ALASKA LEGISLATURE COMMITTEE FILES, 1989-1990 8672

5759 HOUSE JUDICIARY 163

Under Section (a)(1), if the child is 10 years of age or older, the action must be brought within five years of the date of injury.

Section (a)(2) provides that if a child is less than 10 years of age, he would have until he was 12 years of age or five years from the date of injury whichever was longer in which to bring the action.

Section (a)(3) provides that the limitations as provided would not be applicable if there was fraud or collusion by the parents, guardian, insured or physician which resulted in an action not being brought on behalf of the injured minor if the wrong was intentional or if an unintended foreign body was left in a minor patient who had been treated.

S E C T I O N 6

A.S. 09.10.070. This section brings the existing statute of limitations into harmony with existing case law by adding the language "the accrual of an action" which is interpreted to mean when a person discovers or should have discovered the person's right to bring the action. Under present case law, the statute of limitation commences to run when a person knew or should have known that he had been injured by the negligent acts of another.

S E C T I O N 7

A.S. 09.10.070. This provision provides for the tolling of the statute of limitations in the case of minority, incompetency or imprisonment.

A.S. 09.10.070(b). This proposed amendment would preclude an action from being initiated more than 20 years after the date of injury irrespective of the legal incompetency of the injured person except in the event of an intentional tort.

S E C T I O N 8

A.S. 0.17.040(f). This section amends the existing statute, passed during the 1986 "tort reform package", to expressly require that consideration be taken into account of future inflation if a judgment is to be paid in future installments and that an appropriate fund be included to provide for such inflation. Such a provision is already implicitly contained in any judgment ordering future periodic payments, but insurance carriers have made contentions to the contrary in some courts.

S E C T I O N 9

A.S. 09.17.050(a). This section provides tort immunity, except in the case of gross negligence, for negligent conduct which

causes personal injury, death, or damage to property if the person committing such an act does so in the course of membership of a board of directors or as an officer of a non-profit corporation, profit hospital, the citizens advisory board of any hospital, member of a school board, member of any governing body, commission or citizens advisory committee of the municipality of this state. This amendment adds to those already immunized, members of the board of directors of an electric or telephone cooperative. There has been no showing that this class of individuals should be protected and given tort immunity and that they cannot obtain adequate insurance coverage. There has been no showing made that directors of electric or telephone cooperatives should be entitled to such immunity. Some of these organizations, as evidenced by ATU, operate some of the largest businesses in the state.

Reviewing this amendment discloses a glaring error in the 1986 statute. The intent of the statute is to protect board members and officers for managerial decisions. As passed in 1986, it is much broader. It covers all acts within the scope of official duties. Thus, if driving an insured vehicle while dropping off a report to another board member, one of them runs a red light and kills or maims another person, there could be no recovery from the auto insurer for the injuries or death.

SECTION 10

A.S. 09.17.070. Under present law, a jury may not consider collateral benefits the party has received to compensate them for the tortious conduct of another. Such evidence is presented to a judge who, applying appropriate statutes, makes appropriate deductions to eliminate from the award medical and other like benefits which have been paid by an injured party's insurer. This statute would permit all of these benefits to be considered by a jury but it would also permit the injured party, if these benefits were introduced by the defendant, to introduce into evidence the actual attorney's fees incurred by him in achieving recovery and the amount paid by him to secure the right to an insurance benefit. Thus, the jury would be advised of the true net recovery that an injured party would receive from the litigation.

It is doubtful that such a provision would add to the administration of justice. It would complicate, not simplify the tort procedure. It certainly would not reduce costs.

SECTION 11

A.S. 09.30.070. This sections provides that prejudgment interest may not be awarded for future economic and non-economic damages. The apparent intent of this provision is to preclude double interest recovery. However, under existing case law, this does

not occur, as prejudgment interest on future losses is not permitted if projections of future loss are made from the date of trial. City of Whittier v. Whittier Fire & Marine Corp., 577 P.2d 216, 226 (Alaska 1978). As a general rule, the Alaska Supreme Court has held that a double interest recovery is not allowed.

SECTION 12

A.S. 21.06.110. This section provides for gathering of information on a variety and type of claims and directs that the director provide such information to the legislature.

SECTION 13

A.S. 09.10.055(b). This provision repeals an eight year statute of repose with regard to the improvement or construction of real property. This provision has previously been held unconstitutional by the Supreme Court.

A.S. 09.17.040(c). This provision eliminates a litigating party's ability to stipulate that the Beaulieu rule will apply to the computation of future damages and requires a reduction to present value in all cases.

A.S. 09.55.548 This provision would eliminate the special accommodation that is afforded physicians in a medical negligence case with regard to the treatment of collateral sources. Collateral sources would be treated in medical negligent cases consistent with the way they are treated in all other tort actions.

SECTION 14

This section provides for a report by the Department of Commerce and Economic Development on closed insurance claims and insurance company finances.

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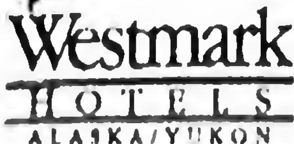


March 14, 1990

Hon. Max F. Gruenberg Jr., Co-Chairman
Hon. Peter Goll, Co-Chairman
House Judiciary Committee
P.O. Box V
Juneau, AK 99811

Dear Co-Chairmen Gruenberg and Goll:

It is with pride that I write on behalf of the some 2,300 people and over 30 organizations who are the Citizens' Coalition for Tort Reform. It was just a few days ago I was chosen, together with Frank Turpin and Dr. David A. McGuire, to be the leadership for the Coalition.

Shortly after its formation in October of 1985, the Coalition took a close look at how the tort reparations system worked. It revealed that it wasn't working. It was inefficient, not cost effective and the bulk of its caseload was not addressed in a timely and fair fashion. The tort reparations system needed a thorough overhaul then and it does today.

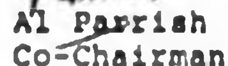
Sixteen proposals were set out to address the major faults of the system. Since that time, several significant proposals were put forth by others to deal with other major faults. Only one issue has been clearly deal with, that is, through Ballot Measure No. 2, the voters on November 8, 1988, voted by a margin of 72% to 28% to change the doctrine of joint and several liability to several liability.

HB 166 addresses most of the proposals, but not all. Further, HB 166 contains significant modifications to the original concepts. I submit that the Citizens' Coalition for Tort Reform has already compromised its agenda in order to be fair.

Much of the body of tort law by which issues are now judged has come about through the judicial process. We believe it is time for public debate. We urge movement of HB 166 from your committee to the floor of the House where that debate can occur.

Sincerely,

WESTMARK HOTELS, INC.



Al Parrish
Co-Chairman

880 H Street, Suite 101
Anchorage, Alaska 99501
(907) 272-9403

Alaska State Legislature

House of Representatives
House Judiciary Committee

P. O. Box V
State Capitol
Juneau, Alaska 99811
(907) 465-4990
(907) 465-4712

April 12, 1990

Ms. Debra Gravo
Executive Director
Alaska Action Trust
P.O. Box 102323
Anchorage, AK 99510

Dear Ms. Gravo:

Thank you very much for your latest letter and the informational package. I will make sure that every member of the committee has the information in their bill files on HB 166.

Sincerely,

Peter Goll

Alaska Action Trust
P.O. Box 102323 • Anchorage, Alaska 99510
Office: 540 L Street, Suite 102 • Anchorage
(907) 258-4040

April 10, 1990

'r RECE... 1990

Rep. Peter Goll
Alaska State Legislature
P.O. Box V (MS 3100)
Juneau, AK 99811

Dear Rep. Goll,

In the ongoing process of keeping you informed as to current developments relating to the perceived insurance "crisis," the Alaska Action Trust has prepared this informational packet for your review.

A. "HOW DOCTORS HAVE RUINED HEALTH CARE"

In an article entitled "How Doctors Have Ruined Health Care" published in the January 9, 1990 issue of Financial World, some startling allegations were made, including:

* About 35% of all surgical deaths and 50% of post operative complications, such as infections, are probably preventable.

* As many as 1/4 of patients who die in hospitals may have been misdiagnosed by physicians.

* Up to 35% of all hospital admissions are not needed.

* Some 15 to 30% of diagnostic tests don't help or aren't even looked at.

The above figures are said to come from a study conducted by a bi-partisan group backed by major corporations and headed by former President's Ford and Carter. The data was apparently not yet made public, but was contained in a confidential memo to a commission.

The article stated that studies published in medical journals tended to confirm these findings, since they reported, for example:

* 44% of by-pass surgeries are unwarranted or questionable.

* 20% of cardiac pacemaker implants are unnecessary and another 36% ambiguous.

* 32% of the delicate procedures performed to clear major neck arteries to prevent strokes were done with little or no justification.

Blame is put on lack of regulation and at the same time lack of self-regulation which would make outside regulation unnecessary--all which is aggravated, in the words or former Surgeon General Koop, by "the absence of such natural market-place controls as competition in regard to price, quality or service."

B. "DEADLY MISTAKES: THE BROKEN PROMISE"

Two years ago, Washington D.C. WRC-TV News 4 investigated mistakes being made in medical laboratories, and caught the attention of the nation. After Lea Thompson's report, there were hearings, then new laws, and, most important, new hope that deadly mistakes would never happen again.

The news report, "Deadly Mistakes: The Broken Promise," indicates that unneeded surgery and death continues because of laboratory errors. Two years after the first investigation, people are still dying because of laboratory mistakes.

The News 4 transcripts for "Deadly Mistakes: The Broken Promise" have been enclosed for your review.

C. "MALPRACTICE CLAIMS TAKE NOSE DIVE"

This article appeared in the October 9, 1989 edition of the St. Louis Business Journal. It reveals how the number of malpractice insurance claims have fallen in Missouri, as have the dollar amount of liability coverage for most doctors. Furthermore, the insurance companies that write medical malpractice insurance are making money.

D. "PRESSURE OFF DOCTORS AFTER INSURANCE CRISIS"

This Miami Herald cover story announced the end of the perceived medical malpractice insurance "crisis." These days, doctors are back at work, new insurers are competing to sell the high-risk coverage, and in Dade County, once the hotbed of medical malpractice lawsuits, the number and size of jury awards are on the wane. Fewer cases are being filed.

Meanwhile, Florida doctors, who claim that 30 percent of medical costs are linked to malpractice premiums and defensive medicine, have yet to cut their fees. Few physicians who dropped their coverage have renewed their policies now that rates are lower.

E. MEDICAL MALPRACTICE EXPERIENCE OF PHYSICIANS: PREDICTABLE OR HAPHAZARD?

This study uses a large malpractice database from Florida to assess the concentration of losses among physicians, predictability of claims experience, characteristics of physicians with favorable vs. unfavorable experience, and effect of claims experience on physicians' practice decisions and on action taken by the state's licensing board. Most payments by insurers involved a comparatively small number of physicians. Physicians with relatively prestigious credentials had no better, and by some indicators, worse claims experience. If anything, physicians with adverse claims experience were less likely to make subsequent changes in their practice, such as quitting practice or moving to another state. Physicians with very poor claims histories were more likely to have complaints filed against them with th Florida licensing board, but the sanctions against physicians with either poor or excellent histories were not severe. Physicians with adverse claims experience from incidents that arose between 1975 and 1980 had appreciably worse claims experience from incidents that arose during 1981 to 1983.

F. MEDICAL MALPRACTICE AND THE TORT SYSTEM

This study analyzes how evolutionary changes in legal doctrine and practice have contributed to increased claim frequency and award severity in medical malpractice cases. The author concedes that these changes do not provide a full explanation for the continued rise in awards and that no single doctrinal change has led to recent malpractice liability problems. Thus, changes in legal doctrine alone are not likely to reverse current trends, although may help to stabilize and moderate award severity. Effective medical professional peer review, risk management, and the continued development of standards to define appropriate medical intervention are needed to reduce the incidence of substandard medical care.

G. "HOSPITAL STUDY FINDS FEW SUITS, MUCH NEGLIGENCE"

This article appeared in the January 29, 1990 edition of The New York Times, and addresses the Harvard Study. The Harvard Study, carried out under contract to the State of New York, was designed to inform the policy debate now going on in New York and elsewhere about how society can best deal with its

medical injuries and malpractice.

The study had four principal components:

1. A population based measure of the incidence of injuries resulting from medical interventions, called "adverse events," and a determination of the percentage of such events that resulted from fault or negligence of the physician or other provider.

2. A determination of the percentage of adverse events, both negligent and non-negligent, that led to claims and suits. In addition, information about the numbers of claims and suits by patients in whose hospital records no evidence of injury were found.

3. Measures of the costs of medical expenses, lost wages, and lost household production to the victims of medical injuries and to their families, and their compensation for such losses under current arrangements.

4. Estimates of the degree to which variations in the threat of litigation affected the incidence of adverse events.

Among the study's other findings:

* 3.7% of patients sustained a disabling injury while they were in the hospital, or about 99,000 out of 2.7 million hospital admissions in 1984.

* 28% of injuries - representing 27,000 patients, or 1% of all admissions - resulted from negligent care. Most cases were minor: 57% of patients recovered within a month and 70% within six months. But 14% of patients, or about 14,000, died from injuries.

* About 16 times as many patients suffered an injury from negligent care as received compensation by filing malpractice suits. Only 2% of the patients that suffered a negligent injury actually filed a claim, the study said.

The Alaska Action Trust has copies of the Harvard Study in complete and executive summary form. If you would like to receive a copy, please call 258-4040.

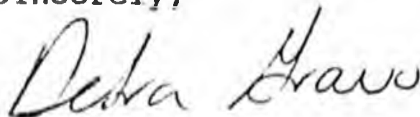
F. "MEDICAL MALPRACTICE CRISIS SHOWS SIGNS OF ABATING IN STATE"

This article appeared in the October 16, 1989 edition of the Minneapolis/St. Paul City Business Bi-Weekly. Two major Minnesota medical malpractice insurers claim that premiums are leveling off, and at the same time, the number of malpractice

claims are declining. This clearly signals the end of the perceived medical malpractice insurance "crisis" in Minnesota.

If you or your staff have any questions about any part of this informational packet, please contact the Alaska Action Trust office at 258-4040.

Sincerely,



Debra Gravo
Executive Director
dch/encl.

POSITION PAPER
CS FOR HOUSE BILL NO. 166

For an Act entitled: "An Act relating to civil actions; amending Alaska Rule of Civil Procedure 68; and providing for an effective date."

CSHB 166 offers a variety of changes to current statutes with regard to civil liability. The high cost of personal injury litigation has led the Legislature to look at methods of distributing the costs and risk of this litigation more fairly. In no area of service has the impact from personal injury litigation been more keenly felt than in the provision of health care; particularly in the cost and availability of professional liability insurance for medical providers.

The Governor's Interim Commission on Health Care made the following findings with regard to the issue of professional liability:

1. An estimated 10 percent of every medical bill in Alaska goes to medical liability insurance.

2. Medical liability insurance premiums in Alaska more than doubled between 1985 and 1988.

3. Nationally, it is estimated that 15 percent of medical costs pay for defensive medicine.

4. Rural providers, particularly those providing obstetrics care, have been particularly hard hit by the increase in professional liability insurance.

As these findings indicate, the high cost of health care and the availability of some medical services are directly linked to the high cost of professional liability insurance.

