The Medical Malpractice Insurance Crisis: Opportunity for State Action

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by

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EXECUTIVE SUMMARY

Rapidly rising medical malpractice insurance premiums and the departure of many insurance companies from the medical malpractice market have created a crisis of affordability and availability in certain areas of the country. State efforts to address the emergency have been hampered by the paucity of conclusive data on the causes and effective solutions to the problem. While an increase in litigation and higher damage awards are often blamed for rising premiums, insurance companies may be equally culpable due to their pricing policies of the 1990s. Furthermore, the move toward more restrictive tort reform does not address the complexity of the problem. Previous rounds of tort reform that followed the malpractice insurance crises of the 1970s and 1980s have not succeeded in preventing periodic and dramatic rises in insurance premiums. And tort reform does not address the important and related issues of patient safety and medical errors.

Conflicts among insurance companies, the medical profession, and trial lawyers are inherent to the debate over how to solve the crisis and often create a chilling effect on efforts to improve patient safety. While a full and open disclosure of medical errors is seen as an essential step in addressing the issue of patient safety, doctors and hospitals resist reporting errors for fear of increased malpractice litigation. One promising approach to the problem may be contained in a comprehensive legislative initiative developed in Pennsylvania, an intiative that combines tort and insurance reforms with patient safety initiatives and reporting requirements.

The United States is going through its third medical malpractice crisis in as many decades. Medical malpractice insurance premiums, which had been stable for over a decade, are rising across the country, in some areas dramatically. In addition, many insurance companies are reducing coverage or withdrawing completely from the malpractice market. This is leaving doctors in certain areas of the country, especially those practicing in high risk specialties (e.g., obstetrics, orthopedics, neurosurgery), facing extremely high insurance premiums, unable to find coverage at any price, or having to opt for the most expensive coverage of last resort. Alarming reports of doctors retiring or moving to other states, dropping high-risk patients and procedures, and practicing defensive medicine abound. There is a growing clamor for states to do something about this latest crisis.

The issue is polarizing and the debate acrimonious. Insurers and doctors blame "predatory" trial attorneys, "frivolous" law suits, and "out of control" juries for the spike in insurance premiums. In turn, consumer groups accuse insurance companies of "price gouging," while plaintiffs' attorneys point to an exorbitant rate of medical errors and the need to deter malpractice and provide compensation to injured patients. This animosity and defensiveness create a closed environment and impede state efforts to address broader issues of patient safety. Medical malpractice is not the same as medical error, yet the malpractice crisis has created an environment of distrust that spreads to include all efforts to improve patient safety. Litigation in some cases may simply be a symptom of distrust in an environment where all errors are kept secret.

The discussion of possible solutions is equally contentious. Insurers and physicians demand tort reform, changes in the legal system that will limit the frequency of litigation and the amount of damage awards. Attorneys argue that past legal reform has unfairly blocked victims' access to the courts while doing nothing to bring down the costs of malpractice insurance. They see the solution in regulation of the insurance industry. Patient advocates focus on safety and suggest mandatory reporting of medical errors and a no-fault approach to victim compensation.

Medical Malpractice Insurance Crisis

- The data are inconclusive as to the causes of rapidly rising medical malpractice insurance premiums. While there are reported increases in frequency and severity of medical malpractice claims, the underpricing of malpractice premiums throughout the 1990s and a downturn in the stock market exacerbated by Sept 11 attacks are also to blame.
- The data are inconclusive as to whether there has been an increase in medical malpractice claims greater than that which corresponds to growth in population, an increase in the number of doctors and hospitals, or growth in technological advancements.
- Because of the reluctance to report errors, the data are inconclusive as to whether any increase in malpractice claims corresponds to an increase in incidents of medical malpractice or medical errors.
- The data are inconclusive as to the efficacy of tort reform as remedy for periodic malpractice insurance crises. Previous rounds of tort reform have not prevented periodic malpractice insurance crises. Tort reform does not address the issue of patient safety.
- Medical errors are a serious and costly problem, killing between 44,000 and 98,000 people annually in the United States. Total national cost of medical errors is estimated to be between $17 billion and $29 billion annually.[1]
- The great majority of patients injured by medical negligence do not file a malpractice claim and of those who do file only a third receive any compensation for their injuries.

