JUDtestimony

From: Myron Berney [redacted]
Sent: Friday, March 28, 2008 12:07 PM
To: JUDtestimony
Subject: HCR 349
Attachments: Medical Malpractice Caps Fail to Prevent Premium Increases,.pdf; MMSOFTMARKET.pdf; StableLosses.pdf; Patient Safety and Medical Malpractice A Case Study.pdf

LATE TESTIMONY

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HCR 349-- *requesting the legislative reference bureau to study the effects of medical tort reform on access to health care.*

OPPOSE

I Support the development of new and innovative solutions to the Medical Malpractice Issues that doesn't rely upon abusive and adversarial means and methods.

Abusive and adversarial means and methods didn't work in Divorce and abusive and adversarial means and methods don't work in Medicine. Medical Malpractice is the worst kind of consumer protection but still some kind of consumer protection.

Tort reform by merely capping claims is just putting a Band-Aid without any medicine.

Current adversarial means and methods abuse both the Doctor and the Patient and takes a tremendous toll on the attorneys and the courts too.

The issue has been framed as Doctors v. Attorneys. However, Doctors and their Insurance Companies employ vast teams of attorneys to defend the physicians and the insurance company.

Not only do the Doctors and their Insurance Companies employ a legal defense team, they also employ and rely upon a team of defense physicians, IME docs, upon whom for a fee will say just what the Insurance Company needs. In general, their IME reports consistently say: can't find anything wrong, the patient is a malingerer, and the doctor was right all along. IME doctors make thirty to ninety times the fee [3000% to 9000%] for their time compared to practicing and treating physicians.

The patient gets harmed twice. Once by failures in the medical system [which may or may not be due to physician care] and again by the adversarial system itself and the huge fees associated with winning. Often only the attorney's make money.

Studies are split on the real basis of rising rates.

Most studies demonstrate that malpractice rates are linked to the health of the economy more than to payouts.

Even the studies that profess to link payouts to rates demonstrate a very small difference in payout resulting huge rate increases. However, this suggested link is not consistent through time. Sometimes there is a rate increase and sometimes not.

On the other hand, due to regulations requiring liability to asset ratios for insurance companies, when assets go down rates go up consistently.

Suggested changes in Language, if you elect to undertake or review current studies.
Rising rates affecting physician shortages affect availability not accessibility of health care. Change access or accessibility to availability.

On the other hand:
The physician shortage was engineered by the Insurance industry as an attempt to lower cost per patient. The Insurance Industry Lobbied successfully for decreasing the number of practicing physicians and reduced physician payments so that doctors would have to see more patients faster lowering the cost per patient. Along with this medical schools were paid to not teach new doctors. The Insurance industry was successful in their prior agenda and created this physician shortage with government support.

If you want more doctors you need to teach more students and pay existing physicians more money.

Malpractice rates didn't cause the problem so it won't fix the problem.

Since there are doctor shortages, so why does Dr. Green MD, HMA and the Governor harm health care delivery by Naturopathic Physicians? Personal conflict of interests and illegal acts, lies and slander characterize Dr. Green's, HMA's and the Governors health care reform package.

The Governor has permitted and actively contrived insurance fraud for payment to massage therapist to work beyond the scope of their license but won't let Naturopathic Physicians work within the 4 corners of their Law.

Although small in number, Naturopathic Physicians have reformed health care delivery by competition in the healthcare marketplace. Diet, Exercise and home-like birthing in hospitals are just a few examples. Currently over 60% of cancer patients use natural health care as part of Choice in cancer therapy, however, neither the patient nor the MD trained physician know how to use natural medicine successfully. Natural medicine is taught to MD to be bad, quackery and fraud when in fact NIH in two reports holds that Vitamin C will selectively kill human cancer cells! Many studies have demonstrated cancer killing role of vitamins, minerals and herbs…safe and effective therapy that MD don't know and won't deliver. MD's even have a free pass from the State and Federal Government in Hawaii to prescribe Medical Marijuana to Cancer patients but won't deliver herbal medicine to ease patient suffering and save lives instead opting for more addicting and less effective psychoactive drugs. Some meds cost $300 a pill, $1000 a day, to block serotonin which can be augmented by inexpensive melatonin with add health building results or augmented, supplemented and replaced with ginger and other herbs.

Although in an effort to mitigate rising medical malpractice insurance premium rates, states have passed various medical tort reform laws, some of which include caps to restrict the size of damage award payments and other measures to limit costs such measures did not produce any substantial or long term

control of rates as the primary factors influencing rates are not addressed by these measures.

MD's like big hospitals and the new and expensive technology accessible at hospitals; ND are trained in the old time "country doctor" "family doctor" primary care model. That's why MD's don't like "country doctor" settings. **The most highly desired medical specialty for residents is Cosmetic Surgery and Dermatology for the glamour and the goods. Cosmetic Surgery and Dermatology is a "cash" practice, the most profitable and lucrative area of medicine despite high medical malpractice claims, payouts and rates.**

It's good to do studies but probably will find the same findings of other studies. At best the study will be inconclusive or fail to find the link sought by Dr. Green and the Insurance Industry.

Please review the attached studies available on the Internet.

From the Annals of Internal Medicine, please review Dr. Brennan and Mello's suggestions on Page 5 – A New Paradigm.

The other studies link rates to the economy. When markets rise stockholder take profits and when markets fall insurance companies raise rates siphoning money out of health care into investors and foreign investors pockets.

Americans for Insurance Reform (AIR), a coalition of nearly 100 consumer groups around the country, has produced a comprehensive study of medical malpractice insurance, examining specifically what insurers have taken in and what they've paid out over the last 30 years

Medical insurance premiums charged by insurance companies do NOT correspond to increases or decreases in payouts, which have been steady for 30 years.

Rather, **premiums rise and fall in concert with the state of the economy** —insurance premiums (in constant dollars) increase or decrease in direct relationship to the strength or weakness of the economy, reflecting the gains or losses experienced by the insurance industry's market investments and their perception of how much they can earn on the investment "float" (which occurs during the time between when premiums are paid into the insurer and losses paid out by the insurer) that doctors' premiums provide them.

Thank you for you attention and assistance in these matters.
Respectfully, Dr. Myron Berney, ND Lac

WEISS RATINGS INC.

(Revised June 3, 2003)

Medical Malpractice Caps Fail to Prevent Premium Increases, According to Weiss Ratings Study

Physicians in States with Caps Suffer 48% Increase in Median Annual Premiums Even While Insurers Enjoy Slowdown in Payouts

PALM BEACH GARDENS, Fla., June 2, 2003 - Caps on non-economic damages have failed to prevent sharp increases in medical malpractice insurance premiums, even though insurers enjoyed a slowdown in their payouts, according to a white paper released today by Weiss Ratings, Inc., the nation's leading independent provider of ratings and analyses of financial services companies, mutual funds, and stocks.

In reviewing the impact that tort reform has had on both medical malpractice (med mal) premiums paid by doctors in three high-risk specialties[1] and insurers' claim payout levels[2] between 1991 and 2002, Weiss noted the following trends:

Physicians continued to suffer a rapid increase in med mal premiums despite caps: In 19 states that implemented caps during the 12-year period, physicians suffered a 48.2 percent jump in median premiums, from $20,414 in 1991 to $30,246 in 2002. However, surprisingly, in 32 states *without* caps[3], the pace of increase was actually somewhat *slower*, as premiums rose by only 35.9 percent, from $22,118 to $30,056.

At the same time, among the 19 states with caps, only two of the states, or 10.5 percent, experienced flat or declining med mal premiums. In contrast, states without caps were actually *better* able to contain premium rate increases, with six, or 18.7 percent, experiencing stable or declining trends.

Meanwhile, the insurers enjoyed slowed increases in claims payout levels: The median payout in states without caps surged 127.9 percent, from $65,831 in 1991 to $150,000 in 2002. In contrast, the median payout grew by 83.3 percent in states with caps, from $60,000 to $110,000. Likewise, in states without caps, the median payout for the entire 12-year period was $116,297, ranging from $75,000 to $220,000, while the median payout for states with caps was 15.7 percent lower, or $98,079, ranging from $50,000 to $190,000[4].

"Tort reform has failed to address the problem of surging medical malpractice premiums, despite the fact that insurers have benefited from a slowdown in the growth of claims," said Martin D. Weiss, chairman of Weiss Ratings, Inc. "The escalating medical malpractice crisis will not be resolved until the industry and regulators address the other, apparently more powerful, factors driving premiums higher."

Other Factors Contributing to the Med Mal Crisis

Weiss identified six factors driving the increase in medical malpractice rates, each of which may be exerting a greater impact on premiums than the presence or absence of caps:

- ***The medical inflation rate:*** Medical costs have risen 75% since 1991.
- ***The insurance business cycle:*** The property and casualty industry suffered a 12-year "soft" period through 1999, during which marketing goals often superceded prudent underwriting practices and decision-makers typically relied too heavily on high investment income to make up for losing operations. In an attempt to catch up, insurers have tightened underwriting standards and raised premiums.
- ***The need to shore up reserves for policies in force:*** Med mal insurers have been consistently under-reserving since 1997—to the tune of $4.6 billion through December 31, 2001. The only way to shore up reserves is to increase premiums.
- ***A decline in investment income:*** Investment income declined by 23 percent in 2001 and then *another* 2.5 percent in 2002, which is particularly critical for lines of business like med mal since the duration of claims payouts typically spans several years.
- ***Financial safety:*** Based on the Weiss Safety Ratings, 34.4 percent of the nation's med mal insurers are vulnerable to financial difficulties, compared to 23.9 percent of the property and casualty insurance industry as a whole. To restore their financial health, many med mal insurers will remain under pressure to increase rates despite new laws to cap payouts.
- ***Supply and demand for coverage:*** The number of med mal carriers increased through 1997 to 274, but has since fallen to 247 in 2002.

Weiss Recommendations

Although the implementation of non-economic caps has resulted in a slowdown in payout increases for insurers, most insurers have not passed those savings on to physicians, continuing to jack up premiums due to other powerful pressures. Thus, caps have been ineffective in reducing medical malpractice premiums for medical professionals. To adequately address this national crisis, Weiss suggests several comprehensive steps, including:

- ***Legislators*** should put all proposals for non-economic damage caps on hold until convincing evidence can be produced to demonstrate a true benefit to doctors in the form of reduced med mal costs;
- ***insurance companies*** must never again allow marketing to divert or pervert prudent actuarial analysis and planning; and
- the ***medical profession*** must assume more responsibility for policing itself.