ANALYSIS

The Department has two concerns regarding Section 10, "Collateral Benefits" of this Legislation. First, paragraph (c) of this section provides that a source of collateral benefits may not recover from the claimant an amount paid as compensation for the injury, and may not be subrogated to the rights of the claimant. For the Department this means that medical assistance costs paid through the Medicaid and General Relief Medical program cannot be recovered by the state from the claimant. Furthermore, the Department may not be subrogated to the rights of the claimant to an amount paid as compensation for the injury to recover the costs of the medical assistance paid. Section 10 is in direct conflict with AS 47.05.070 which expressly subrogates the Department to the rights of the claimant to the extent of

the medical assistance provided after calculation and payment of attorneys fees.

The second problem with Section 10 derives from the first problem and relates to the Department's relationship with the federal government with regard to the Medicaid program. Each state which participates in the Medicaid program must have a state plan, which is a contract with the federal government. This plan details the way in which the state is implementing its Medicaid program. The state must, within its state plan, assure that the Medicaid program is the payor of last resort. To ensure that Medicaid is the payor of last resort, the Social Security Act at Section 1902(a)(25) requires the state to take all reasonable measures to ascertain the legal liability of third parties to pay for care and services available under the plan. Further, the Social Security Act at Section 1912 requires that a state plan provide that, as a condition of eligibility for medical assistance, the individual is required to assign the state any rights to payment for medical care from any third party. Section 10 of CSHB 166, which disallows the state from seeking reimbursement from claimants awards, places the state in the position of violating the requirements of the Social Security Act, the state plan provisions and subsequently in jeopardy of federal sanctions of part or all of its match to the state's Medicaid program.

POSITION

The Department recognizes that the high cost of professional liability insurance is contributing significantly to the rise in health care costs and the unavailability of some health care services. However, the provisions of CSHB 166 which threaten the federal government's participation in the state's Medicaid program are sufficiently serious that the Department opposes the bill in its present form.

RECOMMENDED: Kim Busch
Kim Busch, Director
Division of Medical Assistance

DATE: 3-30-90

RECOMMENDED: Myra M. Munson
Myra M. Munson, Commissioner
Dept. of Health & Social Services

DATE: Apr 3, 1990

NOTICE: This opinion is subject to formal correction before publication in the Pacific Reporter. Readers are requested to bring typographical or other formal errors to the attention of the Clerk of the Appellate Courts, 303 K Street, Anchorage, Alaska 99501, in order that corrections may be made prior to permanent publication.

THE SUPREME COURT OF THE STATE OF ALASKA

BRETT JACKSON and LINDA ESTRADA, Petitioners, v. JOHN POWER, M.D.; FAIRBANKS MEMORIAL HOSPITAL; LUTHERAN HOSPITAL AND HOMES SOCIETY OF AMERICA, INC.; EMERGENCY ROOM, INC.; WILLIAM H. MONTANO, M.D.; and GEORGE VRABLICK, M.D., Respondents.	File No. S-1677 OPINION [No. 3237 - October 16, 1987]

Petition for Review from the Superior Court of the State of Alaska, Fourth Judicial District, Fairbanks, Gerald J. Van Hoomissen, Judge.

Appearances: Michael Cohn, Dan A. Hensley, L. Ames Luce, Law Offices of L. Ames Luce, Anchorage, for Petitioners. James J. Delaney, Howard A. Lazar, Delaney, Wiles, Hayes, Reitman & Brubaker, Anchorage, for Respondents Fairbanks Memorial Hospital and Lutheran Hospital & Homes Society. Peter J. Maassen, Burr, Pease & Kurtz, Anchorage, for Respondents John Power, M.D. and Emergency Room, Inc. David C. Crosby, Council & Crosby, Juneau, for Health Association of Alaska, Amicus Curiae.

Before: Rabinowitz, Chief Justice, Burke, Matthews and Compton Justices. [Moore, Justice, not participating.]

BURKE, Justice.

STATE OF ALASKA
1990 LEGISLATIVE SESSION

BILL VERSION: ____

PUBLISH DATE: 5/9/89

FISCAL NOTE

REQUEST:

Revision Date: ____

Title: An Act relating to Civil Actions; Amending Alaska Rules of Civil Procedure 68

Sponsor: Cotton, Larson, Hoffman et al.

Requestor: ____

Agency Affected: Dept. of Health & Social Svs.

BRU: Medical Assistance

Components: Medicaid Facilities, Medicaid Non-Facility, GRM

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL	(400.0)	(400.0)	(400.0)	(400.0)	(400.0)	(400.0)
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	(400.0)	(400.0)	(400.0)	(400.0)	(400.0)	(400.0)
CAPITAL						
REVENUE						

FUNDING: (Thousands of Dollars)

	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
GENERAL FUND	545.8	545.8	545.8	545.8	545.8	545.8
FEDERAL FUNDS	(295.8)	(295.8)	(295.8)	(295.8)	(295.8)	(295.8)
OTHER	(650.0)	(650.0)	(650.0)	(650.0)	(650.0)	(650.0)
TOTAL	(400.0)	(400.0)	(400.0)	(400.0)	(400.0)	(400.0)

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

* *See the Attached Analysis* *

Prepared by: Kim Busch, Director [signature]

Phone: 465-3355

Division: Medical Assistance

Date: 2-27-90

Approved by Commissioner: (A) [signature]

Date: 4-3-90

Agency: Health and Social Services

Distribution (by preparer):
- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget
- Impacted Agency(ies)

Fiscal Note
CS for House Bill No. 166

There will be no FY90 impact.

The FY91 Medical Assistance program has budgeted program receipts of 400.0 in the contractual line for the Third Party Liability (TPL) contractor's contingency fee and 250.0 for collections and recoveries in the grants line. Total budgeted FY91 program receipts are 650.0. The following displays the budgeted program receipts allocations within the Medical Assistance components:

Line Item	GRM	Medicaid Non-Facility	Medicaid Facility	Total
300	36.0	104.0	260.0	400.0
700	22.5	65.0	162.5	250.0
	58.5	169.0	422.5	650.0

First, this fiscal note assumes that passage of this legislation would eliminate the need for the TPL recoveries contract. Secondly, this fiscal note assumes that expenditures for program services will continue regardless of whether recoveries are made or not. A third assumption is with regard to the Health Care Financing Administration's (HCFA's) reaction to the invalidation of the State Medicaid plan as a result of passage of this legislation. If past actions are indicative of future action, HCFA, at the least, will annually estimate the amount of recoveries foregone as a result of this legislation and disallow that amount from the state's claims for federal reimbursement. The most HCFA could do would be to deny federal financial participation (FFP) for all Medicaid program expenditures of 116.8 million. For purposes of this fiscal note we have presented the most optimistic reaction on the part of HCFA. Lastly, this fiscal note assumes third party recoveries will remain stable at approximately 600.0 per fiscal year.

The following table displays the FY91 impact of this legislation:

Line	Item	GRM	Non-Facility	Medicaid Facility	Total
1	300	(36.0)	(104.0)	(260.0)	(400.0)
	TOTAL	(36.0)	(104.0)	(260.0)	(400.0)
2	GF Program	(58.5)	(169.0)	(422.5)	(650.0)
3	GFM	-	(84.5)	(211.2)	(295.7)
4	Federal	-	(84.5)	(211.3)	(295.8)
5	GF	22.5	234.0	585.0	841.5
	TOTAL	(36.0)	(104.0)	(260.0)	(400.0)

The following line numbers relate to the corresponding line number on the preceding page:

1. Eliminates the TPL recoveries contract expenditure authority in accordance with the first assumption.

2. Eliminates the budgeted program receipts of the Medical Assistance components which would have been collected by the TPL contractor. As shown previously, these represent the sum of both the contract and grants expenditure lines.

3&4. The federal HCFA disallowance of estimated recoveries foregone during the year. See assumption three above.

5. Represents the required additional state general fund appropriation to maintain the program at the same level of services in light of eliminating the TPL recoveries and federal disallowances.

Introduced: 4/29/90 6-2455A
Referred: Judiciary

BY THE LABOR & COMMERCE COMMITTEE

1 IN THE HOUSE

2 HOUSE BILL NO. 597

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 SIXTEENTH LEGISLATURE - SECOND SESSION

5 A BILL

6 For an Act entitled: "An Act relating to civil actions; amending Alaska

7 Rules of Civil Procedure 68 and 82; and providing for

8 an effective date."

9 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

10 * Section 1. FINDINGS AND PURPOSE. (a) Tort law in this state has

11 generally been developed by the courts on a case-by-case basis. While this

12 process has resulted in some significant changes in the law, including

13 amelioration of the harshness of many common law doctrines, the legislature

14 has periodically intervened in order to bring about needed reforms. The

15 purpose of this Act is to enact further reforms in order to create a more

16 equitable distribution of the cost and risk of injury and increase the

17 availability and affordability of insurance.

18 (b) The legislature finds that boroughs, cities, and other govern-

19 mental entities are faced with increased exposure to lawsuits and awards

20 and dramatic increases in the cost of insurance coverage. These escalating

21 costs ultimately affect the public through higher taxes, loss of essential

22 services, and loss of the protection provided by adequate insurance. In

23 order to improve the availability and affordability of quality governmental

24 services, comprehensive reform is necessary.

25 (c) The legislature also finds comparable cost increases in profes-

26 sional liability insurance. Escalating malpractice insurance premiums

27 discourage physicians and other health care providers from initiating or

28 continuing their practice or offering needed services to the public and

29 contribute to the rising costs of consumer health care. Other

1 professionals, such as architects and engineers, face similar difficult
2 choices, financial instability, and unlimited risk in providing services to
3 the public.

4 (d) The legislature also finds that general liability insurance is
5 becoming unavailable or unaffordable to many businesses, individuals, and
6 nonprofit organizations in amounts sufficient to cover potential losses.
7 High premiums have discouraged socially and economically desirable activ-
8 ities and encourage many to go without adequate insurance coverage.

9 (e) The legislature also finds that citizens should be encouraged to
10 serve as board members and officers of public corporations and electric or
11 telephone cooperatives. These organizations serve important governmental
12 functions, and their vitality and effectiveness depend upon the willingness
13 of experienced individuals to seek leadership and decision-making roles
14 within them. Accordingly, these board members and officers should be
15 protected from liability arising from an act or omission within the scope
16 of their duties, unless the act or omission constitutes gross negligence.

17 (f) It is the intent of the legislature to reduce costs associated
18 with the tort system, while ensuring that adequate and appropriate compen-
19 sation for persons injured through the fault of others is available.

20 * Sec. 2. AS 09.10 is amended by adding a new section to read:

21 Sec. 09.10.052. CERTAIN ACTIONS THAT MUST BE BROUGHT IN SIX
22 YEARS. (a) Notwithstanding AS 09.10.140, a person may not bring an
23 action for personal injury, death, or property damage unless the
24 action is brought within six years of the earliest of

25 (1) the date a product alleged to have caused the personal
26 injury, death, or property damage was purchased;

27 (2) the date of substantial completion of the construction
28 alleged to have caused the personal injury, death, or property damage;
29 or

1 (3) the date of the last act alleged to have caused the
2 personal injury, death, or property damage.
3 (b) This section does not apply if
4 (1) the personal injury, death, or property damage was
5 caused intentionally; or
6 (2) a shorter period of time for bringing the action is
7 imposed under another provision of law.
8 * Sec. 3. AS 09.10.070 is amended to read:
9 Sec. 09.10.070. ACTIONS TO BE BROUGHT IN TWO YEARS. A [NO]
10 person may not bring an action (1) for libel, slander, assault, bat-
11 tery, seduction, or false imprisonment [, OR FOR ANY INJURY TO THE
12 PERSON OR RIGHTS OF ANOTHER NOT ARISING ON CONTRACT AND NOT SPECIF-
13 ICALLY PROVIDED OTHERWISE]; (2) upon a statute for a forfeiture or
14 penalty to the state; or (3) upon a liability created by statute,
15 other than a penalty or forfeiture; unless commenced within two years.
16 * Sec. 4. AS 09.10 is amended by adding a new section to read:
17 Sec. 09.10.075. LIMITATION ON ACTIONS INVOLVING INJURY TO PERSON
18 OR PROPERTY. (a) Notwithstanding AS 09.10.140, a person may not
19 bring an action for personal injury, death, or property damage unless
20 the action is brought within two years of the accrual of the action.
21 (b) This section does not apply if a shorter period of time for
22 bringing the action is imposed under another provision of law.
23 * Sec. 5. AS 09.17.020 is amended to read:
24 Sec. 09.17.020. PUNITIVE DAMAGES. Punitive damages may not be
25 awarded in an action, whether in tort, contract, or otherwise, unless
26 supported by clear and convincing evidence of malice, bad motive, or
27 reckless indifference to the interests of another and conscious acts
28 showing deliberate disregard by the defendant.
29 * Sec. 6. AS 09.17.030 is amended to read:

1 Sec. 09.17.030. DAMAGES RESULTING FROM COMMISSION OF A CRIME. A
2 person who suffers personal injury or death may not recover damages
3 for the personal injury or death if the injuries or death occurred
4 while the person was engaged in the commission of a crime [FELONY],
5 the person has been convicted of the crime [FELONY], including con-
6 viction based on a guilty plea or plea of nolo contendere, and the
7 crime [FELONY] substantially contributed to the injury or death. This
8 subsection [SECTION] does not affect a right of action under 42 U.S.C.
9 1983.
10 * Sec. 7. AS 09.17.030 is amended by adding new subsections to read:
11 (b) This section does not apply to a person who suffers personal
12 injury or death if the person liable for the damages
13 (1) was engaged in the commission of a crime at the time
14 the personal injury or death occurred; and
15 (2) has been convicted of the crime, including conviction
16 based on a guilty plea or plea of nolo contendere.
17 (c) In this section "crime" has the meaning given in AS 11.81.-
18 900(b).
19 * Sec. 8. AS 09.17.040(d) is amended to read:
20 (d) In an action to recover damages, the court shall, at the
21 request of a [AN INJURED] party, enter judgment ordering that amounts
22 awarded a judgment creditor for future damages be paid to the maximum
23 extent feasible by periodic payments rather than by a lump-sum pay-
24 ment. If a portion of the judgment awarded is owed to an attorney
25 under a contingent fee agreement, that portion of the judgment shall
26 be reduced to present value and paid in a lump sum.
27 * Sec. 9. AS 09.17.040(f) is amended to read:
28 (f) A judgment ordering payment of future damages by periodic
29 payment shall specify the recipient, the dollar amount of the

1 payments, including any increases in future payments for anticipated
2 inflation, the interval between payments, and the number of payments
3 or the period of time over which payments shall be made. Payments may
4 be modified only in the event of the death of the judgment creditor,
5 in which case payments may not be reduced or terminated, but shall be
6 paid to persons to whom the judgment creditor owed a duty of support,
7 as provided by law, immediately before death. In the event the judg-
8 ment creditor owed no duty of support to dependents at the time of the
9 judgment creditor's death, the money remaining shall be distributed in
10 accordance with a will of the deceased judgment creditor accepted into
11 probate or under the intestate laws of the state if the deceased had
12 no will.
13 * Sec. 10. AS 09.17.050(a) is amended to read:
14 (a) Unless the act or omission constituted gross negligence, a
15 person may not recover tort damages for personal injury, death, or
16 damage to property for an act or omission to act in the course and
17 scope of official duties, from [ONE OF] the following:
18 (1) a member of the board of directors or an officer of a
19 nonprofit or public corporation;
20 (2) a member of the board of directors of a public or
21 nonprofit hospital, or a member of a citizen's advisory board of any
22 hospital;
23 (3) a member of a school board of a school district;
24 (4) a member of the governing body, a commission, or a
25 citizen's advisory committee of a municipality of the state;
26 (5) a member of the board of directors or an officer of an
27 electric or telephone cooperative organized under AS 10.25.
28 * Sec. 11. AS 09.17.070 is repealed and reenacted to read:
29 Sec. 09.17.070. COLLATERAL BENEFITS. Except when the collateral