The interests of the states straddle the divide. States want quality medical care and hospital services to be accessible throughout their jurisdictions and are concerned that medical liability insurance be available and affordable for all providers. States also want to see medical errors reduced or eliminated, while making sure that patients who are injured, either by error or malfeasance, can be fairly compensated. The challenge facing the states—to determine the cause and find a solution to this pressing and complicated problem—is made that much more difficult by the crossfire of accusations and dearth of empirical research. Is there really a litigation explosion? How extensive is medical malpractice? Has the latest crisis been instigated by the insurance industry as a strategy to push through

[1]Institute of Medicine, *To Err is Human: Building a Safer Health Care System* (Washington, D.C.: National Academy Press, 1999).

tort reform? Where should the states focus their attention? Reforms aimed at patient safety? The legal system? The insurance industry?

This latest medical malpractice insurance crisis offers an opportunity to state policy makers to take a comprehensive approach and address patient safety and medical errors in addition to tort reform and insurance regulation.

UNDERSTANDING THE CRISIS

"...deja vu all over again."
–Yogi Berra

What has come to be known as the medical malpractice insurance crisis is cyclical, having recurred three times in the past 30 years.[2] The recent dramatic increases in malpractice premiums have hit some areas and specialties harder than others. For a variety of reasons, malpractice insurance premiums vary widely throughout the United States with doctors paying vastly different amounts depending on their specialty, geographic location, and history of malpractice claims. For example, according to the Medical Liability Monitor, an obstetrician practicing in Florida can pay as much as $200,000 for an annual malpractice premium, whereas the same specialist would pay $73,000 in New Jersey and $25,000 in Maine.[3] The range for annual premiums for physicians of internal medicine is between $3,000 in Arkansas to $50,000 in Florida.[4] West Virginia, Pennsylvania, New Jersey, Texas, and Nevada have all recently been the subject of alarming news articles and ominous projections about the effects of the rise in malpractice premiums.[5]

The issue is not only one of cost, but also of availability. The problem of high premiums has been compounded by insurance companies failing and going out of business or ceasing to offer medical malpractice policies.

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[2]Early 1970s, mid-1980s, and early 2000s.

[3]Trends in 2001 Rates for Physicians' Medical Professional Liability Insurance, *Medical Liability Monitor,* Vol. 26, No. 10 (October 2001)

[4]Ibid.

[5]E.g., Francis X. Clines, "Insurance-Squeezed Doctors Fold Their Tents," *New York Times*, June 13, 2002; Maria Newman, "In Mass Trenton Rally, Doctors Protest Malpractice Insurance Costs," *New York Times*, June 14, 2002; Rita Rubin, "Soaring malpractice premiums stun many doctors," *USA Today,* December 3, 2001.

Why Are Premium Costs Rising?

▸ Frequency and severity of malpractice claims?

During each of the previous crises, when malpractice premiums experienced a sharp rise, insurance companies were quick to blame an explosion of litigation and skyrocketing jury verdicts. This time the argument is no different, but the statistics on both the extent of litigation and amounts of awards are conflicting and difficult to come by. Jury Verdict Research, a firm frequently cited by insurers, claims that the *median* jury award in medical malpractice cases rose from $500,000 in 1995 to $1,000,000 in the year 2000.[6] These figures are vehemently criticized as misleading by consumer groups.[7] The Consumer Federation of America, in a study of medical malpractice awards that includes all claims, even those with damage awards of zero, shows that the *average* payout for medical malpractice claims has risen only slightly over the past ten years, to an average of $42,607 in the year 2000.[8] A U.S. Bureau of Justice Statistics survey of state courts cites a figure of $285,576 as the *median* award for 1996, about half the amount cited by Jury Verdict Research for that same year.[9]

The same discrepancy in statistics occurs when trying to determine the frequency of claims. While some reports indicate an alarming increase, others maintain that frequency of claims has remained steady or even shown a slight decline.[10] What is not disputed is that the percentage of patients injured by medical negligence who actually bring suit is very small. Estimates range

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[6]Jury Verdict Research, Horsham, PA. (Http://www.juryverdictresearch.com)

[7]Press Release, "Flawed Jury Data Masks Trends,"*Center for Justice & Democracy* (March 23, 2002). Jury Verdict Research figures are questioned because they include only claims that result in a jury award and do not factor in the malpractice suits in which the injured patient gets no award at all (the majority of suits), non-jury awards, or settlements and do not reflect awards that were lowered by the judge (remittur) or overturned on appeal. The resulting figures are thus skewed toward the high end.