Weiss Ratings issues safety ratings on more than 15,000 financial institutions, including HMOs, life and health insurers, Blue Cross Blue Shield plans, property and casualty insurers, banks, and brokers. Weiss also rates the risk-adjusted performance of more than 12,000 mutual funds and more than 7,000 stocks. Weiss Ratings is the only major rating agency that receives no compensation from the companies it rates. Revenues are derived strictly from sales of its products to consumers, businesses, and libraries.

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1 Medical malpractice premiums paid by doctors in three high-risk specialties: internal medicine, general surgery, and obstetrics/gynecology. Data source: Medical Liability Monitor.

2 Data source: National Practitioner Data Bank

3 For the purposes of this analysis, the District of Columbia is being referred to as a "state" since it effectively operates as such with regard to insurance regulation.

4 Adjusted for inflation in order to evaluate figures spanning multiple years.

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Note to Editors: Read Weiss Ratings' white paper, ***Medical Malpractice Caps: The Impact of Non-Economic Damage Caps on Physician Premiums, Claims Payout Levels, and Availability of Coverage***, online at **http://www.thestreetratings.com/malpractice.asp**. Copies are available upon request.

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INSURANCE "CRISIS" OFFICIALLY OVER –

MEDICAL MALPRACTICE RATES HAVE BEEN STABLE FOR A YEAR

By: Joanne Doroshow, Executive Director, Center for Justice & Democracy and J. Robert Hunter, Director of Insurance, Consumer Federation of America, former Texas Insurance Commissioner and former Federal Insurance Administrator.

February 27, 2006

The most recent data from the Council of Independent Agents and Brokers now confirms that the large medical malpractice insurance rate increases that took hold around the nation in 2001 and 2002 have ended.

The average rate hike for doctors over the past six months has been ***0 percent.*** This is following similar results for the last quarter of 2004, which saw rates rising only 3 percent at the end of that year. By comparison, rates jumped 63 percent during the same quarter of 2002.

This phenomenon it is occurring whether or not states enacted restrictions on patients' legal rights, such as "caps" on compensation.

This study explains why.

Introduction

In the last few years, the nation's medical lobbies, insurance and health care industries have been advancing a legislative agenda to limit their liability for medical malpractice that causes injuries and death. One of the principal arguments on which these industries rely is that laws that make it more difficult for the sick and injured to go to court (i.e., "tort reform") will reduce medical malpractice insurance rates for doctors.

Great pressure has been brought to bear on Congress and state legislatures around the country to restrict the rights of innocent patients to recover for their injuries and to hold accountable in court those responsible. Many states succumbed to this pressure and have enacted "caps" on compensation or other so-called "tort reforms."

Contrary to the medical and insurance lobbies' message – that medical malpractice lawsuits and claims were to blame for the increase in insurance rates – the fact is that in 2001, commercial property insurance rates jumped *across the board.* In other words, rate hikes for doctors were only a small part of a much larger insurance problem that affected homeowners, motorists and all kinds of policyholders. It also affected states whether or not they had already enacted severe "caps" on compensation for patients, such as Missouri and Maryland.

These kinds of volcanic eruptions in insurance premiums have occurred three times in the last 30 years – in the mid 1970s, again in the mid-1980s, and then again following the year 2001. The cause is always the same: a severe drop in investment income for insurers compounded by underpricing in prior years. Each time, insurers and the health care industry have tried to cover up their mismanaged underwriting by blaming lawyers and the legal system. To buy this position, one would have to accept the notion that juries engineered large jury verdicts in the mid-1970s, then stopped for a decade, then engineered large verdicts again in the mid-1980s, stopped for 17 years and then did it again beginning in 2001 – only to stop once again. Of course, this is ludicrous and untrue.

As with every insurance cycle, rates have now stabilized and availability is improving around the country, irrespective of tort law restrictions enacted in particular states. In all commercial lines, rate increases have slowed to a standstill and in most cases are dropping. This is despite the impact of Hurricane Katrina.

Rates for doctors have stabilized as well, having gone up on average *0 percent* during the entire last half of 2005. This is occurring whether or not a state has a "cap" on compensation for patients.

These data are further proof that the insurance crisis for doctors was caused by the economic cycle of the insurance industry, and not a tort law cost explosion as the insurance industry and others had claimed. As in the past, taking away the legal rights of injured patients made no difference on insurance rates for doctors, which are dropping everywhere.

The attached charts in the Appendix show the rate trends during this most recent hard market period, beginning in 2001 and 2002. The medical malpractice data alone is striking:

MEDICAL MALPRACTICE INSURANCE AVERAGE RATE HIKES PER QUARTER

3Q 2002	4Q 2002	1Q 2003	2Q 2003	3Q 2003	4Q 2003	1Q 2004	2Q 2004	3Q 2004	4Q 2004	1Q 2005	2Q 2005	3Q 2005	4Q 2005
61%	**63%**	54%	48%	28%	34%	19%	9%	6%	3%	2%	2%	**0%**	**0%**

Source: Council of Insurance Agents and Brokers
Commercial Property-Casualty Market Survey
By Quarter as indicated

Why Rates For Doctors Went Up: The Insurance Cycle, Not The Legal System

The Investment Cycle. Insurers usually do not make money from the underwriting of insurance; they make money by the investments of the float (the fact that the insurers collect the premium today but pay out the claims much later)[1]. This is particularly true of long-tailed lines (that is, lines with a very long float, such as medical malpractice. During years of high interest rates and/or excellent insurer profits, insurance companies engage in fierce competition for premium dollars to invest for maximum return. Insurers severely underprice their policies and even insure poor risks just to get premium dollars to invest. This is known as the "soft" insurance market.

But when investment income decreases — because interest rates drop or the stock market plummets or the cumulative price cuts make profits become unbearably low — the industry responds by sharply increasing premiums and reducing coverage, creating a "hard" insurance market usually degenerating into a "liability insurance crisis."

A hard insurance market occurred in the mid-1970s, precipitating rate hikes and coverage cutbacks, particularly with medical malpractice and product liability insurance. (This led California to enact MICRA in 1975, a law that caps non-economic damages at $250,000 with no inflationary adjustment.) A more severe crisis took place in the mid-1980s, when most liability insurance was impacted. At that time, many more states enacted "caps" after being told by insurers that this would bring rates down and guarantee stability in the insurance market.

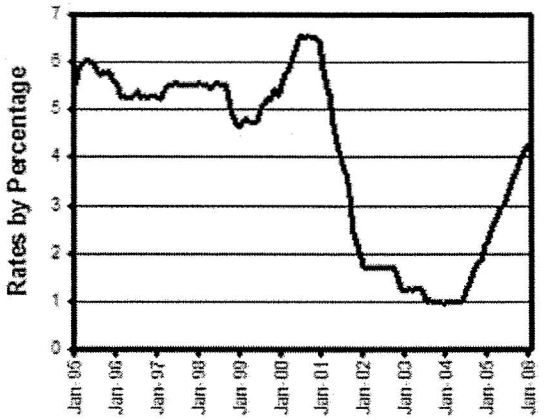
Again in 2001, the country began experiencing a "hard market," this time impacting property as well as medical malpractice coverages with some lines of insurance seeing rates going up 100 percent or more.

Prior to late 2000, the industry had been in a soft market since the mid-1980s. The strong financial markets of the 1990s had expanded the length of the usual six- to-ten year economic cycle. No matter how much they cut their rates, the insurers wound up with a great profit year when investing the float on the premium in this amazing stock and bond market. (The "float" occurs during the time between when premiums are paid into the insurer and losses paid out by the insurer —*e.g.*, there is about a 15-month lag in auto insurance and a 5 to 10 year lag in medical malpractice.) Further, interest rates were relatively high in recent years as the Fed focused on inflation.

But in 2000, the market started to turn with a vengeance and the Fed cut interest rates again and again. This became a classic economic cycle bottom.

See chart below.

Federal Reserve Rate by Year, 1995-2005



It should be noted that the few medical malpractice insurance companies that did pull out of the market during this recent insurance "crisis" did so because of mismanaged underwriting practices. In 2001, one of the country's largest medical malpractice insurance companies, St. Paul, pulled out of the medical malpractice insurance market, creating significant supply and demand problems in some states. According to a June 24, 2002, *Wall Street Journal* front-page investigative article, St. Paul, with a 20 percent share of the national market, pulled out after mismanaging its underwriting and reserves. The head of a leading medical malpractice insurer described problems in the med mal insurance market: "I don't like to hear insurance-company executives say it's the tort [injury-law] system – it's self-inflicted."[2]

As one insurance industry insider also put it at the beginning of the most recent hard market in 2001: "The [medical malpractice insurance] market is in chaos.... Throughout the 1990s ... insurers were ... driven by a desire to accumulate large amounts of capital with which to turn into investment income. Regardless of the level of ... tort reform, the fact remains that if insurance policies are consistently underpriced, the insurer will lose money."[3]

The Legal System. As they do each time the market turns hard, insurers blame the legal system for the price jumps. The data has never supported this allegation.

The National Center for State Courts (NCSC) data shows that the number of medical malpractice filings dropped over the last decade preceding the most recent insurance crisis. The NCSC – which is the country's most accurate and comprehensive overview of state court litigation statistics – found that the 1993 to 2002 trend in medical malpractice filings per 100,000 population has only fluctuated minimally, with an overall one percent decrease in per capita filings over the last five years.[4] Similarly, the U.S. Department of Justice found that the number of medical malpractice trials "remained stable" from 1992 through 2001.[5]

Total compensation paid to victims dropped 6.9 percent from 2001 to 2002 according to National Practitioner Data Bank (NPDB) analysis by Public Citizen. When adjusted for medical services inflation, the one-year drop was even more dramatic: 11.2 percent.[6] Between 1991 and 2004, the

median payment grew from $125,000 in 1991 to $146,100 in 2004 when adjusted for inflation – an average annual increase of only 1.2 percent. Moreover, the number of malpractice payments paid on behalf of doctors fell from 16,682 in 2001 to 14,441 in 2004, a drop of 13.6 percent. The 2004 number is only 5.5 percent higher than the 13,687 payments recorded for 1991."[7]

As with its predecessors, the most recent insurance "crisis" had absolutely nothing to do with the U.S. legal system, tort laws, patients, lawyers or juries. It was driven by the insurance underwriting cycle and remedies that do not specifically address this phenomenon will fail to stop these wild price gyrations in the future.