1 source by law or contract must be repaid and except death benefits
2 paid under life insurance, a person may recover only damages that
3 exceed amounts received by that person as compensation for the injur-
4 ies from collateral sources, whether private, group, or governmental,
5 and whether contributory or noncontributory. Evidence of collateral
6 sources, other than a source that must by law or contract be repaid
7 and the death benefit paid under life insurance, shall be considered
8 by the trier of fact in determining the amount of an award, and shall
9 be considered by the court in determining if an award is excessive.
10 The trier of fact shall be informed of the tax implications of an
11 award of damages. The court may take into account the value of the
12 person's rights to coverage exhausted or depleted by payment of these
13 collateral benefits by adding back a reasonable estimate of their
14 probable value, or by earmarking and holding for possible periodic
15 payment under AS 09.17.040 that amount of the award that would other-
16 wise have been deducted, to see if the impairment of the person's
17 rights actually takes place in the future.
18 * Sec. 12. AS 09.30.070(a) is amended to read:
19 (a) The rate of interest on judgments and decrees for the payment
20 of money is <u>eight</u> [10.5] percent a year, except that a judgment or
21 decree founded on a contract in writing, providing for the payment of
22 interest until paid at a specified rate not exceeding the legal rate
23 of interest for that type of contract, bears interest at the rate
24 specified in the contract if the interest rate is set out in the
25 judgment or decree.
26 * Sec. 13. AS 09.30.070 is amended by adding a new subsection to read:
27 (c) Prejudgment interest may not be awarded for future economic
28 or noneconomic damages.
29 * Sec. 14. AS 09.55.580(c) is amended to read:

1 (c) Except as provided in (g) of this section, in [IN] fixing
2 the amount of damages to be awarded under this section, the court or
3 jury shall consider all the facts and circumstances and from them fix
4 the award at a sum which will fairly compensate for the injury result-
5 ing from the death. In determining the amount of the award, the court
6 or jury shall consider but is not limited to the following:
7 (1) deprivation of the expectation of pecuniary benefits to
8 the beneficiary or beneficiaries, without regard to age thereof, that
9 would have resulted from the continued life of the deceased and with-
10 out regard to probable accumulations of what the deceased may have
11 saved during the lifetime of the deceased;
12 (2) loss of contributions for support;
13 (3) loss of assistance or services irrespective of age or
14 relationship of decedent to the beneficiary or beneficiaries;
15 (4) loss of consortium;
16 (5) loss of prospective training and education;
17 (6) medical and funeral expenses.
18 * Sec. 15. AS 09.55.580 is amended by adding a new subsection to read:
19 (g) The amount awarded by the court or jury for nonpecuniary
20 damages may not exceed $50,000.
21 * Sec. 16. AS 09.60.010 is amended to read:
22 Sec. 09.60.010. COSTS ALLOWED PREVAILING PARTY. The supreme
23 court shall determine by rule or order the costs, if any, that may be
24 allowed a prevailing party in a civil action. Unless specifically
25 authorized by statute or by agreement between the parties, attorney
26 fees may not be awarded to a party in a civil action for personal
27 injury, death, or property damage related to or arising out of fault,
28 as defined in AS 09.17.900 [, UNLESS THE CIVIL ACTION IS CONTESTED
29 WITHOUT TRIAL, OR FULLY CONTESTED AS DETERMINED BY THE COURT].

1 * Sec. 17. AS 09.65 is amended by adding a new section to read:
2 Sec. 09.65.096. CIVIL LIABILITY OF HOSPITALS FOR NONEMPLOYEES.
3 (a) A hospital that is required to provide services by AS 18.20 or
4 regulations implementing that chapter, or that is subject to regu-
5 lation with respect to the provision of services, is not, solely for
6 that reason, liable for civil damages as a result of an act or omis-
7 sion in administering those services by a health care provider who is
8 not an employee of the hospital.
9 (b) Compliance with the standards of a public or private licens-
10 ing or accreditation agency with respect to provision of services, or
11 adoption by the hospital of bylaws or regulations governing provision
12 of services, may not be construed as an assumption of civil liability
13 by the hospital for the acts or omissions of a health care provider
14 who is not an employee of the hospital.
15 (c) A hospital is not, solely for reason that a health care
16 provider was the actual, apparent, or implied agent of the hospital,
17 liable for civil damages caused by the acts or omissions of a health
18 care provider who is not the hospital's employee, if the hospital
19 provides notice that the health care provider is an independent con-
20 tractor. The notice required by this subsection must be posted con-
21 spicuously in all admitting areas of the hospital, published at least
22 annually in a newspaper of general circulation in the area, and must
23 be in substantially the following form:
24 Notice of Limited Liability
25 The following health care providers are independent
26 contractors and are not employees of the hospital:
27 (List specific health care providers)
28 The hospital is responsible for exercising reasonable care in
29 granting staff privileges to practice in the hospital, for reviewing

1 those privileges on a regular basis, and for taking appropriate steps
2 to revoke or restrict privileges in appropriate circumstances. The
3 hospital is not otherwise liable for the acts or omissions of a health
4 care provider who is an independent contractor.
5 (d) This section does not preclude liability for civil damages
6 that are the proximate result of the hospital's own negligence or
7 intentional misconduct.
8 (e) In this section,
9 (1) "health care provider" has the meaning given in AS 18.-
10 23.070, except that it does not include a hospital or an employee of
11 the hospital;
12 (2) "hospital" has the meaning given in AS 18.20.130 and
13 includes a governmentally owned or operated hospital.
14 * Sec. 18. AS 21.06.110 is amended to read:
15 Sec. 21.06.110. DIRECTOR'S ANNUAL REPORT. As early in each
16 calendar year as is reasonably possible the director shall prepare and
17 deliver an annual report to the legislature and the commissioner,
18 showing, with respect to the preceding calendar year,
19 (1) a list of the authorized insurers transacting insurance
20 in Alaska, with such summary of their financial statement as the
21 director considers appropriate;
22 (2) the name of each insurer whose business was closed
23 during the year, the cause of the closing, and the amount of ascer-
24 tainable assets and liabilities of each closed business;
25 (3) the name of each insurer against which delinquency or
26 similar proceedings were instituted, and a concise statement of the
27 facts with respect to each proceeding and its present status;
28 (4) a statement in regard to examination of rating organi-
29 zations, advisory organizations, joint underwriters, and joint

1 reinsurers as required by AS 21.39.120;

2 (5) the receipts and expenses of the division for the year;

3 (6) recommendations of the director as to amendments or

4 supplementation of laws affecting insurance, or the office of direc-

5 tor;

6 (7) other pertinent information and matters the director

7 considers proper;

8 (8) an analysis of medical malpractice insurance rate

9 changes occurring as a result of court decisions in the state involv-

10 ing personal injury or death.

11 * Sec. 19. AS 47.37.170(g) is repealed and reenacted to read:

12 (g) A person may not bring an action for damages against a peace

13 officer, or members of the emergency service patrol, based on the

14 performance or failure to perform a duty imposed under this section,

15 unless the act or omission of the peace officer or member of the

16 emergency service patrol is grossly negligent, reckless or intention-

17 al.

18 * Sec. 20. AS 09.17.010(c), 09.17.040(c) and AS 09.55.548 are repealed.

19 * Sec. 21. REPORT. The Department of Commerce and Economic Develop-

20 ment, with the cooperation of all state agencies, shall report to the

21 legislature by the 30th day of the Second Session of the Seventeenth Alaska

22 State Legislature on closed insurance claims and insurance company fi-

23 nances. The report must consist of

24 (1) a study of closed insurance claims to identify

25 (A) the extent to which the legal system has or has not

26 been the cause of dramatic liability insurance increases or decreases

27 and coverage reduction in crisis lines in the state;

28 (B) how victims are faring under the present system;

29 (C) what the various specific tort reform measures have

1 actually accomplished; and

2 (D) if the passage of this Act has resulted in a measurable

3 decrease in insurance rates in the state;

4 (2) a study of insurance company finances to determine the

5 extent to which

6 (A) dramatic liability insurance rate increases and cover-

7 age limitations in the state are, or are not, cost-justified in re-

8 lation to awards, settlements, and relevant court decisions in the

9 state involving personal injury, death, or property damage bas on

10 fault; and

11 (B) legislative or regulatory actions affecting the tort

12 system in the state are necessary to resolve the state's liability

13 insurance rate increases.

14 * Sec. 22. AS 09.30.070(c) as added by sec. 13 of this Act, has the

15 effect of amending Alaska Rule of Civil Procedure 68 by providing that

16 prejudgment interest may not be awarded for future economic or noneconomic

17 damages.

18 * Sec. 23. AS 09.60.010 as amended by sec. 16 of this Act, has the

19 effect of amending Alaska Rule of Civil Procedure 82 by prohibiting the

20 award of attorney fees in a civil action for personal injury, death, or

21 property damage, unless allowed by statute or by agreement of the parties.

22 * Sec. 24. APPLICABILITY. This Act applies to all causes of action

23 accruing on or after the effective date of this Act.

24 * Sec. 25. This Act takes effect immediately under AS 01.10.070(c).

Helene M. Cole, MD, Section Editor

Medical Malpractice and the Tort System

Peter D. Jacobson, JD, MPH

FEW TOPICS in health care policy generate more contentious commentary than medical malpractice. To some, the recent trend of increasing liability awards and malpractice insurance premiums is a major crisis that affects the organization and practice of medicine. To others, it is a sign that the medical profession has not yet developed adequate controls to sanction deviations from standard practice. In either case, the escalation in medical professional liability awards raises important public policy issues concerning the underlying reasons for the awards and the potential effects on medical practice and service delivery.

See also p 3291.

While the full dimension of the crisis is difficult to specify, rising malpractice insurance premiums and increased claim frequency and award severity have been, until recently, its primary manifestations. Various explanations for these trends have been proposed, with little agreement as to the nature or causes of the problem.[1-8]

Although lawyers, the legal system, the medical profession, and the insurance industry have all been "blamed" for the current medical professional liability situation, there is a growing perception that something is wrong with the manner in which the tort system assesses liability and awards compensation in medical malpractice cases. Many physicians contend that the entire claim-settlement process fails to distinguish between negligent and nonnegligent behavior in assessing liability[8,9,10] and thus exposes them to liability for adverse outcomes as well as for negligent medical practice. Large jury verdicts and relatively easy access to the court system contribute to these perceptions.

In response, much of the recent debate has focused on reforming the tort system as a solution to the recurring malpractice crisis.[11] It is more likely, however, that this crisis results from complex interactions between the medical, legal, and insurance industries and cannot be blamed on any one source. Rising health care costs, for instance, contribute to larger jury [illegible]ts, which in turn contribute to increased medical ma[illegible]tice insurance premiums. As such, medical malpractice is not one problem but a series of interrelated problems that involve the regulation and social control of medical practice, quality of care, insurance markets, and the consistent assessment of [illegible]ability by the courts.

To provide a broader context for the malpractice debate, this article will evaluate changes in legal doctrine and practice over time. The tort system op[illegible]tes to provide compensation to an injured party, to pro[illegible]entives for reducing the risks and costs of injuries (th[illegible]nce), and to provide accountability for injurious co[illegible]hough this system has been criticized as being an economically inefficient regulatory mechanism whose costs vastly exceed its benefits, this article is neither an analysis of the tort system's [illegible]rengths and weaknesses in resolving medical malpractice disputes[12] nor a broad critique of tort law.

Instead, I will analyze how evolutionary changes in legal doctrine and practice have contributed to increased claim frequency and award severity. I conclude that these changes do not provide a full explanation for the continued rise in awards and that no single doctrinal change has led to recent malpractice liability problems. Thus, changes in legal doctrine alone are not likely to reverse current trends, although tort reforms will help to stabilize and moderate award severity. Effective medical professional peer review, risk management, and the continued development of standards to define appropriate medical intervention are needed to reduce the incidence of substandard medical care.

The first part of this article is a review of medical professional liability data trends during the past 20 years. In the next section, I discuss legal trends during this period, focusing on several hypotheses that might explain the data. Finally, I suggest several public policy measures that might be undertaken in response to these trends.

MEDICAL PROFESSIONAL LIABILITY DATA TRENDS

General Trends

Assembling data to analyze empirically recent trends in medical malpractice cases can be difficult. For the most part, malpractice data are not systematically collected and analyzed, making it difficult to estimate the scope of the malprac-

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The conclusions expressed in this article are those of the author and do not necessarily reflect those of The RAND Corp.

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tice problem.[1] We know very little about the incidence of negligent iatrogenic injuries, the relationship between quality of care and tort awards, or why people seek recovery through the tort system. Other gaps in available information include the deterrent effects of malpractice liability on medical practice, the effects of malpractice insurance premium increases on the availability of services for high-risk patients, and the effects of risk-management or loss-prevention programs on claim frequency and award severity.

Regardless of these gaps, the trend in claim frequency and award severity is unmistakable. No one disputes that from the 1970s until the mid-1980s, medical malpractice award severity and claim frequency increased sharply and without interruption. Nor is there much dispute that, although there is considerable unexplained variation, awards are systematically related to injury severity, and for permanent injuries, to life expectancy.[1,4,13,14]

The available data suggest that malpractice liability is not randomly distributed in the physician population,[15] but varies according to specialty and practice location. It does not appear, however, that only a "few" physicians are responsible for a disproportionate share of malpractice tort awards. Certain specialists (particularly surgeons and obstetricians and gynecologists) have a much higher risk of being sued and of being subjected to higher awards than other physicians,[1,6,16] although there is no reason to suspect that they are more negligent than other physicians. In all likelihood, this occurs because certain procedures have a higher probability of producing adverse outcomes in the absence of error. Also, errors in these specialties are more detectable and can result in more severely injured patients than in most other areas of medical practice.

It is also generally agreed that the proportion of potentially compensable malpractice incidents that reach the claim-settlement process or tort system is low.[6,17,18] According to the widely cited study by Mills[17], only 1 in 10 legitimate malpractice incidents reaches the tort system. From this perspective, the problem is that too few, rather than too many, cases reach the tort system or claim-settlement process.[18,19] Of the cases in which a claim is filed, available data suggest that the tort system overcompensates those with modest losses while undercompensating those with very serious injuries and large losses.[1] In some cases, the tort system fails to compensate a negligently injured patient; in other cases, compensation may be awarded to someone who was not injured through substandard medical care.[19]

Claim Frequency and Award Severity

Looking first at the frequency of filed claims, Fig 1 shows sharp increases from the 1970s to the mid-1980s, with reductions occurring in the late 1980s. Between 1975 and 1985, claims per 100 physicians more than doubled,[20] while between 1976 and 1981, claims against obstetricians and gynecologists tripled.[11] Because the proportion of incidents that results in claims is very low, claim filing could show major increases over time without suggesting any increase in substandard medical practice if the percentage of claims from legitimate malpractice incidents filed rises even slightly.

For the time being, the rise in claim frequency appears to have moderated, as some recent studies have indicated a drop or leveling in both claim and paid-claim frequency.[12,21,22] In Florida, for instance, Nye et al[4] suggest that claim filing peaked in 1984. Major medical malpractice insurers report similar trends beginning in 1986.[23] It is too soon to determine whether this is a statistical aberration, a leveling before new increases, the increased costs of litigating marginal claims, or the long-term effects of state tort reforms, hospital risk-management efforts, and enhanced professional sanctions.