[8]Travis Plunkett, Consumer Federation of American (CFA), "Regarding Medical Malpractice Insurance Rates," testimony before the Subcommittee on Health of the House Committee on Energy and Commerce, July 17, 2002. The CFA data includes all claims, including settlements and those that resulted in no monetary award.

[9]Marika Litras, et al., "Tort Trials and Verdicts in Large Counties, 1996," *Bureau of Justice Statistics Bulletin,* August 2000. The survey included jury and bench trials and did not include settlements.

[10]*Examing the Work of State Courts, 2001: A National Perspective from the Court Statistics Project* (2001); Brian C. Shuck and Susan Martin, "Wyoming Tort Reform and the Medical Malpractice Insurance Crisis: A Second Opinion," 28 *Land and Water Law Review* 593, 625 (1993);

from one-in-eight to one-in-ten. Of those who do sue, only one in three receive any compensation.[11]

▸ Insurance underwriting cycles and practices?

Even assuming a growth in frequency of claims and size of awards, the insurance companies may share culpability in the current crisis. A similar pattern can be seen during each of the three malpractice crises that have occurred since 1970. Insurance underwriting practices are cyclical with periodic adjusting of rates after the fact to reflect actual losses during a given period. The premiums are invested and the return on investment is factored in as part of a company's profits and losses. During times of high interest rates or a strong stock market, insurance companies keep their premiums low in order to remain competitive, increase their market share, and acquire revenue to invest. This is possible because their income is augmented from the high rate of return on investments. A downturn in the stock market or a drop in interest rates results in a lower rate of return on investments and leads to an increase in premiums.

After premium increases in the 1970s and again in the 1980s, the medical malpractice market remained stable through the economic boom years of the 1990s. During this period, medical liability insurance was one of the most profitable lines in the industry, and new companies entered the market enticing customers with bargain rates.[12] This price war for new customers prompted many insurers to sell malpractice coverage at rates too low to cover the costs of subsequent claims.[13] When the boom stock market went bust, exacerbated by the September 11th terrorist attacks, many of these companies suffered large losses and either went out of business, drastically raised premiums, or stopped offering medical malpractice insurance. The departure of St. Paul Companies, the single largest carrier of malpractice insurance in the country, was a serious blow that created an availability crisis that affected many practitioners around the country.[14]

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[11] Harvard Medical Practice Study, *Patients, Doctors and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York* (1990)

[12] National Association of Insurance Commissioners, Report on Profitability 1997 (1999).

[13] Rachel Zimmerman and Christopher Oster, "Insurers' Missteps Helped Provoke Malpractice 'Crisis'", *Wall Street Journal*, June 24, 2002.

[14] While the insurance industry blames the departure of companies from the malpractice market on the malpractice litigation "explosion," at least part of the attrition can be attributed to mismanagement, artificially low premiums throughout the 1990s, and huge losses suffered by many companies after September 11th. See, e.g., Cy Ryan, "State Doctors' Insurance Woes Blamed on Enron Fall," *Las Vegas (Nevada) Sun* (February 1, 2002) and Deena Beasley, "Obstetricians Call for Liability Insurance Reform," *Reuters* (May 6, 2002).

Effects of the Crisis: Fewer Doctors? Defensive Medicine?

Dramatically rising malpractice premiums understandably cause great anxiety and concern on the part of physicians and may cause them to avoid high risk patients and procedures, notably in the field of obstetrics.[15] Malpractice litigation and the recurring insurance crises create an environment of fear and hostility. The concern about being sued for malpractice apparently affects physicians' perceptions about their actual risk. Several studies have shown that the perceived risk of being sued was much greater than the actual risk.[16] It is not clear, however, that the alarming anecdotal reports of fleeing doctors supports the conclusion that malpractice crises cause physicians to move to other states or leave the practice of medicine in significant numbers.[17] Neither can it be shown that states that passed tort reform in previous years have attracted physicians to a greater extent than states that did not.[18] While there is an ongoing problem with a shortage of physicians in certain areas, especially rural areas, this may have more to do with other factors, such as concentration of hospitals, than malpractice claims or any one state policy decision.[19] Of course, a loss of even one physician in an underserved area, whatever the cause, can have a disproportionate impact.