The Impact Of "Tort Reform" On Insurance Rates

Rates for doctors are now stabilizing, whether or not a state has enacted a "cap" on compensation for patients. Here are a few examples:

> **Connecticut (no cap):** "Rate increases are even slowing or stopping in some states that have not limited awards for pain and suffering, including Connecticut, where premium increases in the past have soared as much as 90 percent in a single year."[8]
>
> **Maryland (cap since 1986):** "[T]he state's largest malpractice insurer said it does not need a rate increase for next year, leading some to question whether the much-debated malpractice crisis ever existed."[9]
>
> **Pennsylvania (no cap):** "Pennsylvania's largest medical-malpractice insurer has announced it will not raise premiums in 2006, breaking a string of annual double-digit rate increases that symbolized an insurance market physicians said was increasingly unaffordable."[10]
>
> **Arkansas (cap on punitive damages):** "The cost of malpractice insurance for Arkansas doctors didn't rise as much this year, but a new law limiting damages in liability suits isn't getting the credit."[11]
>
> **Washington (no cap):** "Physicians Insurance, which is owned by doctors, has proposed a 7.7 percent cut in medical malpractice rates."[12]
>
> **Texas (hard cap, recently passed):** "JUA now joins the host of insurers that are part of this turnaround in the last year and half, either through reducing rates or re-entering the medical liability market."[13]
>
> **Massachusetts (cap with exceptions since 1986):** "[T]he state's largest malpractice insurer said it will not raise doctors' premiums…"[14]
>
> **Illinois (prior to passage of cap):** "ISMIE Mutual Insurance Company said that for the first time since 1999, rates won't increase for the policy year beginning July 1." [15]

What the Studies Show. Most studies reject the notion that enactment of caps on damages will lower insurance rates. Weiss Ratings, an independent insurance-rating agency, found that between 1991 and 2002, states with caps on noneconomic damage awards saw median doctors' malpractice insurance premiums rise 48 percent – a greater increase than in states without caps. In states without caps, median premiums increased only 36 percent.[16]

A study by law professors at the University of Texas, Columbia University and the University of Illinois based on closed claim data compiled by the Texas Department of Insurance since 1988 reached similar conclusions. That study found that "the rapid changes in insurance premiums that sparked the crisis appear to reflect insurance market dynamics, largely disconnected from claim outcomes."[17]

Similarly, an econometric analysis of the malpractice market by two Dartmouth economists found that "past and present malpractice payments do not seem to be the driving force behind increases in premiums," and that premium growth may be affected by many factors beyond increases in claims payments, such as industry competition and the insurance underwriting cycle. They found, "There is a fairly weak relationship between malpractice payments (for judgments and settlements) and premiums – both overall and by specialty." Also, "past and present malpractice payments do not seem to be the driving force behind increases in premiums. Premium growth may be affected by many factors beyond increases in payments, such as industry competition and the insurance underwriting cycle."[18]

Indeed, "tort reform" advocates have long rejected the notion that enactment of caps on damages would lower insurance rates. The American Insurance Association (AIA) and the American Tort Reform Association (ATRA) admitted long ago in published statements that lawmakers who enact "tort reforms" should not expect insurance rates to drop, with the AIA declaring at the start of the most recent hard market, "[T]he insurance industry never promised that tort reform would achieve specific premium savings."[19]

Past Experience With "Tort Reform": Rate Hikes, not Decreases. In the midst of the last insurance "crisis" in the mid-1980s, state lawmakers enacted often-severe tort restrictions on patients' rights after being told this was how to reduce insurance rates. These laws had absolutely no impact on insurance rates. Some states that resisted enacting any "tort reform" experienced low increases in insurance rates or loss costs relative to the national trends, and some states that enacted major "tort reform" packages saw very high rate or loss cost increases relative to the national trends. In other words, there was no correlation between "tort reform" and insurance rates.[20]

Maryland and Missouri are both examples of states that enacted severe caps on damages in the mid-1980s, only to be hit with huge rate hikes during the last hard market. For example, Maryland, an American Medical Association (AMA) "problem state"[21] and a "crisis state" according to the American College of Obstetricians and Gynecologists,[22] has had a cap on non-economic damages since 1986, originally $350,000 but later increased somewhat.[23] Despite the cap, the state recently experienced premiums that "rose by more than 70 percent."[24]

Missouri, identified by the AMA as a so-called "crisis state,"[25] has had a cap on non-economic damages since 1986. The cap started at $350,000 and has been adjusted annually for inflation, reaching $557,000 in 2003.[26] "New medical malpractice claims dropped 14 percent in 2003 to what the [Missouri Department of Insurance] said was a record low, and total payouts to medical malpractice plaintiffs fell to $93.5 million in 2003, a drop of about 21 percent from the previous year." And "the National Practitioner Data Bank, a federally mandated database of malpractice claims against physicians, found that the number of paid claims in Missouri fell by about 30 percent since 1991. The insurance department's database found that paid claims against physicians fell 42.3 percent during the same time period." Yet doctors' malpractice insurance premiums rose by 121 percent between 2000 and 2003.[27]

In California, 13 years after the state's severe $250,000 cap on damages was enacted, "doctors' premiums had increased by 450 percent and reached an all-time high in California." But, in 1988 California voters passed a stringent insurance regulatory law, Proposition 103, which "reduced California doctors' premiums by 20 per within three years," and stabilized rates.[28] In the thirteen years after MICRA, but before the insurance reforms of Prop. 103, California medical malpractice premiums rose faster than the national average. In the 12 years after Prop. 103 (1988-2000), malpractice premiums dropped 8 percent in California, while nationally they were up 25 percent.[29] Moreover, the law has led to public hearings on recent rate requests by medical malpractice insurers in California, which resulted in rate hikes being lowered three times in the last two years.[30]

History is clear on this matter: legislative attempts to reduce insurance rates by taking away the rights of the most seriously injured in our society has been and continues to be a failed public policy.

Conclusion

In 1989, Michael Hatch, then Commerce Commissioner of Minnesota (and now Attorney General), released an investigation of two malpractice insurers including the country's then largest, St. Paul. Hatch found that during the prior six years, at the time of America's last insurance "crisis," these companies had increased doctors' malpractice premiums some 300 percent. Yet the number of claims against doctors had not gone up, the amount paid out by insurance companies had not increased, and the number of frivolous claims had not increased.

In response to a question by ABC's *Nightline* as to how this could happen, Hatch responded, "Because they had the opportunity to do it. There was a limited market. People need coverage. The companies knew they had a corner on it, and they raised their rates accordingly."

Sadly, not much has changed in the world of insurance. Over the last few years, the medical lobbies and the insurance industry and other large corporations blamed the insurance crisis that doctors' had been experiencing on the legal system and lobbied extensively for what they called "tort reform" – laws that restrict the rights of injured patients to obtain compensation for deaths and injuries. They claimed that enactment of "tort reform" would cause insurance rates to stabilize and even fall.

However, as this most recent data shows, the "crisis" was caused not by legal system excesses but by the economic cycle of the insurance industry. Following large rate increases and cut backs in coverage that started in the years 2001 and 2002, the insurance cycle has now turned again and prices are falling. The nation is now enjoying a relatively "soft" insurance market with rates of liability insurance not only stable but down. And the "tort reform" remedy pushed by these advocates failed to do anything except hurt patients.

APPENDIX

OVERALL PROPERTY/CASUALTY LINES – 2001 THROUGH 2005

	2001	2Q 2002	3Q 2002	4Q 2002	1Q 2003	2Q 2003	3Q 2003	4Q 2003	1Q 2004	3Q 2004	4Q 2004	1Q 2005	2Q 2005	3Q 2005	4Q 2005
Small Comm. Accounts	21%	20%	15%	8%	11%	7%	4%	4%	3%	-3%	-3%	-5%	-5%	-5%	-3%
Mid-size Comm. Accounts	32%	27%	22%	19%	14%	8%	5%	5%	1%	-6%	-6%	-9%	-10%	-8%	-5%
Large Comm. Accounts	36%	34%	25%	21	15%	8%	4%	4%	-3%	-9%	-9%	-10%	-11%	-9%	-5%