With regard to award severity (Fig 2), median awards have increased steadily over time in medical malpractice cases,[1,6,23,27] but the average verdict has soared.[24,25] Between 1975 and 1984, average medical malpractice verdicts increased at nearly twice the rate of the consumer price index.[6] In one study,[27] the average expected medical malpractice

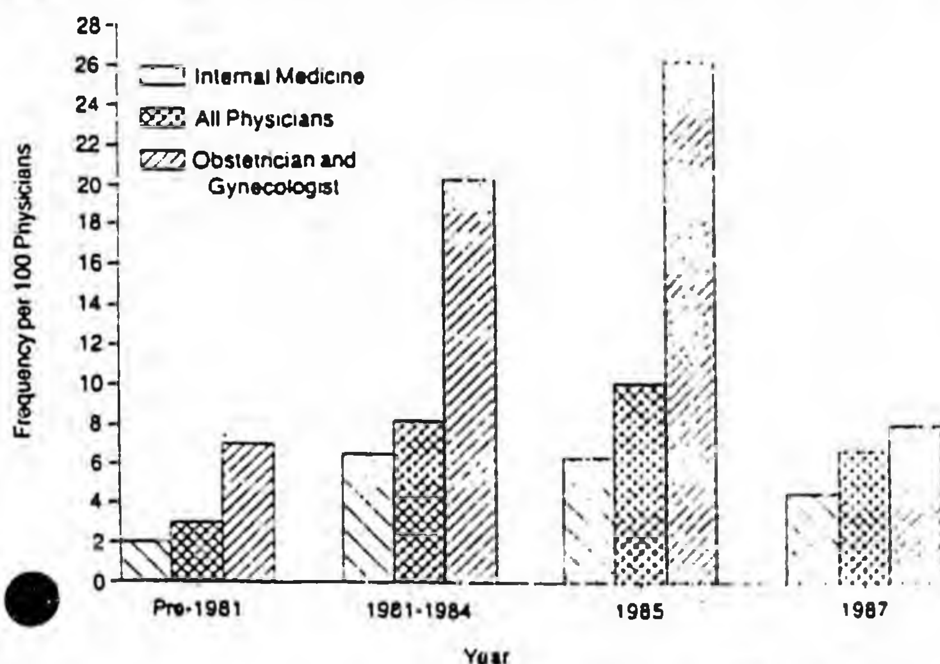

Fig 1.—Malpractice claim frequency. Data from the American Medical Association, Socioeconomic Monitoring System.

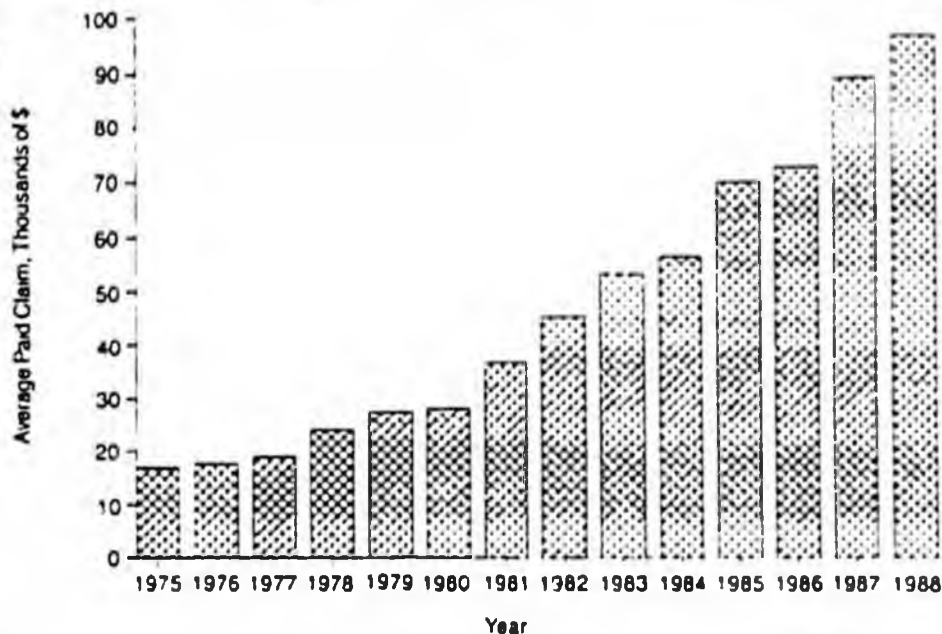

Fig 2.—Trends in medical malpractice paid claims. Data from the St Paul (Minn) Fire and Marine Insurance Company.

verdict in two jurisdictions was compared during two time periods, 1975 to 1979 and 1980 to 1984, showing a threefold rise in San Francisco, Calif, and a fivefold rise in Cook County, Illinois. Likewise, Nye et al[6] found that between 1975 and 1986 inflation-adjusted mean paid claims rose fivefold, while inflation-adjusted median paid claims rose nearly threefold. Average yearly increases reflect these trends.[illegible] In real terms, Nye et al[6] found that the average cost of a paid claim in Florida increased at a compound rate of 7.6% per year from 1975 to 1986.

Even with fewer claims, neither median nor average awards have yet declined, although the steep rise in average awards seems to have moderated. Thus, recent malpractice insurance premium reductions appear to result from declining total paid claim dollars rather than from declining median or average awards. Despite a reduced claim-filing rate, the average award paid by St Paul (Minn) Fire and Marine Insurance Company (a major underwriter of medical malpractice insurance) increased by 16% from 1986 to 1987 and by 6% from 1987 to 1988.[illegible] As with the decline in claim frequency, it is too soon to determine whether continuing tort reforms will ultimately result in reduced median and average awards, although local variations may result in greater reductions in certain areas.

The award severity data reflect a skewed distribution, attributable to an increase in large outlier awards. In the 1980s, million-dollar awards accounted for a disproportionate share of tort indemnity awards generally, and of medical malpractice awards in particular.[illegible] Recent data, however, suggest that the frequency of million-dollar awards has declined. If this trend continues, average award severity may also decline.

It seems likely that birth-injury cases have an inordinate effect on malpractice statistics. In 1984, according to the General Accounting Office,[illegible] obstetricians accounted for 10% of total claims, but 27% of total indemnity. The St Paul Fire and Marine Insurance Company[illegible] reports that birth-related injuries have replaced anesthesia-related injuries as the most costly claims. One study of California claims[illegible] found that by excluding birth-injury cases, average indemnity of reported large losses (verdicts and settlements of more than $50 000) would have declined by 28% from 1983 to 1986.

Finally, most claims are settled without any payment and defendants win most of the litigated cases. A recent survey in three largely rural states reported that the defense prevailed in 81% of the litigated cases.[illegible] Data from the 1987 American College of Obstetricians and Gynecologists survey[illegible] indicate that defendants won 68% of all claims adjudicated by arbitration or jury verdict, although this was down from 81% reported in the 1985 American College of Obstetricians and Gynecologists survey.[illegible] At least in urban areas, however, plaintiffs may be winning a higher percentage of medical malpractice verdicts than 20 years ago. Peterson[illegible] reports that plaintiffs' victories in medical malpractice cases increased during a 20-year period from 27% to 53% in San Francisco, Calif, and from 25% to 49% in Cook County. This is consistent with other findings showing that urbanization is an important predictor of award severity.[illegible]

Data Constraints

In evaluating these data, some important limitations must be considered. Aside from major gaps in available data, the reported data cannot be compared easily. Each data-reporting system uses a different standard for defining the principal allegations of negligence, and each system uses different assumptions and numerical bases for data reporting. Some report data from all claims and expenses (ie, defense costs), including settlements and those in which no indemnity was paid. Others report averages only on a claims-paid basis or by looking at nonzero jury awards alone. Because many of the claims filed result in no indemnity payments, how those are incorporated into the figures makes a major difference in the apparent scope of the problem.

One result of these different approaches is that estimates of average verdicts vary widely (Fig 3), and statements about averages need to be scrutinized. As an example, Jury Verdict

Research[#] reports that the annual average medical malpractice verdict rose from approximately $400 000 in 1980 to $1.4 million in 1986. Since this report only includes averages for [illegible]ial jury verdicts (unadjusted for posttrial reductions), it [illegible]vides a misleading picture in view of indications that large jury awards are often substantially reduced in posttrial proceedings. In medical malpractice cases, for instance, Shanley and Peterson[#] found an average posttrial reduction of 33%. They also found that reductions were disproportionate to large awards, with medical malpractice awards between $1 million and $10 million reduced by an average of 39%. Broder[11] found similar reductions. Thus, if the data regarding award severity disregard the effects of posttrial reductions, the averages misstate the dimension, although not the seriousness, of the medical malpractice problem.

Given the rise in health care costs over an equivalent period, it is not surprising that jury verdicts are higher. The soaring economic cost for treating permanent and total disabilities is no doubt a factor in many of these large verdicts. General rising salaries may also account for some portion of larger economic losses (*New York Times*, January 31, 1988;sect 3:2). This raises the question of what proportion of these large verdicts is for noneconomic damages. If most of a large verdict is for injury severity, as expressed through economic damages, and liability is accurately assessed over a range of cases, the rise in award severity may be a function of factors beyond control of the tort system. Unfortunately, the data are inconclusive on this issue, and further research is needed to isolate the effects of noneconomic damages on increased award severity relative to economic loss.[1°]

LEGAL TRENDS

The rise in claim frequency and award severity has occurred during a period of continued advances and improvements in medical care. It thus seems unlikely that a general deterioration in medical practice standards accounts for these trends. Nor is there any reason to believe that individual physicians are less skillful today than they were 20 years ago.[##]

What factors, then, account for the trends described previously? Whatever external factors may also be involved, such as increases in medical costs, it is appropriate to analyze changes in the tort system during the past two decades. Have standards for assessing liability changed so that physicians are now held to higher practice standards? Are courts and juries confusing adverse outcomes with physician error? If not, what other explanations might be explored? The following sections evaluate various hypotheses that link the rise in award severity to changes within the tort system.

Are Physicians Now Held to Higher Practice Standards?

One hypothesis often used to explain trends in medical malpractice liability is that courts and juries are holding physicians to higher liability standards, amounting to strict liability, instead of the traditional fault-based negligence standard of care. If this hypothesis were true, it could certainly explain much of the increase in claim frequency and award severity, as well as suggesting reasonable solutions.

In *strict liability*, a physician could be held liable for adverse outcomes regardless of fault. For a plaintiff to recover in *negligence*, he or she must show that the physician was at fault by failing to maintain the customary standard of care owed to the patient. *Customary care* is typically defined as the degree of care and skill ordinarily used under similar circumstances by members of the profession. In medical malpractice, the applicable standard of care is established by the medical profession itself through expert medical testimony.[#]

Little evidence exists in the reported cases to confirm the strict liability hypothesis. In fact, a perusal of numerous medical malpractice cases decided within the past 20 years indicates considerable stability in the general common-law rules. The standard of liability remains what it has always been: a fault-based determination of whether the physician maintained the applicable standard of care.

Technological Change.—A possible explanation for the perception of strict liability is that although the standard of

Fig 3.—Ways of computing average awards. A indicates St Paul, Minn, 1986, all claims; B, General Accounting Office (GAO) 1984, paid obstetrician and gynecologist; C, St Paul 1981 to 1985, paid obstetrician and gynecologist; D, GAO 1984, paid obstetrician and gynecologist; E, St Paul 1985, average paid losses; F, GAO 1984, paid claims; G, American College of Obstetricians and Gynecologists 1985, average claim; H, all California 1980 to 1984, expected award; I, San Francisco, Calif, and Chicago, Ill, 1980 to 1984, expected award; and J, Jury Verdicts Research 1986, verdict only.

care has not changed, how it operates in practice and what is necessary to meet the standard may have shifted over time. In large part, this change in how the standard operates is driven by advances in technology, improvements and changes in medical practice, and changes in legal organization and practice. As technology changes, medical standards change, and what constitutes a minimum standard of care also changes. Although difficult to quantify, it is likely that the introduction of new technology has raised what is considered to be customary care to much higher levels, giving the appearance of meeting a higher standard in court.

Along with opportunities for improved health care, technological advances create more opportunities for error, either in diagnosis or treatment, and those errors may result in more visible and more severe adverse outcomes. The availability of new technology is a particular problem for obstetric and gynecologic practice because much of it is controversial and may not add to improved health care,[illegible] while paradoxically contributing to a higher operating standard of care. Some technologies, such as genetic testing, electronic fetal monitors, and ultrasonography, carry the risk of increased liability either through failure to use in certain situations or for improperly interpreting the results.[illegible] Technological advances may have also helped to create an environment of perhaps unrealistic patient expectations that every neonate (or indeed any medical outcome) will be perfect. The ability to save a severely injured low-birth-weight infant, when that same infant would not have survived 20 years ago, carries with it the potential for litigation that blames the obstetrician for the injuries.

Expert Testimony.—In addition, with the demise of the locality rule, which virtually limited testimony to the standard of care in the defendant's practice area, plaintiffs have access to a wider array of previously unavailable testimony from experts outside the local area. This moves the changing standard down to the practitioner much faster, particularly since out-of-state or academic experts may practice a different, that is, higher standard of care than practiced locally. However, this does not mean that a de facto strict liability standard has replaced the negligence standard. The question is how quickly these changes should be adopted by the average practitioner at a time when changes occur very rapidly.

Defensive Medicine.—Another possible explanation for the perception of a higher standard of care is that the familiar problem of defensive medicine also operates to raise the standard of care. To the extent that physicians order additional tests as protection against subsequent liability, the added tests become part of the changing standard of care. This may, however, be as much a reaction to new practice standards as a cause of them. It is also difficult to distinguish defensive practices from those that are beneficial and would have occurred anyway,[illegible] and there appear to be no data that link them to increased claim frequency or award severity.

Jury Generosity

A second hypothesis is that "jury generosity" is a major reason for these trends. To be sure, it is possible that juries systematically confuse adverse outcomes with substandard care, disregard judicial instructions, and hold "deep pocket" defendants to a higher standard of care, or even confound the notion of liability with damages.[illegible] Individual juries may hold defendants in medical malpractice cases to a higher standard of conduct than would be applicable to an individual defendant. More broadly, critics of the tort liability system often allege that juries may view themselves as an instrumentality for redistributing wealth.

However, since there is very little systematic evidence regarding jury behavior, it is speculative to blame juries for not following the law when defendants win most of the litigated cases. Indeed, Danzon[illegible] concluded that available data refuted the assertion that juries disregard fault when assessing liability, and judges have the authority to overrule juries that clearly disregard either the evidence or the judge's instructions.[illegible] No doubt, some courts and juries assess liability incorrectly, but it has not been shown that courts or juries systematically assess liability improperly or impose an improper standard of care on physicians.

When evaluating jury behavior in medical malpractice cases, two interrelated issues should be considered. The absence of definitive research on appropriate outcomes from medical procedures (that is, the distribution of outcomes that can reasonably be expected from medical intervention) makes it difficult to establish whether the outcome in any given situation results from inappropriate care (negligence) or bad luck.[illegible] Confounding this problem is the equally difficult issue, particularly in birth-injury cases, of attributing an adverse outcome to a particular cause. Scientific notions of causation (established through probabilistic reasoning) are very different from the legal determination of proximate cause and can be difficult to reconcile in an individual case.