To what extent the threat of malpractice litigation causes doctors to practice defensive medicine and contributes to the soaring costs of health care is also open to debate. While malpractice insurance is among the most expensive, even with the periodic increases the cost of this insurance remains less than 1 percent of the total costs of the U.S. healthcare system.[20] One study which compared one state with malpractice reforms, Indiana, to a neighboring state without reforms, Illinois, found that both states had

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[15]Malpractice insurance rates and concern about being sued has been shown to limit the number of physicians practicing obstetrics. R.A. Rosenblatt, et al., "Tort Reform and the Obstetrics Crisis: The Case of the WAMI States," *Western Journal of Medicine* 154 (June 1991), 693-699.

[16] See Joel C. Cantor, et al., "Addressing the Problem of Malpractice", Chapter 6 of *To Improve Health and Health Care 1997: The Robert Wood Johnson Anthology* (The Robert Wood Johnson Foundation, 1997).

[17]Martha Leonard, "State Has Seen Sharp Increase in Number of Doctors," *The Charleston Gazette* (February 25, 2001). Anne Wlazelek, "Doctors' ad campaign baseless: They're not fleeing PA, but malpractice straits create 'hostile' climate," *Morning Call* (March 24, 2002).

[18]Eleanor D. Kinney, "Malpractice Reform in the 1990s: Past Disappointments, Future Success?," 20 *Journal of Health Politics, Policy and Law* 99, 120 (1995).

[19]Robert Wood Johnson Grant Results Report, "Study of Urban Physicians Supply Trends" (February 2001).

[20]U.S. Congressional Budget Office. See also W. Kip Viscusi and Patricia Born, "Medical Malpractice Insurance in the Wake of Liability Reform," 24 *Journal of Legal Studies* 463, 464 (1995).

similar patterns of health system costs.[21]

The practice of defensive medicine may well contribute to the rising cost of health care, but whether fear of malpractice is causing physicians to practice defensive medicine to a significant extent is not clear. Studies show that the practice of defensive medicine does exist, but probably not to the extent indicated by anecdotal reports.[22] The practice of defensive medicine may have other causes and is not always a response to fear of malpractice.[23] One possible contributing factor to both defensive medicine and malpractice litigation is the technological advancements of the last 50 years that have resulted in expectations that illnesses can consistently be diagnosed and cured with early intervention.[24]

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[21]Eleanor D. Kinney, "Indiana's Medical Malpractice Reform Revisited: A Limited Constitutional Challenge," 31 *Indiana Law Review* 1043 (1998), p.1048.

[22]David Klingman, et al., "Measuring Defensive Medicine Using Clinical Scenario Surveys," 20 *Journal of Health Politics, Policy and Law* 1 (1996).

[23]Peter A. Glassman, et al., "Physicians' Personal Malpractice Experiences Are Not Related to Defensive Clinical Practices," 21 *Journal of Health Politics, Policy and Law* (1996).

[24]Kenneth De Ville, Ph.D., J.D., "Medical Malpractice in Twentieth Century U.S.: the interaction of technology, law and culture," 1 *International Journal of Technology Assessment and Health Care* 98 (1998).

WHAT CAN STATES DO TO ADDRESS THE MEDICAL MALPRACTICE CRISIS?

"The first thing we do, let's kill all the lawyers."
– William Shakespeare, Henry VI

Just as there has been little agreement on the causes of the malpractice crisis, there is little agreement on the cure. States responded to the crisis of the 1970s with a assortment of reforms that addressed the insurance industry and the legal system. Again in the 1980s there was heavy pressure to enact tort reform, measures designed to limit the frequency of malpractice claims and amount of damage awards. To the extent that medical quality was discussed as part of the solution, it was primarily to reinforce risk management through peer review, which would be shielded from legal action. The release of the Institute of Medicine's "To Err is Human" in 1999 did shift the focus of the national debate toward medical error and patient safety, but the cure for the malpractice insurance crisis is still seen primarily as an issue of limiting the frequency and cost of litigation.[25]

Tort Reform

A tort is a wrongful act for which relief may be obtained in the form of damages. The legal system of torts requires the determination of fault or blame. It is designed to compensate those who have been wronged while deterring future wrongs. It is arguable, in the area of malpractice injury, whether tort law does either effectively. Far too many people are injured through medical errors and very few acts of medical negligence result in patient claims. (Cite IoM report) Even fewer receive compensation for their injuries. Also disturbing are studies showing that whether an injured patient will receive compensation depends as much on jury sympathy than on proof of negligence.[26] The tort system may be a costly and inefficient way to address the ills of medical malpractice, but that is not to say that litigation has caused nor that tort reform will solve the malpractice insurance crisis.