SPECIFIC LINES – 2001 THROUGH 2005

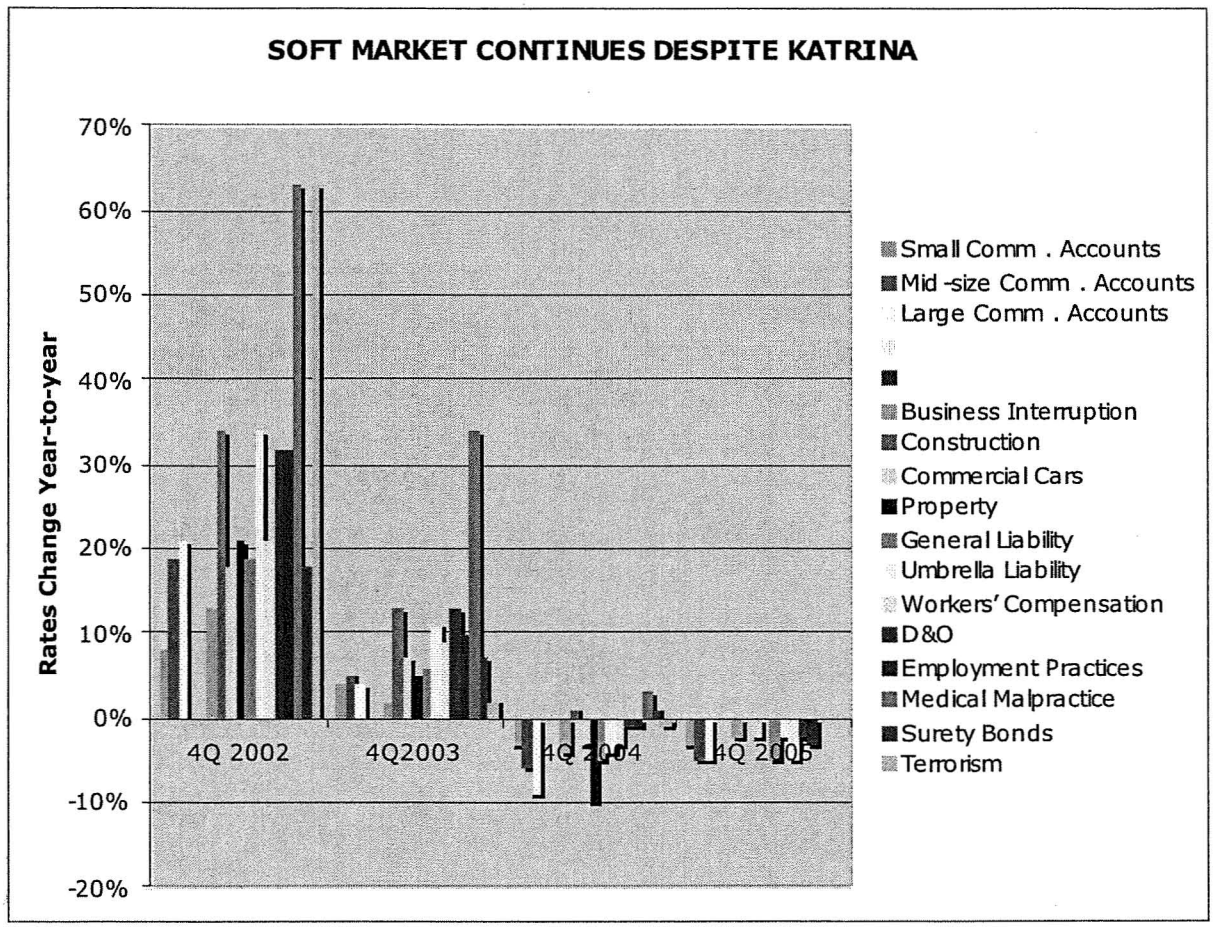
	2001	2Q 2002	3Q 2002	4Q 2002	1Q 2003	2Q 2003	3Q 2003	4Q 2003	1Q 2004	3Q 2004	4Q 2004	1Q 2005	2Q 2005	3Q 2005	4Q 2005
Business Interruption	30%	21%	16%	13%	9%	5%	3%	2%	-1%	-5%	-4%	-7%	-6%	-5%	-2%
Construction	46%	44%	30%	34%	22%	17%	13%	13%	8%	2%	1%	-3%	-3%	-3%	0%
Commercial Cars	28%	27%	18%	18%	15%	11%	6%	7%	3%	-5%	-3%	-6%	-5%	-6%	-2%
Property	47%	42%	24%	21%	12%	6%	1%	5%	-5%	###	###	###	###	-9%	0%
General Liability	27%	24%	18%	19%	14%	11%	7%	6%	3%	-4%	-5%	-8%	-8%	-7%	-5%
Umbrella Liability	56%	52%	36%	34%	26%	18%	11%	11%	4%	-2%	-4%	-6%	-6%	-6%	-2%
Workers' Compensation	24%	26%	19%	21%	17%	15%	10%	9%	4%	-5%	-3%	-5%	-7%	-3%	-5%
D&O			35%	32%	29%	21%	16%	13%	7%	-5%	-1%	-4%	-3%	-4%	-2%
Employment Practices			19%	32%	19%	17%	12%	10%	5%	-2%	-1%	-4%	-4%	-4%	-3%
Medical Malpractice			**61%**	**63%**	**54%**	**48%**	**28%**	**34%**	**19%**	**6%**	**3%**	**2%**	**2%**	**0%**	**0%**
Surety Bonds			14%	18%	18%	13%	6%	7%	6%	1%	1%	0%	-6%	0%	0%
Terrorism				63%	13%	6%	2%	2%	0%	-2%	-1%	-1%	-1%	-1%	0%

OVERALL PROPERTY/CASUALTY LINES – 4TH QUARTER 2002 THROUGH 2005

	4Q 2002	4Q2003	4Q 2004	4Q 2005
Small Comm. Accounts	8%	4%	-3%	-3%
Mid-size Comm. Accounts	19%	5%	-6%	-5%
Large Comm. Accounts	21%	4%	-9%	-5%

SPECIFIC LINES – 4TH QUARTER 2002 THROUGH 2005

	4Q 2002	4Q2003	4Q 2004	4Q 2005
Business Interruption	13%	2%	-4%	-2%
Construction	34%	13%	1%	0%
Commercial Cars	18%	7%	-3%	-2%
Property	21%	5%	-10%	0%
General Liability	19%	6%	-5%	-5%
Umbrella Liability	34%	11%	-4%	-2%
Workers' Compensation	21%	9%	-3%	-5%
D&O	32%	13%	-1%	-2%
Employment Practices	32%	10%	-1%	-3%
Medical Malpractice	**63%**	**34%**	**3%**	**0%**
Surety Bonds	18%	7%	1%	0%
Terrorism	63%	2%	-1%	0%



Source: Council of Insurance Agents and Brokers
Commercial Property-Casualty Market Survey
By Quarter as indicated

NOTES

[1] In fact, except for six years, the property/casualty insurers had underwriting losses in every year since 1967. *Best's Aggregates and Averages, Property/Casualty Edition, 2005*, p. 397.
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Americans for Insurance Reform
"PROTECTING RIGHTS, NOT WRONGS"

Medical Malpractice Insurance: Stable Losses/Unstable Rates

October 10, 2002

Introduction and Summary of Findings

For the first time, Americans for Insurance Reform (AIR), a coalition of nearly 100 consumer groups around the country, has produced a comprehensive study of medical malpractice insurance, examining specifically what insurers have taken in and what they've paid out over the last 30 years. AIR examined everything that medical malpractice insurers have paid in jury awards, settlements and other costs over the last three decades, and compared these actual costs with the premiums that insurers have charged doctors. This study makes two major findings:

- First, the amount that medical malpractice insurers have paid out, including all jury awards and settlements, directly tracks the rates of medical inflation. Not only has there been no "explosion" in medical malpractice payouts at any time during the last 30 years, but payments (in constant dollars) have been extremely stable and virtually flat since the mid-1980s.

- Second, medical insurance premiums charged by insurance companies do not correspond to increases or decreases in payouts, which have been steady for 30 years. Rather, premiums rise and fall in concert with the state of the economy —insurance premiums (in constant dollars) increase or decrease in direct relationship to the strength or weakness of the economy, reflecting the gains or losses experienced by the insurance industry's market investments and their perception of how much they can earn on the investment "float" (which occurs during the time between when premiums are paid into the insurer and losses paid out by the insurer) that doctors' premiums provide them.

Background

The nation's insurance companies are advancing a legislative agenda to limit liability for doctors, hospitals, HMOs, nursing homes and drug companies that cause injury. Federal and state lawmakers and regulators (and the general public) are being told by medical and insurance lobbyists that doctors' insurance rates are rising due to increasing claims by patients, rising jury verdicts and exploding tort system costs in general.

The insurance industry argues and worse, convinces doctors to believe that patients who file medical malpractice lawsuits are being awarded more and more money, leading to unbearably high losses for insurers. Insurers state that to recoup money paid to patients, medical malpractice insurers are being forced to raise insurance rates or, in some cases, pull out of the market altogether.

Since insurers say that jury verdicts are the cause for the current "crisis" in affordable malpractice insurance for doctors, the insurance industry insists that the only way to bring down insurance rates is to limit an injured consumer's ability to sue in court.

Insurance rates for doctors have skyrocketed twice before: in the mid-1970s and in the mid-1980s, each "crisis" occurring during years of a weakened economy and dropping interest rates. Each of these periods was followed by a wave of legislative activity to restrict injured patients' rights to sue for medical malpractice. Medical and insurance lobbyists told legislators that changes in tort law were needed to reduce medical malpractice insurance rates.

One of the first states to react to this now third insurance "crisis" for doctors has been Nevada. At the end of July 2002, Nevada enacted a $350,000 cap on non-economic damages for injured patients. Within weeks of the law's enactment, two major insurance companies announced that despite the new law, they would not reduce insurance rates for the foreseeable future. Quite simply, this is because, as we show below, the legal system is largely irrelevant to the problem.

The Study

For the first time, AIR, under the direction of actuary J. Robert Hunter (Director of Insurance for the Consumer Federation of America, and former Federal Insurance Administrator and Texas Insurance Commissioner), has produced a comprehensive study of medical malpractice insurance, examining specifically what insurers have taken in and what they've paid out, in constant dollars, over the last 30 years. AIR examined everything that medical malpractice insurers have paid in jury awards, settlements and other costs over the last three decades, and compared these actual costs with the premiums that insurers have charged doctors, as well as with the economic cycle of the insurance industry.

This AIR study represents the first major analysis exploring whether or not there is, as the insurance industry claims, an explosion in lawsuits, jury awards or tort system costs justifying an increase in insurance premium rates, or whether premium increases simply reflect the economic cycle of the insurance industry, driven by interest rates and investments.

The Insurance Industry's Economic Cycle

Insurers make most of their profits from investment income. During years of high interest rates and/or excellent insurer profits, insurance companies engage in fierce competition for premium dollars to invest for maximum return. Insurers severely underprice their policies and

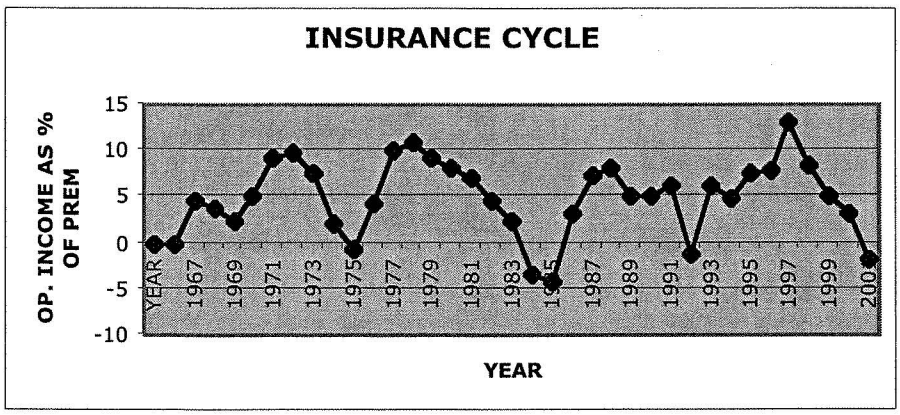
insure very poor risks just to get premium dollars to invest. This is known as the "soft" insurance market.

But when investment income decreases — because interest rates drop or the stock market plummets or the cumulative price cuts make profits become unbearably low — the industry responds by sharply increasing premiums and reducing coverage, creating a "hard" insurance market usually degenerating into a "liability insurance crisis."