While a detailed discussion of the causation issue is beyond the scope of this article, one example might illustrate the problem. According to epidemiologic research, the incidence of newborns who have cerebral palsy has remained stable at anywhere from 1.3 to 2.7 per 1000 live births.[illegible] However, the etiologic factors that lead to cerebral palsy are not well understood and can rarely be predicted on the basis of perinatal events.[illegible] It is thus difficult to attribute an outcome of cerebral palsy to a preventable perinatal event or, in other words, to observed substandard medical care.[illegible] Nonetheless, a jury must decide what happened to an individual victim during the birthing process (based on the best available scientific evidence), hardly an easy task.

Juries may well be more sympathetic to a severely injured newborn in attributing causation to physician error,[illegible] but there is insufficient empirical or case support for that conclusion.[illegible] A review of reported obstetric and gynecologic cases is inconclusive on this point, and insurance company data are not available to confirm or refute this. Once again, the legal rule itself seems to be stable over time[illegible]; whether it operates differently in practice is harder to determine from the reported cases.

For example, it is possible that reduced standards of evidence make it easier for plaintiffs to show a causal connection, or that the availability of expert testimony allows "causation" cases to go forward. Perhaps a greater percentage of causation cases are now reaching the courts, resulting in larger verdicts. A researchable hypothesis, for example, is that courts are seeing different types of cases, raising more difficult notions of causation, than those that were presented 20 years ago. If so, the trends described previously may be a function of judging a different class of issues rather than the unpredictability or randomness of jury verdicts.

Substantive Changes in the Law

Despite the previous discussion, the law has not remained static during the past 20 years; far from it. A third hypothesis is that there have been considerable proplaintiff substantive changes in the law that may affect claim frequency and award severity. Many changes have indeed been proplaintiff, such as the abolition of the locality rule, abolition of charitable immunity, expansion of informed consent, and expansion of *respondeat superior* (that is, employer liability for employee wrongdoing).

Proplaintiff Reforms.—One of the unanswered empirical questions is the extent to which each change has contributed to changes in aggregate tort liability awards. Danzon[9] found statistically significant effects on claim frequency and award severity in jurisdictions that adopted the four proplaintiff doctrines listed previously, but the effects peaked in 1976 and then declined. In an analysis of data from the American Medical Association, Adams and Zuckerman[11] found that none of these doctrines had a statistically significant effect on claim frequency. Although the doctrine of informed consent in particular has generated considerable critical commentary and attention, it does not appear to have had a significant impact on award severity. The study by Adams and Zuckerman[11] indicates that informed consent had a statistically significant relationship to increased claim frequency between 1976 and 1981, but their study did not address award severity. Danzon,[9] however, found the effects of informed consent to be larger on claim frequency than on award severity. If so, this may add to the transaction costs of defending such cases (hence, increasing aggregate costs for insurers), but may not add that much to average award severity.

In view of these findings, it is unlikely that the proplaintiff changes are a major cause of the current malpractice crisis, although they may contribute to the rising percentage of plaintiffs' victories.[9] To be sure, these changes could also contribute to larger aggregate payouts if more claims are successful, even those of modest value.

Prodefendant Reforms.—In reaction to the proplaintiff reforms, a "counterreformation" set in during the mid-1970s (and continued into the 1980s) as several prodefendant tort reforms were enacted. These included caps on noneconomic damages, mandatory collateral offset (that is, any award is net of other benefits), shorter statutes of limitation (the time period in which litigation must be initiated), and the use of arbitration panels. These reforms apparently have reduced award severity from levels they otherwise might have reached.[9,11] While the long-term effects of state tort reform efforts are still not fully known,[9] recent evidence suggests that the counterreformation is introducing greater stability and predictability on average. Over time, tort reforms are likely at least to limit the rate of increase in award severity and claim frequency. These reforms will perhaps reduce average or median awards, but will not reduce the underlying rate of medical malpractice incidents.

Liability Expansions.—Finally, the types of cases in which liability might be determined have expanded during the past two decades. One example is the ability to recover emotional damages without showing a physical impact (although not adopted in all jurisdictions). Another example is recovery for loss of a chance of survival. Where the alleged medical malpractice reduces a chance of survival to an even lower probability, the injured victim may recover to the extent the malpractice reduced the chances of survival. For two reasons, however, this is unlikely to have a major effect on aggregate trends: first, the doctrine is not accepted in all jurisdictions; and second, awards are not likely to be large in any event because recovery is limited to damages that directly result from the premature death, such as lost earnings and additional medical expenses.[44]

An area of new liability that may be extremely troublesome to obstetricians and gynecologists is the tort of wrongful life or wrongful birth. Most jurisdictions deny liability for wrongful life (that is, a claim for damages brought by an impaired child's parents who allege that but for defendant's negligence the child never would have been born), but a growing number of jurisdictions allow recovery for wrongful birth (which is the parents' claim for damages that result from a prenatally detectable severe birth defect).[44] As discussed previously, the technological ability to save infants, albeit in imperfect condition, who would not have survived 20 years ago carries with it the potential for extensive liability awards. Genetic screening tests, although not now a liability problem, also have the potential for large indemnity awards if erroneous test results are imputed to physician error.

At the same time, there are indications that courts are beginning to restrain further expansions. Recent cases in New York, have denied separate compensation for loss of enjoyment of life by an unconscious medical malpractice plaintiff. Such rulings may not reduce current award levels, but they may place upper bounds on aggregate award severity.

Changes in Procedural Rules

Beyond these changes in substantive law, there have been significant procedural changes (that is, the rules of evidence that govern how trials are conducted) that may also affect trial outcomes. Little is known empirically about the relationship between procedural changes and trial outcomes, but it is reasonable to expect that procedural changes can affect both claim frequency and award severity. By the mid-1970s, most state courts had adopted the more flexible federal rules of discovery and federal rules of evidence. These rules allow plaintiffs' lawyers greater opportunities for pretrial discovery and, hence, an expanded ability to discover and introduce into evidence factors that may either prove liability or increase a case's monetary value. In addition, courts have come to rely more heavily on expert witnesses, particularly economists, to estimate future health care costs. With access to a wider array of previously unavailable expert testimony, plaintiffs are able to present stronger cases and damage estimates to juries.[9] Such changes operate to facilitate the plaintiffs' burden of proof and allow any number of cases, which otherwise might not have gone very far, to achieve a positive settlement or to be decided by a jury.

The use and importance of expert witnesses is an aspect of medical malpractice litigation in need of further research. Like other procedural changes, the changing use and reliance on expert witnesses may be an important determinant of large awards, particularly in estimating future health care costs of neurologically impaired infants.

Changes in Legal Practice

An additional explanation for the data trends is that changes in the organization and practice of law may influence

jury behavior[7] and certainly influence the types of cases brought to trial. Lawyers' courtroom presentations and tactics may be more sophisticated (shared information, better pretrial discovery, expert witnesses), so that their trial presentation is more convincing. For example, the use of videotapes and other litigation tools that show a day in the life of an injured patient enables a plaintiff's attorney to present a case more graphically to the jury than before.[7] Juries may also be hearing stronger cases since lawyers may be more selective in cases taken to a jury.

This further suggests that there has been an important shift during the past 20 years in the balance between plaintiff and defense attorneys. Just as the practice of medicine has become increasingly specialized, so has the practice of law, mirroring trends throughout society (*New York Times*. September 9, 1988;sect A:19). In all probability, greater specialization permits larger capital investment in malpractice cases, sharing of knowledge and training with other specialists, and better preparation for litigation. Access to computer databases and institutional support mechanisms increases the likelihood of litigating the "right" cases for substantial awards. One consequence of this is to provide greater access to the tort system for injured patients (at least for those cases where the expected value exceeds the costs of litigation).

Ongoing changes in the organization and practice of law are not likely to affect outcomes to the same extent as changes in legal doctrine or procedure, but they can affect what types of cases reach a jury and how a jury might respond. More research is necessary to determine the extent to which these organizational and practice changes have affected trial outcomes.[M] When taken together, however, these changes provide a clearer picture of the legal system's role in explaining recent trends.

PUBLIC POLICY RESPONSES

If changes in the tort system over time are inadequate to explain fully the rise in claim frequency and award severity, then tort reform alone is unlikely to solve the malpractice problems faced by physicians. Indeed, focusing exclusively on tort reform is likely to obscure the inherent complexity underlying the malpractice conundrum and the need to develop broader approaches for ameliorating the problem.

At a time when demands for changing the tort system are increasingly articulated, the empirical basis for making sound policy decisions is inadequate. Nonetheless, it is quite possible, if not likely, that demands for change will not wait for the extensive research needs cited previously. Assuming that recent reductions in malpractice premiums provide a "window of opportunity" for further debate, several measures can be taken to better inform the policy process, regardless of what mechanism is used to resolve medical practice disputes.

First, and most important, the medical profession should expand work that has already begun to define what constitutes appropriate medical intervention and what the appropriate outcomes are from medical intervention.[4] Defining the range and probabilities of appropriate outcomes will provide a sounder basis for juries to differentiate between adverse outcomes from the natural course of disease and substandard medical care. In conjunction with appropriateness standards, the medical profession should also expand the use of medical practice protocols similar to the one developed for anesthesiology.[M]

Second, to the extent that the problem begins with substandard practice, the burden is on the medical profession to reduce the incidence of negligent iatrogenic injury.[M] The medical profession should continue to improve its sanctioning and risk-management and loss-prevention mechanisms. In the past, these have not been used effectively, and substandard medical practice has often not been punished.[M] As a result, the tort system has imposed certain social controls as a deterrent to substandard medical care. The burden should be shifted back to the medical profession to reduce injury costs through effective monitoring and sanctions. An important research question is the extent to which these self-policing mechanisms operate to reduce injury and litigation costs.

To assist the medical profession, states need to enact legislation that insulates peer review activity from liability except in cases that involve gross negligence or recklessness. In conjunction with the Health Care Quality Improvement Act of 1986, such legislation should provide sufficient protection to encourage active peer review.

Third, policymakers should consider whether cases that involve probabilistic causation, such as with neurologically impaired infants, should be removed from the tort system and resolved under a separate compensation mechanism similar to vaccine injuries. In cases where medical intervention is less likely to alter observed outcomes, such as cerebral palsy, it may be appropriate to spread the risk of birth injury through a separate compensation fund rather than trying to reconcile probabilistic and legal causation in an individual case. This would address a difficult problem facing physicians without undermining the tort system's general deterrence value. As the Virginia legislation dealing with neurologically impaired infants suggests, however, this is not an easy task.

Fourth, in conjunction with the previously mentioned measures, malpractice data need to be collected and arrayed in a more consistent and comprehensive manner to avoid comparability problems and to provide better information for injury prevention. In particular, insurance companies should take the lead in reporting disaggregated data by primary allegation (such as specific birth injury) and alleged treatment error (such as what caused a missed diagnosis). This would allow aggregate trends to be broken down into more discrete injury categories for closer evaluation. While initially more expensive, doing so should assist in reducing injury costs. Insurers should also report median awards and settlements (because they are more representative of the expected result than average awards),[M] and all claims (including claims with no payment and verdicts for the defense) as adjusted for posttrial reductions and increases in medical care costs.

CONCLUSION

As is so often the case when commenting on medical malpractice problems, more questions have been raised than answered. No single explanation of the medical professional liability crisis is likely to answer all questions. Changes in the tort system over time may help explain some of the reasons for increased claim frequency and award severity and may clarify the policy options for reforming the tort system. Tort reform by itself, however, is unlikely to be a panacea without an invigorated response from the medical profession. In the absence of effective sanctions from the medical profession, the tort system is likely to remain the dominant mechanism for monitoring injury prevention.

At best, the tort system is an imperfect instrument for locating risk and resolving medical practice disputes be-;een physician and patient. No-fault and other alternative [illegible]nsation systems are promising reforms, but whether [illegible] are superior alternatives to the tort system remains to : demonstrated.

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HOSPITAL STUDY FINDS FEW SUITS, MUCH NEGLIGENCE

NEW YORK CASE ANALYSIS

Numbers Show 7,000 Deaths and Many More Injuries Are Linked to Errors

By KEVIN SACK
Special to The New York Times

ALBANY, Jan. 28 — A long-awaited study of malpractice in New York hospitals, perhaps the most comprehensive ever conducted in the United States, concludes that thousands of hospital deaths and tens of thousands of injuries are tied to negligence each year but that relatively few victims seek recourse in the courts.

In 1984, the year analyzed in the study, negligence of doctors or hospital staff members may have contributed to approximately 7,000 hospital deaths and an additional 29,000 injuries, according to preliminary estimates made by a team of researchers from Harvard University.

The researchers determined that just over 1 percent of the 30,195 patients studied were treated negligently. But there were 10 times more instances of negligence than malpractice claims filed in the state for that year.

Potential National Debate

Those statistics are expected to fuel a national debate about the efficacy of the medical malpractice system. Because of the study, which was commissioned by the state in 1986, and because New York's Health Commissioner has proposed a controversial system of no-fault malpractice insurance, much of that debate may center in Albany.

The state has yet to release a report detailing the study's findings, which is more than a year overdue. But David Axelrod, the State Health Commissioner, has had a draft of the report since November and members of his staff have been briefing groups of legislators, doctors, lawyers and consumer advocates about its contents.

A transcript of a tape recording of one of those briefing sessions was made available to The New York Times. Several state officials confirmed the statistics in the transcript.

Grist for 2 Mills

They said the statistics are preliminary and might change marginally by the time the final report is issued, possibly within the next two months.

The study's findings are being used by both sides of the debate on medical malpractice to support very different policy proposals.

On Wednesday Dr. Axelrod used the study to support his call for a system of no-fault medical malpractice insurance, a radical overhaul of the existing legal liability system.

Trial lawyers and consumer advocates, meanwhile, believe that the important number is what all sides agree is a disturbing level of malpractice, and they are lobbying for more stringent state policing of the medical profession.

Dr. Axelrod refused to comment on the specific study because it had not been released in final form. His spokesman, Peter Slocum, said the study will show that "neither the malpractice nor the misconduct systems are doing an adequate job in terms of deterring bad medical practice or compensating the victims."

The state commissioned the $2.9 million study to provide guidance for efforts at reforming the legal liability and medical discipline systems.

30,195 Cases Reviewed

The Harvard professors, who come from the university's medical school, law school and school of public health, supervised a review of the records of 30,195 randomly selected patients who were treated in 1984 at 51 hospitals around the state.

Teams of two doctors reviewed each hospital case to determine whether a patient suffered an "adverse event" or a "negligent adverse event."

An adverse event was defined as an injury due to medical management that resulted in a prolonged hospital stay or reduced function at the time of discharge, like an unexpected infection or a fall from a hospital bed. The adverse event became negligent if caused by a failure to meet standards reasonably expected of the average doctor. Among such adverse events are careless surgery, misdiagnosis of condition, or improper prescription of drugs.

In an article about the study's methodology in The New England Journal of Medicine in August, the only example of negligence given by the researchers was prescribing penicillin to a patient with a known hypersensitivity to the drug if the doctor did not ask about the patient's history with the drug. They wrote that a similar injury would not be negligent if a patient was asked his medical history and had never knowingly taken the antibiotic.

Often Not Clear Cut

The researchers conceded in the article that "judgments of causation and negligence are often not clear cut." To determine negligence, they established a scale of one to six points, with one being no evidence of negligence and six being virtually certain evidence.

Cases were considered negligent if the ratings given by the two reviewing doctors averaged four points or more.