Tort reform is essentially an attempt to control the frequency and severity of claims. Common provisions of tort reform include measures that make it more difficult for an injured patient to get into the courts and/or to win a suit and that limit the amount that can be awarded in a successful suit. (See Table 1.)

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[25]Institute of Medicine, *To Err is Human: Building a Safer Health Care System* (Washington, D.C.: National Academy Press, 1999).

[26]Brennan T. A., Sox C. M., Burstin H. R, "Relation between Negligent Adverse Events and the Outcomes of Medical-Malpractice Litigation," *New England Journal of Medicine*, Vol. 335, No. 4 (Dec 26, 1996): 245

Table 2: Common Tort Reform Measures

Measure	States
Damage caps Damages in liability cases are classified as economic and non-economic. Economic damages include actual monetary losses due to negligence such as medical bills and loss of future earnings. Non-economic damages refer to money awarded to a victim for unquantifiable losses such as pain and suffering or loss of consortium.[27] Punitive damages may also be awarded with the intention of punishing an egregious offender. Many states have put a limit on non-economic damages. A few states have limited the total amount of possible damage award.	AK, CA, CO, HI, ID, IN, LA, ME, MD, MA, MI, MO, MT, NE, NH, NM, ND, PA, SD, TX, UT, VA, WV, and WI. Passed but later held unconstitutional in: AL, FL, IL, NH, SD, TX, and WA.
Periodic Payment of Damages Periodic payment allows a defendant to pay a damage award over time as opposed to one lump payment. The argument for this reform is that it will prevent bankrupting providers who lose malpractice suits. Patient advocates argue that it is unfair to victims because it takes away the possibility of investing the large sum which may be necessary in the case of a person severely disabled through medical negligence.	AL, AK, AZ, AR, CA, CO, DE, FL, ID, IL, IN, IA, LA, ME, MD, MI, MN, MO, MT, NH, NM, NY, ND, SD, UT, VA, WA, and WI.
Abolition of the collateral source rule The collateral source rule prohibits juries from hearing evidence that claimants have been fully or partially compensated from other sources (e.g., medical insurance) for their injuries.	AK, AZ, CA, CO, CT, DE, FL, ID, IL, IN, IA, ME, MA, MI, MN, MT, NE, NV, NJ, NY, ND, OK, OR, PA, RI, SD, TN, UT, WA, and WI. Passed but later held unconstitutional in: AL, KS and KY.
Limiting attorney contingency fees Attorneys for plaintiffs in tort cases almost always work on a contingency fee basis, receiving a percentage of the damage award. This arrangement makes it possible for people of all economic levels to bring suit for injuries resulting from negligence. Reformers argue that attorneys fees are often excessive, take away from the victims compensation, and encourage attorneys to bring frivolous suits.	CA, CT, DE, FL, IL, IN, ME, MA, MI, NJ, NY, OK, TN, UT, WI, WY.

[27]Consortium is the legal right of one spouse to the company, affection, and assistance of the other.

Abolition of joint and several liability Joint and several liability is designed to protect victims in cases where more than one party has been found liable or responsible for the injuries inflicted by holding that each is completely responsible for the damages if any other party fails to pay its portion. This is designed to ensure that an injured person will receive his or her entire damage award, i.e., be "made whole," even if one or more of the responsible parties fails to pay. The counter argument is that this rule encourages plaintiffs to sue hospitals or doctors with "deep pockets" or substantial insurance policies. The alternative is comparative or contributory negligence under which rule a jury is asked to apportion responsibility, each defendant paying its share of the damages.	AK, AZ, CO, CT, FL, GA, HI, ID, IA, KS, KY, LA, MS, NE, NV, NH, NJ, NM, NY, ND, OR, PA, TX, UT, VT, WA, WY. Passed but later held unconstitutional in: IL and MT.