A hard insurance market happened in the mid-1970s, precipitating rate hikes and coverage cutbacks, particularly with medical malpractice insurance and product liability insurance. A more severe crisis took place in the mid-1980s, when most liability insurance was impacted. Again, in 2002, the country is experiencing a "hard market," this time impacting property as well as liability coverages with some lines of insurance seeing rates going up 100% or more.

The following Exhibit shows the national cycle at work, with premiums stabilizing for 15 years following the mid-1980s crisis.

Exhibit 1. The Insurance Cycle



(The 1992 data point was not a classic cycle bottom, but reflected the impact of Hurricane Andrew and other catastrophes in that year.)

Prior to late 2000, the industry had been in a soft market since the mid-1980s. The usual six-to-ten year economic cycle had been expanded by the strong financial markets of the 1990s. No matter how much they cut their rates, the insurers wound up with a great profit year when investing the float on the premium in this amazing stock and bond market (the "float" occurs during the time between when premiums are paid into the insurer and losses paid out by the insurer —*e.g.*, there is about a 15 month lag in auto insurance and a 5 to 10 year lag in medical malpractice). Further, interest rates were relatively high in recent years as the Fed focused on inflation.

But in the last two years, the market turned with a vengeance and the Fed cut interest rates again and again. This took place well before September 11th. The terrorist attacks sped up the price increases, collapsing two years of anticipated increases into a few months and leading to what some seasoned industry analysts see as gouging.[1] However, the increases we are witnessing are mostly due to the cycle turn, not the terrorist attack or any other cause. This is a classic economic cycle bottom.

Smoking Guns

AIR tested two hypotheses advanced by the insurance industry: First, if large jury verdicts in medical malpractice cases or any other tort system costs are having a significant impact on the overall costs for insurers' and are therefore the reason behind skyrocketing insurance rates, then losses per doctor should be rising faster than medical inflation over time. Second, if lawsuits or other tort costs are the cause of rate increases for doctors rather than decreasing interest rates and other economic factors, those losses should be reflected in steadily increasing rates, not in sharp ups and downs that might instead reflect the state of the economy, the well-documented insurance economic cycle (Exhibit 1), interest rates, the stock market or the level of insurers' investment income.

AIR finds both hypotheses are completely false. The data in Exhibits 2 and 3 below, are more than simply conclusive. They are "smoking guns" which should, once and for all, end the debate about the cause of these periodic medical malpractice crises. First, they show that since 1975, medical malpractice paid claims per doctor have tracked medical inflation very closely (slightly higher than inflation from 1975 to 1985 and flat since). In other words, payouts have risen almost precisely in sync with medical inflation, which should surprise the doctors who dutifully march off at the insurers' trumpet call to seek tort law changes. These data confirm that neither jury verdicts nor any other factor affecting total claims paid by insurance companies that write medical malpractice insurance have had much impact on the system's overall costs over time.

Second, while payouts closely track medical inflation, medical malpractice premiums are quite another thing. They do not track costs or payouts in any direct way. Since 1975, the data show that in constant dollars, per doctor written premiums — the amount of premiums that doctors have paid to insurers — have gyrated almost precisely with the insurer's economic cycle, which is driven by such factors as insurer mismanagement and changing interest rates, not by lawsuits, jury awards, the tort system or other causes.

In sum, the results of AIR's analysis illustrated in Exhibits 2 and 3 are startling; premiums rise and fall with the economic cycle, as illustrated in Exhibit 1, but losses paid do not.

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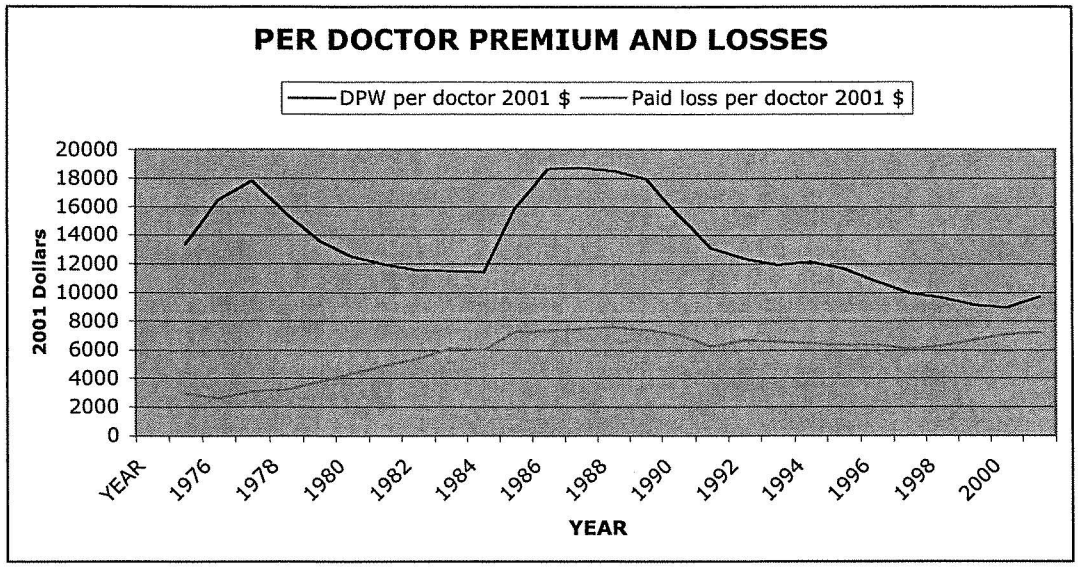
[1] "...there is clearly an opportunity now for companies to price gouge – and it's happening.... But I think companies are overreacting, because they see a window in which they can do it." Jeanne Hollister, consulting actuary, Tillinghast-Towers Perrin, quoted in, "Avoid Price Gouging, Consultant Warns," *National Underwriter*, January 14, 2002.

Exhibit 2



Sources:
A.M. Best and Co. special data compilation for AIR, reporting data for as many years as separately available; U.S. Bureau of the Census, 1975 (2001 Estimated)[2]; Inflation Index: Bureau of Labor Statistics, 1975 (1985 estimated).

Definitions:

- **"DPW"** or **"Direct Premiums Written"** is the amount of money that insurers collected in premiums from doctors during that year.
- **"Paid losses"** is what insurers actually paid out that year to people who were injured —all claims, jury awards and settlements —plus what insurance companies pay their own lawyers to fight claims.[3]

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[2] We calculate the paid losses on a per doctor basis to remove from the trend we are studying the effect of the ever increasing number of doctors in America. We acknowledge that the number of doctors includes a certain number of doctors that are retired or otherwise not in the medical malpractice system, but since we are interested in overall loss trends over time, and since the percentage of doctors in that category should not vary much year to year, this fact should not significantly impact our results.

[3] "Paid losses" are a far more accurate reflection of actual insurer payouts than what insurance companies call "incurred losses." Incurred losses are not actual payouts. They include payouts but also reserves for possible future claims – *e.g.,* insurers' estimates of claims that they do not even know about yet. While incurred losses do exhibit more of a cyclical pattern, observers know that this is because in hard markets, as we are currently experiencing, insurers will increase reserves as a way to justify price increases. In fact, the current insurance "crisis" rests significantly on a jump in loss reserves in 2001. Historically, reserves have been later "released" to profits during the "softer" market years. For example, according to a June 24, 2002, *Wall Street Journal* front page investigative article, St. Paul, which until 2001 had 20 percent of the national med mal market, pulled out of the market after mismanaging its reserves. The company set aside too much money in reserves to cover malpractice claims in the1980s, so it "released" $1.1 billion in reserves, which flowed through its income statements and appeared as profits. Seeing these profits, many new, smaller carriers came into the market. Everyone started slashing prices to attract customers. From 1995 to 2000, rates fell so low that they became inadequate to cover malpractice claims. Many companies collapsed as a result. St. Paul eventually pulled out, creating huge supply and demand problems for doctors in many states. Christopher Oster and Rachel Zimmerman, "Insurers' Missteps Helped Provoke Malpractice 'Crisis,'" *Wall Street Journal*, June 24, 2002.

Exhibit 3

Year	Direct Premiums Written (thousands)	Direct Losses Paid (thousands)	Loss Ratio	Number Doctors in USA (active)	Medical Care Inflation (CPI-U)	Direct Premiums Written per doctor	Direct Losses Paid per doc.	Year	Direct Premiums Written per doctor **2001 $**	Direct Losses Paid per doctor **2001 $**
1975	865,208	190,867	0.221	366,425	47	2361	521	1975	13705	3023
1976	1,187,978	188,545	0.159	378,572	52	3138	498	1976	16463	2613
1977	1,423,091	248,969	0.175	381,969	57	3726	652	1977	17831	3120
1978	1,412,555	294,456	0.208	401,364	61.8	3519	734	1978	15535	3238
1979	1,405,991	391,800	0.279	417,266	67.5	3370	939	1979	13618	3795
1980	1,493,543	521,849	0.349	435,545	74.9	3429	1198	1980	12490	4364
1981	1,616,470	665,570	0.412	444,899	82.9	3633	1496	1981	11956	4923
1982	1,815,056	847,543	0.467	462,947	92.5	3921	1831	1982	11563	5399
1983	2,033,911	1,079,862	0.531	479,440	100.6	4242	2252	1983	11504	6108
1984	2,282,590	1,197,979	0.525	511,090	106.8	4466	2344	1984	11408	5987
1985	3,407,177	1,556,300	0.457	514,000	113.5	6629	3028	1985	15932	7277
1986	4,335,863	1,709,883	0.394	519,411	122	8348	3292	1986	18666	7361
1987	4,781,084	1,905,491	0.399	534,692	130.1	8942	3564	1987	18750	7473
1988	5,166,811	2,128,281	0.412	549,160	138.6	9409	3876	1988	18518	7628
1989	5,500,540	2,273,628	0.413	559,988	149.3	9823	4060	1989	17948	7419
1990	5,273,360	2,415,117	0.458	572,660	162.8	9209	4217	1990	15431	7067
1991	5,043,773	2,423,418	0.480	594,697	177	8481	4075	1991	13072	6281
1992	5,228,362	2,808,838	0.537	605,685	190.1	8632	4637	1992	12387	6655
1993	5,469,575	3,028,086	0.554	619,751	201.4	8825	4886	1993	11954	6618
1994	5,948,361	3,174,987	0.534	632,121	211	9410	5023	1994	12166	6494
1995	6,107,568	3,326,846	0.545	646,022	220.5	9454	5150	1995	11697	6371
1996	6,002,233	3,556,151	0.592	663,943	228.2	9040	5356	1996	10807	6403
1997	5,864,218	3,587,566	0.612	684,605	234.6	8566	5240	1997	9961	6094
1998	6,040,051	3,957,619	0.655	707,000	242.1	8543	5598	1998	9627	6308
1999	6,053,323	4,446,975	0.735	720,900	250.6	8397	6169	1999	9141	6715
2000	6,303,206	4,988,474	0.791	735,000	260.8	8576	6787	2000	8970	7099
2001	7,288,933	5,424,197	0.744	750,000	272.8	9719	7232	2001	9719	7232

Conclusion

Stable Losses/Unstable Rates represents the first comprehensive report on medical malpractice insurance analyzing what insurers have taken in and what they've paid out over the last 30 years, including jury awards, settlements and other costs. Its findings are startling. While insurer payouts directly track the rate of medical inflation, medical insurance premiums do not. Rather, they rise and fall in relationship to the state of the economy. Not only has there been no real increase lawsuits, jury awards or any tort system costs at any time during the last three decades, but the astronomical premium increases that some doctors have been charged during

periodic insurance "crises" over this timeperiod are in exact sync with the economic cycle of the insurance industry, driven by interest rates and investments. In other words, insurance companies raise rates when they are seeking ways to make up for declining interest rates and market-based investment losses.