Of the approximately 30,000 cases studied, the doctors found that adverse events occurred in 1,278 of them, or 4.74 percent when the numbers were weighted for statistical accuracy. They documented 306 negligent adverse events, or 1.35 percent after weighting.

When the professors applied those percentages to the total number of hospital cases in the state that year, they concluded there were 36,000 cases of negligence, including 7,000 deaths related in some way to negligence.

47 Malpractice Claims

State officials stress that those deaths were not necessarily caused by negligence. In some cases, they said, the negligence could have shortened life by only a day.

Although the figures found in the Harvard study generally agree with those found in a study conducted in California in 1974, leaders of some medical and hospital groups expressed skepticism about the methodology of the Harvard study.

"The only time you can really define negligence is through the jury process," said Kenneth E. Raske, president of the Greater New York Hospital Association, adding that negligence is a "subjective judgment."

Of the cases reviewed, only 47 patients filed malpractice claims. Many of those, however, were filed in cases where the researchers found no evidence of negligence. They found that only eight of the 306 negligence victims filed lawsuits.

New York Times, Jan. 29, 1990

Why So Few Lawsuits

Lawyers interviewed last week cited several reasons why few legal claims are filed. Studies by insurance companies show that fewer than 40 percent of malpractice plaintiffs win their cases and that while some winners are awarded multimillion dollar verdicts, the majority receive much lower sums.

The negligence numbers could prompt national debate.

The cases typically are expensive to try, particularly because of the need for expert witnesses, and often take years to complete.

In recent years, lawyers and plaintiffs have been discouraged from filing some lawsuits because of changes in state law. The most significant reform placed a $250,000 limit on the amount a successful plaintiff can be paid in a lump sum, with the rest paid over 10 years.

Dr. Axelrod said he believes that a no-fault malpractice system, which would take most cases of negligence away from the courts and hand them to administrative panels much like workers compensation boards, would make compensation available to more victims. He has said he would be willing to phase in such a system, beginning with no-fault coverage for cases of brain-damaged newborns.

An Unwieldy Process

His critics believe that approach would eliminate the deterrence to poor medical care provided by the threat of legal action. The system is not working now, they claim, because the state has not been stringent in disciplining negligent doctors.

Although the Harvard study estimated there were 36,000 cases of hospital negligence in 1984, the state's Office of Professional Medical Conduct took an an average of 236 disciplinary actions in each of the last four years. Many of those disciplinary measures were for offenses that are unlikely to instigate malpractice suits, like falsifying records or insurance fraud.

The state began pumping more money into the medical discipline system in 1986, but the process remains unwieldy. It involves seven levels of review in both the Department of Health and the Board of Regents. Cases frequently take two to three years.

Gov. Mario M. Cuomo and Dr. Axelrod support legislation to streamline the process, largely by removing the role of the Board of Regents.

The New York Public Interest Research Group, which has lobbied for stricter enforcement, believes the state should also recertify doctors with a vigorous review at least once every five years. The group has encouraged the state to toughen penalties against doctors and hospital employees who do not report cases of negligence they see.

Medical malpractice crisis shows signs of abating in state

Premiums leveling off, and so are concerns over costly jury awards

By RHONDA HILLBERY

Officials with two major Minnesota medical malpractice insurers said the number of malpractice claims is declining, resulting in a leveling off of premium rates.

It may be too soon to conclude that the days of upwardly mobile medical malpractice insurance rates are over, but officials with The St. Paul Cos. and Minnesota Medical Insurance Co. (MMIC) are optimistic.

"That's a trend we're very happy to see," said Lee King, vice president of underwriting at physician-owned MMIC, which was created in 1980 and insures about 73 percent of the state's physicians who buy private insurance.

At MMIC, the average family physician's premium rate rose only slightly from 1988 to 1989, from $3,421 to $3,850, and the premium for a general surgeon dropped from $16,836 to $15,711. MMIC raised premiums 17.5 percent over the past two years, but plans no increases for 1990. MMIC officials said the firm offers doctors and surgeons an average savings of 20 percent of the premiums charged by commercial insurers.

At The St. Paul Cos., the average premium for family physicians in 1989 is $5,679; general surgeons pay $22,718. In April, the firm had slashed premium rates an average of 14.1 percent across the country and 25 percent in Minnesota.

MMIC and similar insurance companies across the country were formed in response to rising malpractice premium costs and the declining availability of the insurance.

In 1985, between 11 and 12 MMIC physicians per 100 filed malpractice insurance claims. That figure dropped off to 8.5 per 100 by 1988, King said. The St. Paul Cos. reported 13 claims per 100 doctors in 1988, the lowest it has received since 1982.

Nationally, The St. Paul Cos. said it remains the dominant single medical liability insurer, but physician-owned groups control an estimated 55 percent of the market for medical malpractice insurance.

Physician-owned insurers proliferated during the national medical malpractice insurance crisis of the mid-1980s. A number of well-publicized, expensive claims drove many commercial insurers out of business, leaving The St. Paul Cos. as one of the few survivors in the risky malpractice arena.

Most of MMIC's business has come from new physicians and former customers of The St. Paul Cos.

"The first year we started, we had 100 physicians," said MMIC's King. "They [The St. Paul Cos.] certainly were in the dominant position then."

MMIC has grown to about 3,500 members statewide. The St. Paul Cos. insures about 1,800 doctors and surgeons in Minnesota and a total of 31,000 nationwide. There are 8,000 practicing doctors and surgeons in the state, according to the state Medical Examiners Board.

"The portion of the profits that a commercial insurer might channel back to the shareholders in the form of dividends, we channel back into the rate formula in the form of lower rates for policyholders."

Said Dr. George V. Tangen, chairman of the MMIC board. "Being physician-owned and -controlled, we've been able to deal with personal concerns of physicians, and have more direct involvement than you would find with a large carrier."

Officials of The St. Paul Cos. declined to discuss the company's competitive relationship with MMIC.

Gloria Vogel, insurance analyst for Bear Stearns in New York City, said that although The St. Paul Cos. has lost many physician policyholders to mutual firms, the company has as much business as it wants.

In 1986, The St. Paul Cos. declared a moratorium on writing new medical liability policies. "We were being inundated with new business proposals, more than we could handle," said company spokesman Barry Johnson. "We needed to maintain a balance between our medical and other lines."

The St. Paul Cos. lifted the moratorium a year and a half ago. Its medical malpractice

insurance subsidiary, St. Paul Fire & Marine Insurance Co., writes 32 percent of its business in medical services, and about half of its medical liability line serves physicians and surgeons, Johnson said.

Why has the climate for malpractice insurance become more hospitable? "People don't seem to be suing their doctors as often," said Vogel. "It's not clear why."

Officials with both The St. Paul Cos. and MMIC said they may have part of the answer: Doctors themselves have helped to lower the incidence of malpractice suits.

The St. Paul Cos. introduced a self-inventory risk assessment that is designed to help doctors identify pressures, handle stress and improve communication with patients.

According to Bruce Barge, director of the firm's loss control program, "Physicians are at a higher than average risk for burnout and other outcomes related to stress. The demands faced by physicians also can affect their performance and the likelihood of a malpractice suit."

MMIC officials said the trend is so new, it is difficult to know precisely why claim rates are lower. "There aren't any revolutionary things going on, but there is better education and doctors are paying more attention to certain things like documentation and that patients are fully informed of what the medical or surgical procedure is," King said.

Despite The St. Paul Cos.' cuts in malpractice insurance premiums earlier this year, the Minnesota Department of Commerce, which regulates the industry, alleges that the premiums are still too high.

The company faces a rate hearing in January before the Commerce Department, which released a study earlier this year in which it concluded that The St. Paul Cos. is charging doctors too much for malpractice coverage.

The company has vigorously disputed the findings of the study, which covered claims filed from 1982 to 1987, and has hired an actuarial firm to help support its position.

The St. Paul Cos. "did roll back their rates about 25 percent after the study was released, but we think they should roll them back another 25 percent," said Heidi Strommen, coordinator of the Commerce Department's study.

During the six-year study period, malpractice premiums tripled at The St. Paul Cos., and rose two and a half times at MMIC, which was not a target of the hearing action.

The study concluded that, despite the industry's claim to the contrary, there was not an explosive rise in the number of malpractice claims filed. The study stated that 10.4 percent of the doctors covered by The St. Paul Cos. and MMIC filed claims in 1982, 13.5 percent in 1985 and 11.5 percent in 1987. "Average payments actually appeared to be decreasing over the period of the study," the report concluded.

Average loss payments dropped from $22,906 in 1982 to $7,550 in 1987, but The St. Paul Co.'s estimate of reserves required to cover future claims far exceeded Commerce Department estimates.

Company spokesman Johnson said rates are determined by two factors: the number and the cost of claims. Both rose dramatically throughout most of the 1980s, he said. In addition, Johnson said, the rate cuts announced this year were not made in response to the Commerce Department study.

Officials of The St. Paul Cos. said the cost of individual claims continues to rise, even though the frequency of claims is lower. □

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Original Contributions

Medical Malpractice Experience of Physicians

Predictable or Haphazard?

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This study uses a large malpractice database from Florida to assess the concentration of losses among physicians, predictability of claims experience, characteristics of physicians with favorable vs unfavorable experience, and effects of claims experience on physicians' practice decisions and on actions taken by the state's licensing board. Most payments by insurers involved a comparatively small number of physicians. Physicians with relatively prestigious credentials had no better, and on some indicators, worse claims experience. If anything, physicians with adverse claims experience were less likely to make subsequent changes in their practice, such as quitting practice or moving to another state. Physicians with very poor claims histories were more likely to have complaints filed against them with the Florida licensing board, but the sanctions against physicians with either poor or excellent histories were not severe. Physicians with adverse claims experience from incidents that arose between 1975 and 1980 had appreciably worse claims experience from incidents that arose during 1981 to 1983.

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MEDICAL malpractice is in its second decade of "crisis," a crisis that has medical, insurance, legal, and public policy dimensions.[1] Physicians frequently complain about the increased threat of lawsuits and the substantial rise in premiums. Moreover, it is said that some physicians are refusing to accept high-risk patients, retiring earlier, leaving certain fields such as obstetrics, and ordering more tests than medically necessary in order to defend themselves in the event of a lawsuit.[2,3]

Questions naturally arise about the relationship of physicians' competence and malpractice experience. Some observers fear that a few "bad apples" among physicians cause the lion's share

See also p 3320.

of malpractice suits. Others contend that the best physicians are most likely to face lawsuits—those willing to provide high-risk care to litigious patients.

All physicians have been affected by the threat of malpractice claims and most have had claims filed against them. However, some physicians have much worse claims experience than others. This study addresses the following issues relevant to the randomness of claims and the appropriate reaction to it: What fraction of total malpractice payments on behalf of insured physicians is accounted for by the physicians with the largest payments? How does the concentration of payments compare across risk classes? How well does claims history predict future claims? What are the characteristics of physicians with adverse claims histories? To what extent does an adverse claims history predict future decisions by physicians about their specialty, movement to another state, and retirement? Are physicians with bad claims experience more likely to be brought up for disciplinary action by the state licensing board?

METHODS

Data Sources

Most data for this study came from the Florida Medical Professional Liability Insurance Claims file, which contained all claims closed in Florida between 1975 and the first quarter of 1988. The data were reported to the Florida Department of Insurance and made available for public use. We selected only claims against physicians for analysis. We used the physician's name as well as the indemnity and associated expenses paid on each physician's claim. The physician's name was needed to match claims with data on all US physi-

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cians obtained from the American Medical Association's Physician Masterfile.[1]

To analyze claims experience, we first aligned claims with the time they occurred and other relevant factors. We constructed an incident-year file, reallocating claims from year of closure to time of occurrence. (We could not develop a file based on the year the claim was filed because year-of-filing information was not requested by the Florida Department of Insurance for claims closed before 1985.)

The year a claim closes is a poor reference date for two reasons. First, it fails to match claims experience with risk factors during years of exposure to claims. Claims often are closed several years after an incident actually occurred.[1] Thus, a claims closing date would provide an inappropriate match with exposure, because a physician could have left the state or retired and still have claims closing several years later. Second, incidents with the highest payments typically take the longest to close. Therefore, a physician's history based on a file of closed claims could substantially underrepresent high-payment cases for those physicians who had more recently started practice in the state. We based our analysis on data from between 1975 and 1980 because this period provided an adequate time span for analysis and gave the latest incidents 5 years in which to close. Previous research indicates that 98% of claims in Florida during that period closed within 8 years.[1]

Physicians' characteristics between 1975 and 1980 from the American Medical Association's Physician Masterfile were merged with the claims file. Only physicians who practiced in the state of Florida for at least 3 years between 1975 and 1980 were included. Using this minimum experience avoids the type of random fluctuation that might result from a single year's unusual experience. The merger produced a physician claims history file that included the number of incidents that resulted in claims for each physician for each exposure-year between 1975 and 1980, indemnity payments and other insurer defense costs per exposure-year for each physician (year for which the physician was providing at least some patient care in the state of Florida), and other selected physicians' characteristics. We dropped closed claims that did not appear to be true claims. Sometimes physicians report an incident to an insurance company purely as a precautionary measure. If the insurer did not spend any money on the case or show any other indication of effort in defense of the claim, we dropped the claim from our analysis.

We focused on three categories of physician specialty—one low risk and two high risk—as designated by the majority of insurance carriers between 1975 and 1980. The low-risk group consisted of several medical and other low-risk specialties—allergy and immunology, dermatology, internal medicine, pathology, pediatrics, psychiatry, public health, and rheumatology. We subsequently refer to this as the *medical specialty group*. One high-risk group consisted of obstetrics and gynecology and anesthesiology (hereafter called the *obstetrics-anesthesiology group*); and the second, orthopedic surgery, plastic surgery, and neurosurgery (hereafter referred to as the *surgical specialty group*).

Classification of Physicians Into Four Payment Groups

We classified physicians in each specialty group into "no-payment," "low-payment," "high-payment," and "very high-payment" physicians based on claims that originated between 1975 and 1980 as follows: (1) *no payment*—physicians with no incidents between 1975 and 1980 that resulted in indemnity or associated loss expense; (2) *low payment*—physicians with one or more incidents between 1975 and 1980 *and* idemnity plus associated loss expense at or less than the mean for the specialty group; (3) *high payment*—physicians with one incident *and* indemnity plus associated loss expense greater than the specialty group mean; and (4) *very high payment*—physicians with two or more incidents *and* indemnity plus associated loss expense greater than the specialty group mean. This same breakdown was also done substituting median for mean values, although we do not report the median results here.

Determinants of Claims Experience

To determine factors associated with adverse vs favorable claims experience between 1975 and 1980, we performed multinomial logit analysis.[7] This form of regression analysis is used when the dependent variable is defined in terms of several mutually exclusive alternatives. In our application, we defined three categories for each specialty: no payment, low payment, and high and very high payment collapsed into a single group. Independent variables consisted of the physician's education characteristics, practice characteristics, and sex. We estimated separate equations for each of the three specialty groups. When characteristics varied by year, we used the characteristics for the physician's last exposure-year between 1975 and 1980.

Physicians' Education Characteristics.—These were (1) year of medical school graduation—before 1938, between 1938 and 1968, and after 1968; (2) board-certification status; (3) country of medical school—developed English-speaking (including the United States and Canada), developed non-English speaking, and less developed; and (4) medical school ranking, represented by a variable distinguishing graduates of the top one third of US medical schools as ranked by the 1977 Gourman Report[8] from graduates of other schools, both domestic and foreign.

