology department, we cancelled routine scans and x-rays, anything that was not an urgent problem, for one day. Patients receiving x-ray therapy for cancer were treated; patients who needed mammography because a lump had been found were evaluated. Needle and lung-mass biopsies were performed, and the office remained open to emergency care.

Medical Crossfire: Why did you choose to attend the meeting of the NJCUHA and ultimately to participate in the work stoppage?

Dr. Denny: Physicians in my community, particularly obstetricians, have decided to stop practicing because of malpractice issues. Colleagues are finding their rates sharply increasing for no apparent reason. Several insurers have announced that they are going to withdraw from New Jersey, and one very notable company has gone bankrupt. The NJCUHA meeting seemed to be a good

opportunity to learn more about the issues, and participation in the work stoppage offered a chance to support local physicians who have been affected by rate increases. I will not know until my renewal is up in May whether my own rates have changed. Honestly, I am a little nervous to find out.

Medical Crossfire: Your institution supported the movement, but were there any cases where tension developed?

Dr. Denny: Some specialties were less interested in participating because they felt the issue might not affect them as much. Other specialties were very heavily involved, particularly the surgical specialties, which have been the hardest hit by boosted malpractice premiums. Many of the obstetricians and gynecologists in the community were strongly behind the work stoppage. Was there any animosity toward those who did not participate? No, not that I am aware.

Medical Crossfire: Do you think that, in the end, the physicians got their message across?

Dr. Denny: The message is out. However, past patterns are not reassuring. When smaller protests have taken place, the legislature has paid attention, just as they are paying attention now, with a flurry of legislative activity that never went anywhere. My optimistic side says, yes, we made our point. My pessimistic side notes that there is still a long way to go. ■

Official Position Statements and Resources on Medical Malpractice Liability Insurance

The following resources, listed alphabetically by organization, are provided for those physicians interested in more information about the issues debated in this *Medical Crossfire* Special Report.

American Academy of Family Physicians

Title: AAFP policies on health issues: professional medical liability
To Access: Visit www.aafp.org/x7019.xml

American Association of Health Plans

Title: News Release: AAHP applauds President Bush's leadership on medical malpractice reform
Release Date: January 16, 2003
To Access: Visit www.aahpechochamber.tv/malpractice/030116.htm

American College of Obstetricians and Gynecologists

Title: News Release: President cites mounting liability crisis, obstetrician is guest at State of Union address
Release Date: January 29, 2003
To Access: Visit www.acog.org/from_home/publications/press_releases/nr01-29-03.cfm

American College of Physicians–American Society of Internal Medicine

Title: Where we stand: affordable professional liability insurance necessary to provide care
A collection of news releases, position papers, and other resources from the ACP-ASIM.
To Access: Visit www.acponline.org/hpp/menu/liability.htm

American College of Surgeons

Title: News Release: ACS applauds president's commitment to health care reforms that preserve patient access to care

Release Date: January 29, 2003

To Access: Visit www.facs.org/news/acsapplauds.html#1

American Medical Association

Title: Spotlight on issues: medical liability reform
The AMA provides a collection of news releases, position papers, and other resources.

To Access: Visit www.ama-assn.org/ama/pub/category/7861.html

Association of Trial Lawyers of America

Title: News Release: Bush sides with millionaire insurance executives instead of American families

Release Date: January 27, 2003

To Access: Visit www.atla.org/ConsumerMediaResources/Tier3/press_room/president/meabushsideswith1-27-03.aspx

Health Care Liability Alliance

The Web site of the HCLA provides physician information and resources on tort reform and malpractice liability insurance issues.

To Access: Visit www.hcla.org

Physician Insurers Association of America

News updates on this issue are available on the PIAA's Web site.

To Access: Visit www.thepiaa.org/public_home.asp