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IMPROVING PATIENT CARE

QUALITY GRAND ROUNDS

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Patient Safety and Medical Malpractice: A Case Study

Troyen A. Brennan, MD, JD, MPH, and Michelle M. Mello, JD, PhD, MPhil*

19 August 2003 | Volume 139 Issue 4 | Pages 267-273

The system of tort liability for medical malpractice is frequently criticized for poorly performing its theoretical functions of compensating injured patients, deterring negligence, and dispensing corrective justice. Working from an actual malpractice case involving serious injury but no apparent negligence, the authors explore these criticisms from the perspectives of both the plaintiff–patient and the defendant–physician. They then examine the tort system through the lens of patient safety and conclude that the tensions between the system and patient safety initiatives suggest a need to reexamine our attachment to adversarial dispute resolution in health care. They propose targeted reforms that could improve the functioning of the system and create incentives to improve safety and quality.

For a list of questions and answers from the Quality Grand Rounds conference, see the Appendix.

"Quality Grand Rounds" is a series of articles and companion conferences designed to explore a range of quality issues and medical errors. Presenting actual cases drawn from institutions around the United States, the articles integrate traditional medical case histories with results of root-cause analyses and, where appropriate, anonymous interviews with the involved patients, physicians, nurses, and risk managers. Cases do not come from the discussants' home institutions.

The physician, Dr. Harris, was interviewed by a Quality Grand Rounds editor on 16 August 2002. The physician's defense attorney, Mr. Dean, was interviewed by a Quality Grand Rounds editor on 14 August 2002. All names are pseudonyms.

Summary of Events

Mrs. Taylor (a pseudonym), a 52-year-old woman with severe pneumonia and impending respiratory failure, was evaluated on the medical ward of a community hospital by Dr. Harris, an internist. Dr. Harris chose to immediately transfer her to the intensive care unit (ICU) for urgent intubation by a critical care specialist. During intubation, Mrs. Taylor had a cardiac arrest, which resulted in permanent brain damage. Dr. Harris was sued for malpractice.

The Case

Mrs. Taylor had a 3-day history of progressive fevers, nausea, and vomiting. She presented to the emergency department at 2:30 a.m., where she appeared to be moderately ill and dyspneic. Her initial temperature was 38.3 °C, her blood pressure was 112/70 mm Hg, her heart rate was 118 beats/min, and her respiratory rate was 26 breaths/min. Her oxygen saturation was 92% on room air. The examination was remarkable for crackles at her right lung base. The examination of her cardiac, abdominal, and neurologic systems was unremarkable. Laboratory studies showed a leukocyte count of 14 x 10^9 cells/L with a left shift, a creatinine level of 1.3 mg/dL (114.9 µmol/L), and a sodium level of 129 mmol/L. A chest radiograph showed a dense right lower lobe infiltrate. Bacterial pneumonia was diagnosed. The patient began receiving levofloxacin, metronidazole, and oxygen and was admitted to the medical ward of the hospital. A pulmonologist

was consulted by telephone about the initial treatment choices.

At 7:45 a.m., a nurse found Mrs. Taylor profoundly dyspneic and diaphoretic. Her oxygen saturation had fallen to 69% on 2 L. The patient was immediately placed on a nonrebreather mask at 15 L/min, which increased the oxygen saturation to 91%. Dr. Harris, who had assumed Mrs. Taylor's care that morning, was paged and arrived within minutes.

Dr. Harris found the patient in marked respiratory distress. She had a temperature of 37.6 °C, a blood pressure of 140/88 mm Hg, a heart rate of 140 beats/min, and a respiratory rate of 50 breaths/min. On examination, she had diffuse rhonchi, as well as crackles, throughout the right lung field. The rest of the examination was unremarkable. An arterial blood gas showed a pH of 7.41, a PCO_2 of 29, and a PO_2 of 63 (on the nonrebreather mask). Portable chest radiography showed a worsening of the right lung infiltrate.

Dr. Harris diagnosed progressing pneumonia and impending respiratory failure. She considered intubating the patient herself on the floor but opted to immediately transfer Mrs. Taylor to the care of a pulmonologist and intensivist who was standing by in the ICU, for probable intubation and mechanical ventilation.

> *Dr. Harris:* In my mind, it was a matter of what would be safest. I really don't have a lot of experience with awake intubation, and I knew that a pulmonologist was already involved in the case, so it was a really easy decision from my standpoint to get ... the patient transferred to the ICU for intubation.

Dr. Harris first saw the patient at 7:57 a.m. and completed her evaluation by 8:20 a.m. It took a few minutes for the logistics to be organized and for Mrs. Taylor to be physically transported. She arrived in the ICU at 8:37 a.m. By this time, her respiratory distress was more pronounced and she had become delirious. Her blood pressure was 142/65 mm Hg, her heart rate was 145 beats/min, her respiratory rate was 38 breaths/min, and oxygen saturation on the nonrebreather mask was 64%.

The pulmonologist preoxygenated Mrs. Taylor with a bag-valve-mask apparatus, administered a dose of midazolam, and attempted intubation at 8:45 a.m. Unfortunately, the attempt was complicated by ventricular fibrillation and a cardiac arrest. The physicians and nurses resumed bag-valve-mask oxygenation, and the oxygenation saturation, which had fallen to the mid-30s, rose to the 80s. Standard cardiopulmonary resuscitation was performed, including 2 to 3 minutes of chest compression, accompanied by boluses of atropine and epinephrine. The patient was defibrillated with 200 J and intubated successfully on the second attempt at 8:49 a.m. Arterial blood gas values after intubation were a pH of 7.09, a PCo_2 of 72, and a Po_2 of 39 on 100% Fio_2.

The patient's oxygenation ultimately improved and her cardiopulmonary status stabilized, but she suffered profound and presumably irreversible brain damage. At the time of discharge, she could not recognize family members or independently perform any activities of daily living. Although the case was informally discussed among the providers involved, it was not forwarded to or reviewed by the hospital's risk management committee. The patient was discharged to a long-term care facility for total custodial care. Several months after discharge, the patient's family sought legal counsel and decided to pursue a malpractice claim. About 20 months later, Dr. Harris received notice that she had been named in Mrs. Taylor's malpractice case.

> *Dr. Harris:* I was sitting in the ICU and my partner calls me up and says, "You're getting sued, and that's why I'm leaving medicine."

Anatomy of a Malpractice Claim

The lawsuit filed against Dr. Harris illustrates a conventional tort claim for medical malpractice against a physician. To recover damages, Mrs. Taylor must prove 1) that the relationship between Dr. Harris and her gave rise to a duty, 2) that Dr. Harris was negligent—her care fell below the standard expected of a reasonable medical practitioner, 3) that Mrs. Taylor suffered an injury that was 4) caused by Dr. Harris's negligence (1). The claim is seemingly that Dr. Harris did not move quickly enough to seek critical care attention for Mrs. Taylor and that the delay caused the cardiac arrest and subsequent brain damage.

We use this case to plumb the broader policy perspectives of malpractice and its effect on patient safety and deterrence of errors. Because some aspects of the litigation are still pending, we could not obtain comments from the plaintiff's attorney; however, we contribute our own thoughts about the plaintiff's likely view of the case.

Why Sue Dr. Harris? The Perspective of the Plaintiff's Attorney

From the plaintiff's perspective, there are three reasons to sue the physician for malpractice. First, filing a lawsuit is a way to secure compensation for the injury (2). Mrs. Taylor no doubt has some uninsured costs associated with this injury; for example, it is highly unlikely that her health and disability insurance will provide coverage for years of rehabilitation or custodial care (3), compensate her family for the loss of her household services, and recompense Mrs. Taylor's and her family's suffering.

Second, suing Dr. Harris may provide a sense of corrective justice (4). An injured party is "made whole" through restitution from the injurer.

Provoking feelings of remorse, shame, and guilt in the defendant is an integral part of this corrective justice.

Finally, tort litigation is meant to have a deterrence function (5). By forcing the negligent party to pay a penalty, the system creates an economic incentive to take greater precautions in the future. Presumably, being sued will cause Dr. Harris to approach acutely dyspneic patients differently in the future.

Presented as such, the tort system has theoretical appeal. It should supplement other methods of quality regulation through its deterrence function (Mello MM, Brennan TA. Regulating health care quality: the case of patient safety. Commissioned paper for the Agency for Healthcare Research and Quality; 2002). It is essentially a cost-free form of regulation for taxpayers because the regulatory vigor is provided by market incentives that direct plaintiffs' attorneys to select and bring cases. Attorneys weigh the costs of bringing a case (investigating the claim, hiring experts, and going to trial) against their expected compensation (usually a percentage of the award made to the plaintiff, referred to as a "contingency fee") (6).