Physicians' Practice Characteristics.—These were (1) number of direct patient care hours per week in three categories—40 hours per week or less, 41 to 60 hours per week, and more than 60 hours per week; (2) whether the physician engaged in research; (3) whether the physician taught; (4) solo vs nonsolo practice; and (5) primary employment of the physician—medical resident, administration, research or teaching, or direct patient care. Direct patient care was further subdivided into self-employed, government, other, or unclassified.

Other.—Location of practice was divided into six areas in Florida (1) all nonmetropolitan standard metropolitan statistical area (SMSA) counties; (2) metropolitan counties in northern Florida other than Jacksonville; (3) Jacksonville SMSA; (4) Orlando, Daytona Beach, Lakeland-Winter Haven, and Melbourne-Titusville-Palm Bay SMSAs; (5) southern central Florida SMSAs other than those previously mentioned; and (6) Miami-Hialeah, Fort Lauderdale-Pompano Beach, and West Palm Beach-Boca Raton-Delray Beach SMSAs. We also included explanatory variables to distinguish among detailed specialties within each of the three broad specialty groupings.

Other Claims-Related Analyses

Responses to Claims Experience.—For all four payment groups, we assessed whether there was a systematic relationship between claims experience with incidents between 1975 and 1980 and specialty, location, and retirement decisions. To isolate the effect of previous claims experience on such decisions, we estimated logit regressions for each type of decision with the following explanatory variables: the payment groups, year of graduation, sex, specialty, whether the physician was a medical student, and board-certification status. We also investigated whether the licensing authority in Florida, the Department of Professional Regulation, was more likely to receive complaints

Table 1.—Distributions of Payments per Exposure-Year by Specialty Group (in 1987 Dollars)

	Medical Specialties			Obstetrics-Anesthesiology			Surgical Specialties		
	Lower Boundary Value, $	Total Payments, %	Total Physicians, %	Lower Boundary Value, $	Total Payments, %	Total Physicians, %	Lower Boundary Value, $	Total Payments, %	Total Physicians, %
Zero payments	0	0.0	85.2	[illegible]	[illegible]	[illegible]	0	0.0	[illegible]
$1-median	[illegible]	[illegible]	[illegible]	[illegible]	4	[illegible]	[illegible]	[illegible]	[illegible]
Median-mean	[illegible]20	[illegible]	4.5	[illegible]	2.0	[illegible]	[illegible]	[illegible]	[illegible]
Mean, [illegible] claim	3929	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Mean, [illegible] claim	3929	[illegible]	[illegible]	[illegible]	49.2	[illegible]	[illegible]	[illegible]	[illegible]
Total		100.0	100.0		100.0	100.0		100.0	100.0
No. of observations	3837			[illegible]302			[illegible]		

about the physicians with the most adverse claims experience and what the disposition of the complaints was. Because the department had to look up records of each physician individually, we limited this latter analysis to the 166 physicians with the most adverse claims experience in the three specialty groups—the very high-payment group—and a comparison group of 166 randomly selected physicians in the same specialties who had no incidents between 1975 and 1980 that resulted in payments.

Prediction of Payments Based on Incidents From 1981 to 1983.—We compared mean payments by insurers for all four payment groups defined on the basis of incidents between 1975 and 1980 with their mean payments from incidents during 1981 to 1983. In this way, we could determine whether experience in the earlier period is predictive of experience during the later period.

RESULTS

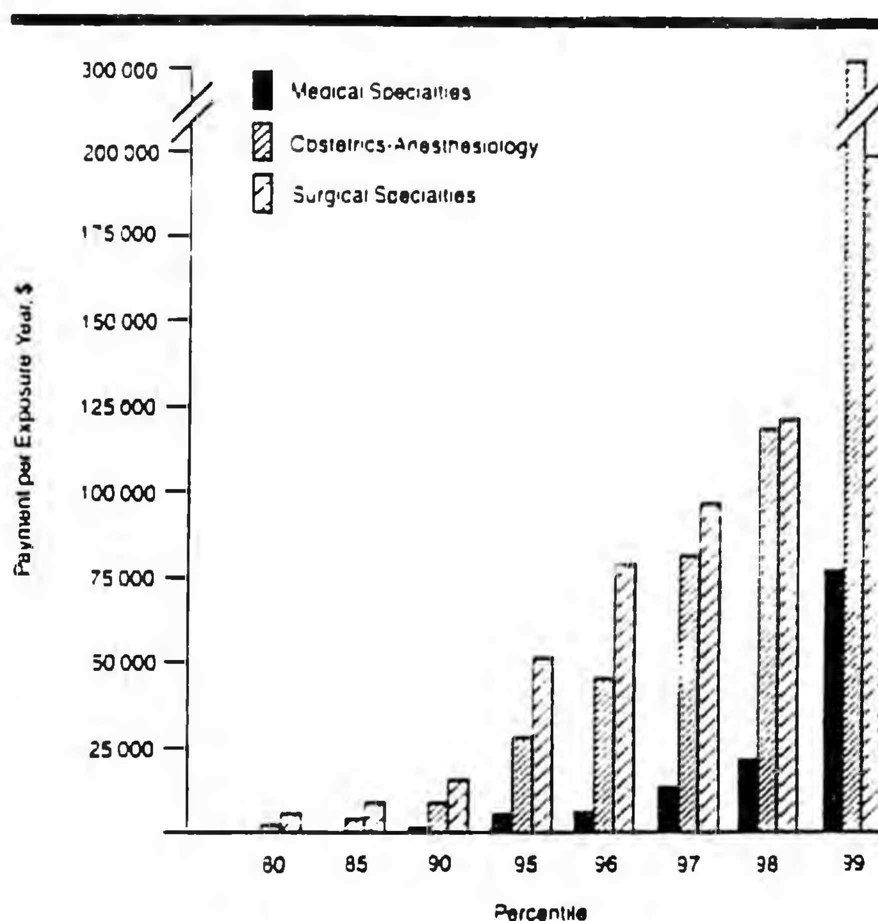
Concentration of Payments

Having a claim was a relatively rare event for physicians in the low-risk, medical specialty group (Table 1). Eighty-five percent of such physicians had not even one incident that resulted in some payment (indemnity payment and/or associated loss expense) between 1975 and 1980. By contrast, 66% of the obstetrics-anesthesiology group and 52% of the surgical specialty group had no such incidents. Payments were often low as well; only small amounts were spent for claims against many physicians who did have claims.

In all three groups, a large share of the total payment by malpractice insurers involved a comparatively small number of physicians (Table 1). More than 85% of the payment for physicians in the medical specialty group were made on behalf of only 3% of physicians (1.7% – 1.3%). Payments in the other two specialty groups were slightly less concentrated. In the obstetrics-anesthesiology group, more than 85% of payments were incurred by approximately 6% of physicians. For the surgical specialty group, three fourths of the total payment was made on behalf of 7.3% of physicians.

The median annual payment on behalf of physicians with payments was low, ranging from slightly more than $1000 for the medical group to almost $3000 for the surgical group. Payments near or below the median were often for the cost of defense rather than for compensating claimants. Mean annual payments were considerably higher than medians, reflecting the skewed distribution of dollars toward large cases: they ranged from approximately $9000 to $21 000 per year. Physicians in the very high-payment group (greater than the mean and more than one claim) incurred substantial losses. Mean annual payments for the physicians in this category were $38 000 for the medical specialties, $109 000 for the obstetrics-anesthesiology group, and $75 000 for the surgical specialties group (not shown).[4]

To examine the concentration of insurance losses from another perspective, we arrayed physicians according to annual spending on their behalf (Figure). For the obstetrics-anesthesiology group, the top 1% of physicians incurred a payment per exposure year of approx-



The payment per exposure-year, various percentiles of payment distribution.

Table 2.—Predicted Probabilities by Group*

	Medical Specialties			Obstetrics-Anesthesiology			Surgical Specialties		
	No Payment	Low Payment	High and Very High Payment	No Payment	Low Payment	High and Very High Payment	No Payment	Low Payment	High and Very High Payment
Physicians' education characteristics									
Year of medical school graduation									
Before 1938	0.967	0.029†	0.004‡	0.732	0.243	0.025	0.657	0.203	[illegible]
1938-1968	0.857	0.110	0.033	0.652	0.288	0.060	0.523	0.374	[illegible]
After 1968	0.827	0.146	0.027	0.667	0.269	0.064	0.482	0.456	0.062
Board certified									
Yes	0.848	0.124	0.028	0.611	0.314†	0.075‡	0.475	0.433†	0.092
No	0.859	0.110	0.031	0.719	0.235	0.046	0.672	0.244	0.084
Medical school country									
Developed non-English	0.829	0.134	0.037	0.705	0.243	0.052	0.268	0.528†	[illegible]
Less developed	0.869	0.106	0.025	0.665	0.261	0.074	0.461	0.460	[illegible]
Developed English	0.850	0.120	0.030	0.651	0.290	0.059	0.535	0.372	0.093
Medical school ranking									
Top one-third, Gourman	0.857	0.116	0.027	0.671	0.265	0.064	0.578	0.361	[illegible]
Other	0.851	0.119	0.030	0.652	0.288	0.060	0.483	0.406	[illegible]
Physician's practice characteristics									
Non-SMSA	0.849	0.137	0.014	0.585	0.368	0.047	0.509	0.406	0.086
Northern SMSA	0.852	0.117	0.031§	0.660	0.277	0.063§	0.516	0.392	0.092§
Southern SMSA	0.827	0.119	0.054	0.630	0.290	0.075	0.477	0.375	0.148
Direct patient care hours									
≤40 h/wk	0.870	0.108	0.022	0.791	0.172†	0.037	0.660	0.290‡	0.050‡
41-60 h/wk	0.853	0.121	0.026	0.642	0.298	0.060	0.567	0.369	0.064†
≥61 h/wk	0.842	0.121	0.037	0.607	0.330	0.063	0.436	0.423	0.141
Medical research									
No	0.850	0.120	0.030	0.661	0.278	0.061	0.516	0.398	0.086
Yes	0.861	0.111	0.028	0.640	0.297	0.063	0.512	0.368	0.120
Medical teaching									
No	0.851	0.115	0.034	0.663	0.280	0.057	0.525	0.411	0.064‡
Yes	0.853	0.121	0.026	0.649	0.284	0.067	0.503	0.373	0.124
Solo practice									
Yes	0.849	0.117	0.034	0.679	0.254	0.067	0.520	0.383	0.097†
No	0.853	0.119	0.028	0.646	0.296	0.058	0.514	0.398	0.088
Primary specialty									
Allergy/immunology	0.841	0.119	0.040						
Rheumatology	0.871	0.106	0.023						
Psychiatry	0.937	0.058†	0.005†						
Pathology	0.855	0.099‡	0.046						
Dermatology	0.825	0.136	0.040						
Public health	0.915	0.086	0.000						
Pediatrics	0.768	0.144	0.088†						
Internal medicine	0.806	0.147	0.047						
Anesthesiology				0.751	0.211†	0.038†			
Obstetrics/gynecology				0.582	0.335	0.083			
Neurosurgery							0.482	0.313	0.205‡
Plastic surgery							0.575	0.385	0.040‡
Orthopedic surgery							0.501	0.406	0.093
Sex									
F	0.888	0.102	0.010‡	0.697	0.290	0.013	0.677	0.323	0.000
M	0.847	0.120	0.033	0.651	0.280	0.069	0.513	0.392	0.095

*The significance levels indicate the underlying parameter estimates were statistically significant in the logit regressions. The last category under a heading was the omitted reference group (eg, after 1968 for year of graduation).

†$P \leq .01$ (two-tailed test).

‡$P \leq .05$ (two-tailed test).

§The northern standard metropolitan statistical areas (SMSAs) taken as a group are statistically significant from the reference group ($P \leq .01$). In our regression analysis, we included separate variables for various northern SMSAs (see text). Our statistical test measures differences in two log-likelihood ratios, with and without northern SMSA variables.

imately $300 000, nearly $2 million for the incident period between 1975 and 1980. By contrast, for such physicians at the top 10% of the payment distribution, the mean dropped to approximately $10 000 per year. For the surgical group, the top 1% incurred approximately $200 000 per year. Payments for the medical specialists were less skewed, but skewed nevertheless.

Sources of Variation in Claims Experience

The logit analysis revealed several systematic relationships between physicians' characteristics and their claims experience. Because the logit coefficients cannot be directly interpreted, we show predicted probabilities of being in the no-, low-, and high- and very high-payment categories as particular characteristics are varied (Table 2). To examine the effect of a particular characteristic on the probabilities of assign-

Table 3.—Effects of Malpractice Experience Between 1975 and 1980 on Physicians' Practice Decisions Between 1980 and 1987

Group*	Active in Florida, Same Specialty†	Active in Florida, Different Specialty	Active in Other State, Same Specialty	Active in Other State, Different Specialty	Retired, Semiretired, or Non–Patient Care	Died or Disabled	Total
	% Distribution						
No payment (N = 4522)	75.4	1.4	5.5	2.0	10.5	5.6	100.0
Low payment (N = 1133)	81.2‡	1.5	3.2‡‖	3.4‡§¶	4.7‡§‖	2.1‡§‖	100.0
High payment (N = 98)	79.5‡	5.1	1.1	2.0	5.1	5.1	100.0
Very high payment (N = 158)	80.3‡	5.5	4.8	1.5	4.8‡	3.3	100.0

*The reference group is no payment.
†We did not estimate a separate equation for this category.
‡Statistically significant difference based on difference of means tests.
§Statistically significant corresponding results from the payment variable coefficients in the regressions.
‖P≤.01 (two-tailed test).
¶P≤.05 (two-tailed test).

ment to each payment category, we set the other independent variables equal to their sample mean values. To conserve space, we assess only the changes in probabilities associated with key independent variables. (Full regression results are available in an unpublished appendix. See National Auxiliary Publications Service [NAPS] document 04723 for five pages of supplementary material.)

Several of the physicians' characteristics had statistically significant effects on whether a physician had no, low, or high and very high payments. Having some characteristics made a substantial difference to the payment group to which the physician belonged, but the effect of many characteristics on the probability of belonging to a particular payment group was small.

Physicians with relatively prestigious credentials had no better experience and, according to some indicators, worse experience than did physicians with less prestigious credentials. Board-certified physicians in the obstetrics-anesthesiology and surgical specialties groups, but not in the medical specialties group, were more likely to have claims filed against them than were their non–board-certified counterparts. For example, among obstetricians and anesthesiologists, being board certified increased the probability of being in the high- and very high–payment group from .05 to .08 and decreased the probability of being in the no-payment category from .72 to .61. Surgeons from the top third of medical schools were less likely to be in the high- and very high–payment group, the only statistically significant difference for this characteristic.

Physicians with degrees from less developed countries had about the same claims experience as others, including physicians with US and Canadian degrees. The only major difference in claims experience by country of graduation was in the surgical specialty group. With one exception (the surgical group), ranking of medical school seems unimportant.

In general, older physicians were less likely to have claims filed against them. However, year of graduation only had a statistically significant effect in the medical specialties group.

Holding other factors constant, there were no statistically significant differences between the claims experience of physicians who engaged in some research or some teaching and the experience of those not engaged in these activities. Differences between physicians in solo vs group practice were small and generally not statistically significant. Physicians in the obstetrics-anesthesiology group and surgical specialty group who were involved in more than 60 hours of direct patient care per week tended to incur more claims and more costly claims than physicians with shorter workweeks. There was no relationship between length of workweek and malpractice payments for the medical specialty group.