In the 1970s and again in the 1980s, many states passed one or more of the above tort reform measures in response to the medical malpractice insurance crises.[28] These measures were passed in the absence of reliable data about the effectiveness of the proposed reforms to alleviate the crisis. Recent studies that take a retrospective look at the malpractice reforms of the 1970s and 1980s are casting serious doubt upon the efficacy of tort reform in addressing the problem of high malpractice insurance rates. One study of reforms in Wyoming found that the state did not experience a medical malpractice litigation crisis during the 1970s and 1980s which could have caused an insurance crisis.[29] The same study revealed that Wyoming's tort reforms had been only minimally effective in reducing either claim frequency or claim severity.[30]

A study of the effect of tort reform nationally on medical malpractice insurance over the period from 1984 to 1991 showed that although reforms had little effect on insurance premiums they did succeed in enhancing insurance profitability and diminishing uncertainty which in turn helped stabilize the malpractice insurance market.[31] Even when tort reforms do become law they often face constitutional challenges in state courts. Many of the reforms passed following the malpractice crises of the 1970s and 1980s were subsequently found to violate state constitutional provisions.[32]

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[28]In 1986 the American Tort Reform Association (ATRA) was formed by a coalition of businesses, corporations, municipalities, associations, and professional firms, with the mission to bring greater "fairness and predictability to the civil justice system and put an end to law suit abuse" through legislative reform. The position of ATRA and other tort reform proponents is that any effective medical liability reform measure will include 1) a $250,000 limit on non-economic damages; 2) a sliding scale for attorney contingency fees; 3) periodic payment of future costs; and 4) abolition of the collateral source rule. (See http://www.atra.org.)

[29]Brian C. Shuck and Susan Martin, "Wyoming Tort Reform and the Medical Malpractice Insurance Crisis: A Second Opinion," 28 *Land and Water Law Review* 593, 625 (1993).

[30]Ibid., p.625.

[31]W. Kip Viscusi and Patricia Born, "The National Implications of Liability Reforms for General Liability and Medical Malpractice Insurance," *24 Seton Hall Law Review 1743* (1994).

[32]Provisions capping damages were passed and subsequently found to be unconstitutional in AL, FL, IL, NH, SD, TX, and WA. Abolishment of the collateral source rule was found unconstitutional in AL (in part), KS, and KY. Abolishment of joint and several liability was found unconstitutional in IL and MT.

Second Generation Reforms

The national debate about the malpractice insurance crisis has been framed largely as a controversy between doctors and lawyers and has centered on the battle over tort reform.[33] This has left little room for consideration of other reforms directed at making the legal system more efficient and more responsive to injured patients. Such proposals have been called "second generation reforms" and include no-fault approaches to medical injuries with a schedule of damages akin to workers' compensation, the availability of alternate dispute resolution (ADR) such as mediation or arbitration of malpractice claims, the use of medical practice guidelines, and enterprise liability.[34] None of these reforms has been widely adopted by states.

A **no-fault system** would compensate patients for injuries without the need to determine blame or negligence on the part of doctors or other medical providers. Injured patients would be compensated according to a pre-determined schedule of damages. Since theoretically all injured patients would be compensated, regardless of the culpability of the providers, this approach could result in higher costs to the health care system.

Several states currently allow, but rarely mandate, **arbitration of claims** or amounts of damages. Other states have established review panels to weed out frivolous claims.

Table 2: Arbitration and Review Panels

Arbitration is permitted in some states, often as a prerequisite to litigation, and may address liability and amount of damages.	AL, CA, FL, GA, HI, IL, LA, ME, MD, MI, MN, NJ(required for claims less than $20,000), NY, ND, OH, PA, SD, TN, TX, VT (mandatory but non-binding), WA (mandatory but non-binding), and WI
Review panels are used as a pre-trial screening mechanism. Findings may or may not be submitted as evidence.	DE, HI, ID, IN, LA, ME (parties agree to binding decision), NE, NV, NM, UT, and VA.

[33]The latest salvo was the initiation of a national campaign by the American Medical Association (AMA) urging Congressional passage of a federal tort reform bill—H.R. 4600: The Health Act—which includes damage caps. On June 12, 2002, the AMA testified before Congress and endorsed this bill. The June 17, 2002, release of an AMA 50-state survey on the malpractice crisis which credited California tort reform for lower insurance premiums in that state was immediately disputed by the Center for Justice and Democracy in a press release pointing out that tort reform restricting access to the courts had been passed by many states following the 1980s crisis and many of those same states are experiencing an insurance crisis today.