This attractive theoretical account of tort law's social role is challenged, however, by the available empirical evidence about how medical malpractice law actually operates. Tort law performs its compensation function relatively poorly because most patients injured by negligence do not bring malpractice claims (7-9). In addition, the system has very high administrative costs—up to 60%, as compared with 5% to 30% for most other social compensation schemes (10) (Table). For example, workers' compensation is estimated to have administrative costs of 20% to 30% and the Social Security Disability Insurance system has costs in the 5% range. The differences are stark: For a $400 000 malpractice award, another $200 000 is spent on administrative costs, primarily in attorneys' fees. In contrast, a Workers' Compensation award of $400 000 requires only about $100 000 in administrative costs. With respect to corrective justice, the malpractice system does induce negative emotions in sued physicians (11), but it rarely inspires genuine remorse or feelings that justice has been done. Rather, most defendants find little merit in the suits brought against them and feel that they are the victims of a random event (12, 13).

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Table. **Comparison of Tort and Administrative Compensation Schemes**

The deterrence function of malpractice litigation also seems unavailing (14). Studies of the relationship between lawsuits and subsequent quality of care have largely centered on obstetrics. Most studies have failed to correlate variations in care patterns or birth outcomes with the obstetrician's history of malpractice claims (15-18). The single broad study of hospital adverse events reported limited evidence that a greater number and severity of malpractice claims was associated with improvement in medical injury rates (12). Even defensive-medicine effects, that is, promoting higher-than-optimal levels of taking precautions, have not been conclusively reported (14, 19). Anecdotal evidence suggests that in periods of "tort crisis," fear of being sued and the unaffordability or unavailability of liability insurance may have a different deterrent effect: It may deter physicians from remaining in practice or continuing to perform high-risk services (20, 21). Such effects, if they become widespread, affect patient access to care. Thus, much of the plaintiff's view of malpractice litigation is controversial.

Is the Lawsuit Fair? The Perspective of the Defense Attorney

From the facts of Mrs. Taylor's case, most readers probably have concluded that there is little evidence of negligence on the part of Dr. Harris. Within 40 minutes of the evaluation, Dr. Harris had moved Mrs. Taylor to the care of an expert in the ICU. Since this action plan was within the standard of care expected of a reasonable practitioner, the malpractice suit seems unfair.

The sense of unfairness is compounded by the fact that the lawsuit blames the individual physician. This event clearly occurred in several layers of the system: the nursing monitoring of the patient's condition; the schedule of attending coverage, as Dr. Harris "picks up" the care in the morning from another physician; the emergency response and admission to the ICU; and the issue of emergency intubation "on the floor." It seems unreasonable to blame Dr. Harris, given the possible contributory role of these systemic factors.

Plaintiffs' attorneys routinely sue several individuals, as well as the hospital. They may not believe that all individuals are liable, but they hope that some will offer at least a small settlement to avoid the nuisance aspects of the suit and the risk for a larger jury award. These settlements enable the plaintiff's attorney to fund further litigation against other defendants in the suit.

Mr. Dean, the defense attorney, is savvy about the respective roles of patient injury and negligence in initiating and settling a malpractice claim:

> *Mr. Dean:* In a case like this, involving a patient who was already in the hospital, who has an arrest and anoxic encephalopathy, one of the very significant perceptual issues we have to consider ... is the fact that there was a catastrophic outcome, and to some jurors, catastrophic outcomes may equate with "somebody must have messed up."

Mr. Dean makes the important point that the degree of injury is critical to the outcome of the case. His contention is supported by empirical

evidence from the Harvard Medical Practice Study, which examined rates of hospital adverse events, negligence, and malpractice claims in New York (7, 22). Negligence was determined by physician reviewers unaffiliated with the sued providers' insurance companies. The investigators followed the malpractice claims for 10 years and determined that the only statistically significant predictor of a payout to the plaintiff was the plaintiff's degree of disability—not the presence of negligence (23). Other studies have suggested that negligence does influence the size of settlements (24, 25), but these analyses have been based on insurance claims adjusters' determinations of negligence rather than independent judgments. If the main factor determining compensation is injury severity or disability even in a system that ostensibly revolves around a negligence determination, then one must ask why we cling to the tort model of compensation for medical injury.

The Case, *Continued*

After a long pretrial period of fact-finding ("discovery"), expert witness reviews, and depositions, Mr. Dean felt that his client's case was very strong. However, Mrs. Taylor's horrendous adverse outcome and concerns (unrelated to Dr. Harris's care) about her care by the hospital and other providers led Mr. Dean to recommend that Dr. Harris offer to settle the case for a relatively small amount of money.

In explaining the decision to settle, Mr. Dean weighed three factors. First, if a jury found his client negligent, what would the plaintiff's damages probably amount to, both in economic and noneconomic ("pain and suffering") terms? Second, how likely is a jury to find in favor of the physician? Third, what is his gut instinct about the case's worth? His judgment incorporates subjective factors, such as the likely composition and liberality of the jury in a given venue and sympathetic or unsympathetic characteristics of the plaintiff, her injury, and her circumstances.

> *Mr. Dean:* The concern was that the jury could be so overwhelmed with sympathy for what occurred to the patient and the patient's family that they would feel it would be impossible to say no ... Even if you are assessed a very small percentage of responsibility by the jury, given the huge potential damage exposure ... it could potentially represent a judgment ... in excess of your malpractice coverage. Mrs. Taylor and her family could come after the physician and force her into bankruptcy, resulting in financial ruin for Dr. Harris.

One would not blame Dr. Harris for feeling that the outcome of her case is unfair. Yet it is perfectly in accord with empirical research on litigation outcomes and with attorneys' strategic decisions as they function within an imperfect tort system. For Dr. Harris, settlement is the most rational choice in a system that could produce an utterly calamitous outcome.

The Perspective of Patient Safety Reformers

Those persons directly involved in this litigation—Dr. Harris, Mrs. Taylor, and their families and attorneys—feel the greatest effect of the malpractice system's shortcomings. However, these failings also have strong implications for the nascent patient safety movement.

The traditional rule in the common law is that all available probative evidence (evidence that proves a fact) should be admitted to the court for consideration (26). But legislators have long recognized that peer reviewers would be chilled if they knew that their review would be available to a plaintiff and to his or her attorney; thus, they have granted a privilege of nondiscoverability to peer review information, which courts generally have enforced (27).

The breadth of the privilege varies from state to state (28), but generally, hospitals must confine discussions about adverse events to small committees of insiders to retain the privilege. The need to minimize legal exposure leads them to eschew more public debate about quality issues. In the Harris case, it seems that it would have been beneficial for the hospital and staff to have openly evaluated issues of seamless cross-coverage, protocols for emergent intubation on the floor, and timely transfer to the ICU. Unfortunately, it appears that nothing of this sort occurred.

> *Dr. Harris:* From a hospital standpoint, to my knowledge, it was never discussed with any of the physicians. It never came up. I guess the things that come to mind are ... intensive care unit transfers and code blue situations ... but if they changed things in regards to this case, that would be news to me ... I don't really know the risk management people ... I know they exist, but who they are and their role and function in a situation like this or day to day, despite the fact that I spend up to 120 hours in the hospital, is just not discussed and I've never met them face to face.

The hospital cannot necessarily be blamed for failing to follow up. Perhaps the hospital concluded after an initial evaluation that there were few grounds for quality improvement. More likely, the hospital realized the extent of the resources necessary to complete a formal peer review process and decided it was not worth the effort. But Dr. Harris's ignorance of the formal mechanics of peer review at her hospital, and its essentially hidden nature, demonstrate the tension between error prevention or quality improvement and medical malpractice. Fear of litigation either stifles injury reduction efforts or drives efforts underground.

Malpractice and Patient Safety Trends

The Institute of Medicine's report on medical errors (29) has fomented a critical change in attitude about patient safety activism. Many risk management offices (a euphemism that obscures whether the "risk" is for a medical injury or for a successful malpractice claim) are now becoming patient safety offices or are partnering with newly created, separate patient safety offices. The use of careful root-cause analysis is becoming prevalent at the departmental level in many institutions (30). Yet malpractice fears continue to retard these salutary efforts, and many hospitals still approach error-related injuries the way Dr. Harris's hospital did.

These apprehensions not only chill educational discussion but also exert profound pressure against initiatives to disclose adverse events to both patients and governmental reporting systems. We (31) and others (32) have long advocated greater transparency about medical errors. Codes of professional ethics, as well as the new patient safety standards promulgated by the Joint Commission on Accreditation of Healthcare Organizations (33), support an obligation of disclosure to patients. The enormous potential for learning about errors through epidemiologic analysis argues persuasively for reporting to centralized data collection systems.

However, providers reasonably fear that greater transparency will tremendously increase the number of successful malpractice claims, with concomitant increases in malpractice premiums and decreases in the availability of insurance. Advocates of reporting counter that honesty may actually decrease physicians' malpractice risk (34): Physicians who have poor relationships with patients are the ones who get sued, and what patients really want is to be dealt with forthrightly (35, 36). The sole piece of published evidence on this issue is methodologically weak and comes from the Veterans Administration system, in which the physicians cannot be sued and institutional liability is limited (37). Researchers have yet to disprove providers' suppositions that greater disclosure will lead to more requests for compensation.

Legislation to protect centralized error reporting from legal discovery can help, but not all states have adopted such protections (38). Even in states that guarantee confidentiality, the continued public and media attention to medical errors—which provides valuable impetus and momentum for patient safety initiatives—may make injured patients more disposed to file claims.

A New Paradigm

The tensions between the tort system and patient safety demand that we reexamine our attachment to adversarial dispute resolution in health care. The options boil down to three paths. First, we can maintain the status quo and simultaneously push the safety agenda harder. It is possible that appeals to physicians' ethical commitments to patient welfare (39) and the demonstrated successes of industry-based models of systemic quality improvement may gradually yield buy-in to safety initiatives. We have our doubts, however. The conflicts between the tort system and error reduction programs are fundamental and severe, and physicians' concerns about being sued and losing their liability insurance have reached a fever pitch. Appeals to professionalism may ring hollow with physicians operating under a siege mentality.

A second option is to take legislative steps to curb the frequency and economic effect of malpractice litigation. During past "tort crises," providers successfully lobbied state legislatures to change litigation rules to make them less favorable to plaintiffs (40). Tort reform aims to decrease the expected value of a case for plaintiffs' attorneys, changing the calculus about when it is worthwhile to bring a claim. Among the most efficacious reforms are caps on noneconomic damages; changes in the amount that attorneys may take as contingency fees; reductions in the length of time that injured patients have to bring a claim; and elimination of the "collateral source rule," which allows plaintiffs to recover medical expenses and other costs even if these have been covered by insurance (41-44).

Today we are in the throes of new tort crisis, with claims rates and average payouts rising in many states, especially those that did not institute tort reform in previous crises (45). The concurrence of the tort crisis and the attention to medical errors has not gone unnoticed by insurers. Lobbying for tort reform at both the state and federal levels is under way (47).

The tort reform strategy is problematic, not the least because of its contentiousness. Many state legislatures cannot pass meaningful reform because of the competitive gridlock interposed by health care providers and trial lawyers. Moreover, traditional tort reforms aim to reduce providers' economic exposure, not create a more efficient system. The system's fundamental flaw is not simply that it costs health care providers too much but that it tends to overcompensate some patients while undercompensating others (8, 47). Reform should strive to do more, and we believe a no-fault approach is the answer.

In a no-fault system, the injured patient would only have to demonstrate that a disability was caused by medical management as opposed to the disease process: There is no need to prove negligence. This approach comports better with the patient safety movement. Modern notions of error prevention, emphasizing evidence-based analysis of systems of care (29) and application of technological and structural methods to foster prevention (50), find little value in assessing individual moral blame. No-fault compensation for avoidable injuries is far better suited to support error prevention than a system that revolves around culpability determinations.

We believe that such an approach could produce important incentives for prevention, the so-called deterrent effect, if risk were aggregated in institutions and medical groups. Experience-rating individual physicians' insurance premiums has not been actuarially feasible because physicians are sued too infrequently and their claims experience fluctuates too radically from year to year (14). However, hospitals and integrated medical groups have a more consistent risk profile and their premiums can be experience-rated.

An even better approach may be to set up so-called channeling programs, in which hospitals and their medical staffs are insured by the same entity and all efforts to prevent medical errors are undertaken jointly. Some medical school and academic medical centers already

use a channeling approach, and, as links grow between hospitals and integrated medical groups, the potential for a substantial amount of the health care system to operate under channeling approaches increases. In a channeled program, the foundation for greater safety is established by integrating the physician and hospitals or health care centers. The enterprise bears the liability for injury and has incentives to address prevention of errors in both inpatient and ambulatory settings.

We have also noted that in practice, compensation in the current tort system turns on severity of injury more than negligence—so why maintain a system focused on determining negligence? It is expensive and administratively cumbersome to make these determinations, as it involves an adversarial "battle of the experts." Moreover, even negligence judgments by financially disinterested expert reviewers are notoriously unreliable (48). In the context of a vigorously adversarial system, the focus on negligence also incites emotion-provoking behavior by litigants. Not only does this leave lasting psychological scars on persons involved, it pollutes what otherwise might be a useful exercise in root-cause analysis leading to quality improvements (49).

Finally, good data suggest that the no-fault approach would be less costly administratively. Similar no-fault programs in Workers' Compensation and vaccine liability operate at less than half of the costs of tort litigation, largely by minimizing the role of the lawyers. This is where politics will play an important role: Lawyers will fight to maintain the present system.

Elsewhere we have described a limited no-fault approach to medical injury compensation that could work on an elective basis [14]. We believe that no-fault compensation can 1) promote greater transparency about adverse events, 2) partner with a hospital-based, experience-rated insurance system that does not remove incentives for error prevention, and 3) lead to more equitable and efficient compensation (Table).

There are people who doubt no-fault proposals; they highlight the historical absence of effective self-policing, the possibility that the present malpractice system has improved safety by promoting vigilance and better documentation, and the uninspiring example of other no-fault systems, such as Workers' Compensation (51). Mr. Dean's view of the matter reflects the prevailing uncertainty about its probable outcomes:

> *Mr. Dean:* If we reinvent the system and take lawyers completely out of the equation ... is that going to result in safer medical care? One argument is that if physicians know that their care is not going to be subject to scrutiny ... that can actually decrease patient safety. On the other hand, I think that a reasonable argument can be made that if a physician or health care provider knows that every judgment is not going to be subjected to intense microscopic scrutiny under the "retrospectoscope," they are going to be more liberated and free to practice what they see as good medicine, and not be subject to second-guessing at every turn, and that can improve patient safety. It seems to me that until we have some hard data comparing safety in a pure no-fault system, we are not going to know the answer.

We acknowledge this uncertainty, but believe the proposal is worthy of experimentation.

The Harris case illustrates how difficult it is to move forward with an error prevention agenda in a heated malpractice environment. It is not surprising that providers are reluctant to buy in. Patients deserve innovative approaches that will reduce their chances of being injured by errors and lead to fair compensation if an avoidable injury occurs; providers deserve an environment in which participating in patient safety and compensation initiatives does not put them at risk for financial and professional ruin.

Appendix

Questions and Answers from the Conference

Dr. Robert M. Wachter, Quality Grand Rounds Editor: Where do you think the locus of action for improving patient safety should be? How would the malpractice system or the no-fault system play into creating incentives for institutions to improve safety?

Dr. Brennan: The only place where we find any real evidence of the deterrent effect of malpractice on errors is at the level of the institution. That makes sense because it is very difficult for individual practitioners to institute systematic approaches to reducing the number of medical injuries. In our most recent proposal for a no-fault system, we suggested that individual hospitals could choose to check out of the tort system and into a voluntary, no-fault program. The only places that can do that are those with integrated medical groups, which you find mostly in so-called channeling institutions. That's an insurance company term for a place where a single insurer covers both the doctors and the hospitals. Doctors who see patients in a primary care setting could have them sign a waiver saying that they understand they can't sue because the organization is in a no-fault compensation scheme. What I find attractive about this is that it could afford a competitive advantage in today's environment. We can tell patients that we can compensate them through the administrative system and that the compensation is going to be fair. We also have very strong incentives to report any injury to patients and to the administrative system. The average community hospital is going to have a harder time because physicians are separately insured and separate entities from the point of view of patient safety. From our point of view, the no-fault system creates an environment that encourages reporting, analyzing these reports, and publicizing the results. Many patients are going to find that attractive.

A physician: In a no-fault system that has no negligence, who decides what an adverse event is?

Dr. Brennan: An adverse event is defined as something that results in a prolongation of hospitalization or disability at the time of discharge, as a result of medical management as opposed to the disease process. That is actually a lot easier to define reliably than is the negligence judgment. What people are being compensated for today is their injury, not the negligence. Trying to identify the negligence is eating up a lot of administrative cost and poisoning the system with the morality play. Determining if an avoidable adverse event occurred would be easier in an administrative compensation scheme and would run similarly to the way things are adjudicated by insurance companies today, with expert testimony and decision-making along those lines. I am fairly confident that the system would work.

Dr. Mark Smith, President and Chief Executive Officer, California HealthCare Foundation, and Quality Grand Rounds Editor: Perhaps as a result of the rise of managed care, much of the most heavily publicized litigation in California has been at the health plan; not targeting physicians or hospitals, but, for instance, about coverage for bone marrow transplantation for breast cancer. Are there implications in a no-fault approach for liability when a health plan declines to cover treatment?

Dr. Brennan: Probably not. These cases occur infrequently, and the protections afforded insurance companies, because of the Employee Retirement Income Security Act (ERISA), make them relatively difficult cases to bring. These two factors tend to overwhelm a need for a no-fault approach there.

A physician: Under the no-fault program, the physician has a strong incentive to report adverse events to the patients and the hospital. Hopefully we all do that, but in a busy physician's schedule, I would think that they would find it easier not to report.

Dr. Brennan: You can build in some penalties for failure to report. Some insurance companies already charge an extra malpractice premium if a claim comes in and you haven't forewarned the insurance company. We would do the same thing in a no-fault program. Although we're trying to avoid a sense of penalty, there nonetheless have to be inducements to report.

Dr. Wachter: Informing patients of errors in their care is ethically the right thing to do. Increasingly, people cite evidence that full disclosure also will not increase the risk of a lawsuit. Is this correct?

Dr. Brennan: There are no good studies on that point, unfortunately. There are seasoned risk managers who will tell you that a lot of what people get upset about, and bring suits about, is the feeling that someone lied to them. Nonetheless, those same seasoned risk managers are not necessarily in favor of full reporting. The literature that people cite is a 1999 article in the *Annals of Internal Medicine* (37), which observed that at a couple of hospitals in a VA [Veterans Administration] system that promoted reporting errors to patients, claim rates were no higher than in other hospitals. However, there was absolutely no case-mix adjustment, and the VA system is a lot different from other hospital systems. First of all you have the Federal Tort Claims Act, which provides protection from suit, and second, you can't sue the individual doctors. So there is really no evidence right now.

A physician: Can you comment from the charts that you've reviewed about the quality of documentation and the role that it plays in the merits of the suit or on the outcome?

Dr. Brennan: In general, the quality of documentation is helpful in terms of nailing down whether or not a medical injury occurred or whether or not there was negligence. A few might take from this that if you don't document well, it's going to be more difficult to bring a case against the doctor, but crummy documentation actually plays very poorly in litigation. From the point of view of preventing medical injury, it is probably best to do the documentation.

Dr. Wachter: I can't let you leave without talking about the estimate of 44 000 to 98 000 yearly deaths due to medical errors in the Harvard Medical Study practice, which you led. These numbers, more than anything, captured the public's attention when they were touted in the 1999 IOM [Institute of Medicine] report. Yet, you have been circumspect about their accuracy. Could you comment?

Dr. Brennan: These are statistical analyses and I think we did them about as well as they can be done. But the reliability of these judgments from a statistical point of view is fairly poor with a kappa statistic of 0.4 to 0.5 for adverse events and even lower for negligence. What that means is that one person may say an event is a negligent adverse event, while another would says it's not. The other issue is that the IOM took our state-level data on adverse events and upweighted them to generate national mortality estimates. Whenever you extrapolate from relatively small samples, you have concerns about the statistical precision of the estimates. We always tried to point out the sponginess of these numbers in our public statements, but the IOM made a specific decision to go with them. The IOM performed a very important service in terms of putting patient safety back into the common vernacular of the American medical system and for that we owe them a debt of gratitude. Although we don't know exactly how many people die from medical errors, there is no doubt that it is at least 50 000 per year in hospitals and many additional outpatients. In the end, the actual number doesn't make much difference. Whatever the numbers, we have a tremendous burden of morbidity and mortality caused by errors and relatively little attention being paid to trying to prevent them.

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