[34]Kinney (1995), p.99.

Medical practice guidelines specify appropriate treatment for patients in particular circumstances. Guidelines have been proposed as an affirmative defense to rebut a charge of negligence but could also be used offensively to establish negligence in litigation.

Enterprise liability shifts liability from the individual physician to the institution or "enterprise" (hospitals or other health care institutions, large medical groups, health plans). This eliminates the need for the plaintiff to prove negligence against an individual physician and would distribute the costs of insurance more evenly across specialties.

Insurance Reform

Insurance reforms, designed to increase the availability of malpractice insurance, include patient compensation funds, joint underwriting associations, limits on the ability of companies to cancel policies, and requirements for insurers to report the disposition of claims to insurance regulators.[35]

Many states have set up joint underwriting associations to make medical malpractice insurance available to persons who are unable to obtain such insurance in the regular market. A joint underwriting association is a type of shared market mechanism wherein the costs of providing the insurance is borne by all companies writing insurance in a state. The cost of insurance under a joint underwriting association is pegged to the cost of private insurance and is almost always more expensive than private insurance. Compensation funds are set up by states to provide coverage in excess of the coverage limits of a malpractice insurance policy. These and other insurance reforms have been effective in increasing availability of insurance but do not necessarily increase the affordability of malpractice insurance.[36]

As previously noted, a primary goal of medical malpractice reforms, whether tort or insurance reforms, is to decrease the frequency and severity of claims. A National Center for State Courts study of the impact of reforms on the frequency of medical malpractice litigation, which studied cases disposed of in 21 states during 1992, yielded surprising results.[37] The authors found that while certain malpractice or tort reforms were associated with a decrease in the frequency of litigation, other reforms had no impact or were associated with an increase in the frequency of malpractice litigation. (See Table 3.)

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[35] R. Bovbjerg, "Legislation on Medical Malpractice: Further Developments and a Preliminary Report Card," 22 *University of California-Davis Law Review* 449 (1989).

[36] McKinney, p. 102.

[37] Roger Hanson, Brian Ostrom, and David Rottman, "What is the Role of State Doctrine in Understanding Tort Litigation?" National Center for State Courts, (1996).

Since recurring malpractice crises are at least partially the result of insurance pricing and business practices, any attempt at solution that does not address insurance company practices would be incomplete.

Table 3: Impact of Specific Reforms on Rate of Malpractice Litigation

Decrease Rate of Litigation	No Impact	Increase Rate of Litigation
Abolition of Collateral Source Rule	Caps on economic damages	Periodic payment of damages
Penalties to punish frivolous lawsuits	Limits on attorney fees	Mandatory pretrial screening panels
Patient Compensation Funds		Optional arbitration of malpractice cases

Source: National Center for State Courts 1992

Patient Safety

Framing the issue differently might allow a solution to emerge from the haze of hostility surrounding the discussion of medical malpractice. If the focus is shifted to patients, the crisis can be looked at as one of patient safety, a crisis that is being articulated in two ways:

- in a growing number of reports showing an alarming number of medical errors that cause a multitude of deaths in America each year,[38] and
- in increasing complaints over malpractice insurance premiums and the costs, both financial and emotional, of malpractice litigation.

Any progress toward a solution on either front has been hampered by the toxic environment generated by the adversarial conflict between the insurance companies and doctors on the one hand and the trial lawyers and patient advocates on the other. The problem with tort reform in this context is that it does nothing to promote patient safety even as it takes away the only remedy currently available to aggrieved patients. In addition, evidence suggests that tort reform has not always been successful in lowering premium costs or in decreasing litigation.

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[38]The Institute of Medicine study, *To Err is Human,* estimated that, nationally, medical errors cause as many as 98,000 deaths per year in hospitals alone. A recently released study estimates that more than one in five Americans, or 8.1 million households, have experienced a serious medical or prescription error. See Karen Davis et al., *Room for Improvement: Patients Report on the Quality of Their Health Care* (New York: The Commonwealth Fund, 2002).

Following the release of the Institute of Medicine's *To Err is Human,* states responded quickly. To date, legislation addressing some aspect of the problem has been introduced in 26 states.[39] In accordance with recommendations of the Institute of Medicine report, approximately one-third of the states have established mandatory reporting requirements of hospital-based events that cause serious injury or death.[40] But the medical community is strongly resisting anything but voluntary and confidential reporting of errors because of the fear of malpractice litigation. Since the key to getting to the root causes of medical errors may be a completely open environment that exposes all information to scrutiny, states will have to address the obstacles to reporting caused by the current malpractice system before progress can be made. The current crisis presents the states with an important opportunity to promote patient safety and reduce medical errors as they take on the challenge of resolving the malpractice insurance crisis.

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[39]CA, CT, FL, GA, HI, IL, IN, IA, KY, ME, MD, MA, MI, MN, MO, NV, NH, NJ, NY, OR, OK, PA, SD, VA, WA, and WV. See Lynda Flowers, *State Responses to the Problem of Medical Errors: An analysis of recent state legislative proposals* (Portland, ME: National Academy for State Health Policy, 2002).

[40]Sharon Conrow Comden and Jill Rosenthal, *Statewide Patient Safety Coalitions: A Status Report* (Portland, ME: National Academy for State Health Policy, 2002).

PENNSYLVANIA: LINKING QUALITY, PATIENT SAFETY AND MALPRACTICE REFORM

"All government,
indeed, every human benefit and enjoyment, every virtue and every prudent act,
is founded on compromise and barter."
--Edmund Burke

In 2002, Pennsylvania passed a comprehensive law addressing the medical malpractice insurance crisis. The law encompassed reforms aimed at the legal system, the insurance industry, and patient safety. This inclusive approach provoked intense lobbying, and each side in the dynamic debate had to compromise cherished positions. The final law gives tort reform proponents a cap on punitive damages,[41] a change in the collateral source rule so that patients are now prohibited from collecting damages on medical expenses already paid by health insurance companies, and the possibility of periodic payment of future medical expenses exceeding $100,000. Responsibility for making periodic payments end with the death of the patient. The law also allows a judge to consider the effect a large verdict would have on the availability or access to a physician or health care in the community when a request is made to lower a verdict. Strict qualifications for expert witnesses are established. A cap on non-economic damages was dropped from the final bill. The controversial provision abolishing joint and several liability was initially included, then dropped from the final bill. Six months later the Pennsylvania legislature passed a separate bill which abolished joint and several liability. (See Table 1.)

The new law lowers the amount of mandatory professional liability coverage from $1.2 million to $1 million. An insurer's liability is limited to the coverage limit of the policy, and the ability to cancel policies is restricted. A joint underwriting association is established to offer coverage to physicians and health care workers who are unable to obtain private coverage.

Provisions in the law designed to limit litigation and to reduce or stabilize insurance rates are counterbalanced with wide-ranging patient safety requirements.

Physicians, other health care workers and medical facilities in Pennsylvania are now required to report serious events and incidents to a newly established Patient Safety Authority which in turn must contract with an outside agency to analyze the reports and make recommendations to improve patient safety.[42]

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[41]The law allows punitive damages only when a physician's conduct is "willful and wanton" and rules out punitive damages for "grossly negligent" conduct. Punitive damages may not exceed 200 percent of the compensatory damages awarded.

[42]A serious event is broadly defined by the law to include any event involving the clinical care of a patient in a medical facility that results in an unanticipated death or patient injury requiring further medical

The Authority has the ability to impose penalties for non-compliance.
Patients affected by a serious event in a medical facility must receive written notice of the event.
Physicians and licensed health care workers are required to inform their licensing boards of any complaints or disciplinary or legal action against them, and the State Medical Board has the enforcement authority to conduct independent investigations.

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care. An incident is an event which could have caused serious injury but did not. The Patient Safety Authority is composed of the Physician General and 10 additional people appointed by the Governor and representing the various healthcare professions and sectors.

CONCLUSION

"A hard beginning maketh a good ending."
--Proverbs

A comprehensive approach to the medical malpractice insurance crisis that addresses tort and insurance reform in conjunction with reporting requirements and other strategies aimed at reducing medical errors may be the most effective course of action for states. Although evidence suggests that tort reform is not the definitive solution to the malpractice insurance crisis, some reform may be beneficial if it serves to diffuse the defensiveness and antagonism of the malpractice debate and provides the opportunity to build patient safety initiatives.

In a less hostile environment states may be able to work collaboratively with stakeholders and develop creative strategies that meet the goals of affording victims of medical negligence fair compensation, ensuring available and affordable liability insurance to all medical practitioners, and reducing or eliminating medical errors.