Particularly in view of the publicity about the malpractice problem in southern Florida and the higher premiums charged there, we expected to find geographic differences in the claims experience among Florida physicians. In fact, we found only a few systematic patterns by location within Florida given the other explanatory variables in the equations. For purposes of assessing predicted probabilities, we combined the SMSAs into two categories—northern and southern—and compared them with one non-SMSA category. The estimated marginal probabilities in Table 2 suggest surprisingly small differences between metropolitan (SMSA) and nonmetropolitan areas within the state.

Female physicians in the obstetrics-anesthesiology group and the medical specialties tended to have a more favorable claims experience than their male counterparts, other factors held constant. Because of the paucity of female surgeons, statistical power is lacking, but, even for this group, being a woman raised the probability of having no incidents with claims between 1975 and 1980 from .51 to .68. Not surprisingly we found differences by specialty in the probabilities of being associated with particular payment groups.

Change in Physicians' Specialty and Location and Retirement Decisions Between 1980 and 1987.—Physicians with paid claims and/or associated loss expense because of incidents between 1975 and 1980 were less likely to make subsequent major changes in their practices (Table 3). This was true even after adjusting for other likely determinants—year of graduation, specialty, whether the physician was a medical resident, sex, and board-certification status. The percentages shown in Table 3 are not adjusted for the effects of these covariates; taking the covariates into account does not affect our conclusion. (See appendix available from NAPS.)

The major differences among physicians in various payment categories were in the percentages of physicians who remained in Florida but changed specialty and of those who were retired, semiretired, or switched from patient to non–patient care. Virtually all of the specialty changes for obstetrician-gynecologists involved dropping obstetrics. In general, the changes for the low-, high-, and very high–payment groups were quite similar, but were quite different from changes made by the no-payment group.

Malpractice Experience and Decisions of Professional Licensure

Table 4.—Malpractice Experience and Decisions of the Professional Licensure Board

	% of Department of Professional Regulation Decisions						
	Total	Case Dismissed	Letter of Guidance	Probation	License Temporarily Suspended	License Revoked	Voluntary Relinquishment
No payment (N = 166)	4.2* (n = 7)	1.2 (n = 2)	1.8* (n = 3)	0.0	0.6 (n = 1)	0.6 (n = 1)	0.0
Very high payment (N = 166)	8.4 (n = 14)	0.6 (n = 1)	4.8 (n = 8)	2.4 (n = 4)	0.0	0.0	0.6 (n = 1)

*Difference between no-payment sample and very high–payment population, $P \leq .05$ (two-tailed test). We dropped two physicians from the very high–payment group in the process of matching specialties.

Board.—Twice as many of the very high–payment physicians (14 [8.4%]) as no-payment sample physicians (7 [4.2%]) had complaints filed against them with the Florida Department of Professional Regulation that were closed between 1980 and 1988 (Table 4). The difference in proportions is statistically significant ($P \leq .05$). However, the majority of the sanctions against both groups were not severe. None of the very high–payment physicians had their licenses revoked or suspended.

Ability of Claims Experience From Incidents Between 1975 and 1980 to Predict Claims Experience From Later Incidents.—Claims and payment experience from incidents between 1975 and 1980 does predict experience from incidents that occurred later (Table 5).

To assess the relationship between past and future experience, we, as before, assigned each physician to one of the four payment groups, defined on the basis of losses attributable to incidents that occurred between 1975 and 1980. For each previously identified payment group, we computed (1) the fraction of physicians with some loss attributable to incidents from 1981 to 1983, and (2) for those with some loss during this second period, the mean payment per exposure-year. The frequency distribution of payments is approximately lognormal. Since one cannot take the logarithm of 0 and the lognormal distribution is only defined for positive values, for testing purposes, we separated the distribution into these two parts.

As with incidents between 1975 and 1980, the very high–payment group had by far the highest claims frequency that arose out of incidents from 1981 to 1983. Although the high-payment group's claims frequency from 1981 to 1983 was less than the claims frequency for the low-payment group, this was also true for incidents between 1975 and 1980. All three payment groups had far higher claims frequency than the no-payment (reference) group. Similarly, while nearly half of the very high–payment physicians incurred some loss on care rendered during 1981 to 1983, only 15% of no-payment physicians incurred some loss. Low- and high-payment physicians fell in between. Mean payment per exposure-year for those with some loss was more than twice as high for the very high–payment as for the no-payment physicians. Considering differences among groups in the fraction with some payment, there was a sevenfold difference in payment between the very high- and the no-payment groups that arose from incidents during 1981 to 1983 (0.46 × $65 895 vs 0.15 × $29 815).

Table 5.—Claims Frequency and Payment Experience Between 1975 and 1980 vs 1981 to 1983

	1975-1980		1981-1983		
Category Based on 1975-1980 Experience	Claims per Exposure-Year	Mean Payment per Exposure-Year, $	Claims per Exposure-Year	Fraction of Physicians With Payment	Mean Payment per Exposure-Year for Physicians With Payment*
No payment (N = 3873)	0.000	0.0	0.073	0.15	29 815
Low payment (N = 1089)	0.282	2622	0.204†	0.36†	33 593‡
High payment (N = 92)	0.193	47 909	0.141†	0.28†	44 275
Very high payment (N = 157)	0.614	75 484	0.331†	0.46†	65 895†

*Test of significance based on means of logarithm of payment.
†$P \leq .01$ (one-tailed test).
‡$P \leq .05$ (one-tailed test).

COMMENT

Our results show that malpractice claims are quite frequent for physicians in the surgical specialties we examined compared with the medical specialties. Approximately half of these surgeons in Florida had at least one claim filed against them in 6 years. Claims frequency alone (although widely used in rating by insurers in other lines, such as automobile, property, and liability[7]) is a rather misleading indicator of the cost of insuring a physician for medical malpractice. In Florida, claims closed with payments of $300 000 or more to claimants (not counting associated loss expense) accounted for approximately 68% of total indemnity payments, but only 11% of total closed claims. Moreover, these large payments were concentrated on relatively few physicians. Almost all payments for compensation and associated costs went to cover losses incurred by a handful of physicians.

Persistence of High-Expense Categorization

When we followed the experience from 1981 to 1983 for our payment groups between 1975 and 1980, we found that differences in mean payments for the various payment groups remained. This persistence suggests that, at the group level at least, future payments within specialty are predictable. If anything, our comparisons understate the differences in payments attributable to the period from 1981 to 1983 since some claims, especially larger ones, had not closed by 1988, the most recent year for which data were available at the time we conducted our analysis. It is plausible that the very high–payment physicians incurred a disproportionate share of these claims that were still open.

Claims Experience and Quality

The link between claims experience and quality is difficult to establish, and our data do not yield conclusive results on the issue. We performed the following three tests: first, we compared claims experience with physicians' credentials, such as board-certification status, prestige of medical school attended, and country of medical school.

Our analysis found few relationships with these supposed indicators of quality. In the case of board certification, we found that board-certified physicians often had more adverse claims experi-

ence. We found no consistent results with regard to foreign medical school graduates, medical school ranking, or solo practice. These findings are consistent with previous analyses of foreign medical graduates' experience,[1,6] and comparisons of group vs solo practitioners.[1] Physicians with more recent degrees may be more up-to-date. We found no evidence that recent graduates had more favorable claims experience; some of our evidence suggests exactly the opposite.

Second, we considered a "market test" of whether physicians with adverse 1970s claims experience were more likely thereafter to change specialties, enter retirement or semiretirement, or leave the state. Perhaps bad physicians are forced to change by their patients, their hospitals, or their insurers. The main difference we detected was that physicians with the most favorable claims experience were *more* likely to leave Florida for practice in another state. They were also somewhat more likely to retire or to change from patient to non-patient care. Thus, either the physicians with adverse experience were not considered "bad" or the market enforcement mechanisms did not work in this way. Perhaps, opportunities that face those with adverse experience are limited.

Third, we applied a "regulatory test" of whether physicians with adverse claims experience were more likely to face subsequent discipline by the state licensing board. Indeed, such physicians were more likely to receive letters of guidance and probation. On the other hand, none of the physicians with the most adverse claims experience had their licenses suspended or revoked, and fewer than 10% of these physicians were disciplined in any manner. This pattern is consistent with two opposing hypotheses: perhaps physicians with adverse claims experience are not bad physicians. Bad claims experience may reflect taking on harder cases or a litigious client. Perhaps such physicians are bad, but the licensing system failed to act. Unfortunately, the data did not permit a rigorous examination of these possibilities.

Traditionally, state medical boards have been reluctant to address physician incompetence.[11] In 1986, the Florida licensing board handled more complaints than any state except New York.[11] So, if anything, this board has been relatively active.

Some but not all of our findings are consistent with the view that physicians with adverse experience are competent physicians. Our results regarding board certification suggest that physicians with high payments may have provided more complex procedures. Perhaps older physicians, who have a better malpractice record on average, provide fewer technologically sophisticated and risky services. If physicians, their practice content, and their patients were homogeneous, one would expect physicians engaged in research and teaching to do poorly, given these explanations. However, holding other factors constant, we found little difference between them and other physicians. Female physicians had a better track record than male physicians. This difference seems more likely to reflect a patient-physician practice style that is less conducive to claims than to indicate that male physicians take the risky cases. If physicians, their practice content, and their patients were homogeneous, one would expect physicians who work more to have greater exposure to adverse outcomes and hence to have a worse malpractice record. We found some evidence that losses rise with an increased number of hours worked per week. Clearly, there is an important need for careful research to determine why physicians differ in claims experience.

From an insurance perspective, it is important to know that the past predicts the future. This study shows considerable variation in expected losses within the groups commonly used for underwriting purposes by medical malpractice insurers.

The Health Care Quality Improvement Act of 1986 requires that any entity that makes payment under an insurance policy or a self-insured plan must report the physician's name, the amount paid, and a description of the incident to a national data bank.[13] Empirical evidence available up to now, including our study, however, does not demonstrate that claims experience is a valid indicator of physician quality, although it does correlate with future claims. A recent report by the US Office of Technology Assessment[12] suggests that malpractice information available from the data bank might be validly used for quality screening purposes by hospitals, licensing boards, and others. Data collected pursuant to the act might be useful for replicating an analysis like ours, but definitively linking physicians' malpractice experience with their quality of care will require more information, such as data regarding patient-physician relationships and practice-specific information regarding procedure and patient mix. Such information cannot be obtained from closed malpractice claims.

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See National Auxiliary Publications document 04723 for five pages of supplementary material. Order from NAPS c/o Microfiche Publications, PO Box 3513, Grand Central Station, New York, NY 10163-3513. Remit with your order, not under separate cover, in US funds only, $7.75 for photocopies or $4 for microfiche. Outside the United States or Canada, add postage of $4.50 for the first 20 pages and $1 for each 10 pages of material thereafter. The postage charge for any microfiche order is $1.50. Institutions and organizations may order by purchase order. However, there is a billing and handling charge for this service of $15, plus any applicable postage.

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The Miami Herald

MONDAY, NOVEMBER 27, 1989

Pressure off doctors after insurance crisis

Juries give smaller, fewer malpractice awards

By ROSALIND RESNICK
Herald Business Writer

Florida's medical malpractice crisis, which only two years ago threatened to rip a huge hole in the state's health care system, has quietly gone away.

In 1987 the malpractice crisis was making front-page headlines.

Doctors' insurance premiums were going through the roof.

Personal injury lawyers were making megabucks suing doctors.

Then it got worse: St. Paul Cos., the state's biggest malpractice insurer, pulled out of the state. Neurosurgeons staged emergency room boycotts, obstetricians refused to deliver babies, and doctors of all stripes threatened to flee Florida in droves.

These days, doctors are back at work. Malpractice insurance rates are coming down. New insurers are competing to sell the high-risk coverage. And in Dade County, once the hotbed of medical malpractice lawsuits, the number and size of jury awards are on the wane. Fewer cases are being filed.

"Definitely, the crisis is over," said Stuart Grossman, a Miami trial lawyer who makes his living suing doctors in medical malpractice cases.

While it is difficult to isolate any single reason why, most observers point to these:

- Fewer and smaller jury awards and settlements.
- More insurers competing for business.
- More care by doctors in limiting medical mistakes.
- A "soft" market for liability insurance.
- A new state law that screens out frivolous lawsuits.

Under the new law, lawyers can no longer simply file a suit and take their chances. They must first assemble all the relevant medical records, then hire an expert to swear that there is good reason for suing the physician for negligence.

When the cases finally do get to the courtroom, jurors are often less than sympathetic to the patients' plight.

"A lot of it has to do with the fact that all the media attention that was focused on this problem through tort reform and Amendment 10 has raised the consciousness of jurors," said Robert White, director of claims and loss prevention at the Physicians Protective Trust Fund in Coral Gables. "Jurors are finding for doctors more than ever before. And when they're finding for the patient, they're awarding fewer dollars."

Even in cases of clear-cut medical negligence, it's not always easy to find a lawyer to file a suit.

Some doctors suspect this has more than a little to do with the decision by many Florida physicians to drop their insurance coverage and use the state's liberal debtors' laws to shelter their assets from malpractice judgments. Doctors can continue to practice in the state so long as they make good on the first $250,000 of any malpractice judgment.

Sheltering assets is easier in Florida than in most other states. In fact, an entire cottage industry has sprung up to advise physicians on how to hold onto their wealth. Under state laws, debtors can keep their home, wages, annuity, pension plan and any property owned jointly with their spouse safe from creditors' judgments.

Though doctors can't shelter their assets after they've been sued, they can rearrange their finances now if they think they might be sued in the future.

Surgeons dropping insurance

A recent poll found that one-third of Broward surgeons say they no longer carry any malpractice insurance. One-third carry only the minimum $250,000 in coverage.

Personal injury lawyers, who generally take cases on a contingency fee basis, don't relish the idea of spending several years and tens of thousands of dollars on a case — only to find that their million-dollar judgment can't be collected.

"I got about one suit a year when I had insurance," said Dr. Amos Stoll, a Fort Lauderdale neurosurgeon who says he hasn't been sued since he dropped his coverage three years ago. "I don't think it's a coincidence."

Said J.B. Spence, Miami's best-known personal injury lawyer: "It's a hollow victory to go to the courthouse and spend a week or 10 days and spend a lot of money and not be able to collect anything. It doesn't do anything but break the client's heart again. And it doesn't do anything for the lawyer.

Some lawyers charge that Florida's doctors, though unsuccessful in capping noneconomic damages at $100,000 through the Amendment 10 referendum last fall, have solved the problem by poisoning the public against the legal profession.

During last year's fight, the doctors aired TV spots depicting lawyers as money-hungry ogres, wolfing down plates of caviar and lobster. The lawyers hit back with spots accusing the doctors of giving a free ride to drug dealers and toxic waste polluters.

"The pendulum in the last few years has swung toward the defense, and I don't think it will ever swing back," said Stanley Rosenblatt, a Miami personal injury lawyer. "Their propaganda has been much more effective than the trial lawyers' propaganda."

The indicators

Whether or not the trend lasts, key indicators show that the malpractice crisis is over for now:

- The Physicians Protective Trust Fund, which insures 5,700 Florida doctors, has asked state regulators to approve a 13.4 percent rate reduction as of Jan. 1. Jacksonville's Florida Physicians Insurance Co., which insures 3,000 doctors, recently obtained an 8.5 percent rate decrease.
- In Dade County, malpractice verdicts in favor of the defense rose from 56 percent in 1985 to 71 percent in early 1988, according to Chief Judge Gerald Wetherington's most recent survey. The number of malpractice cases filed in Dade County last year declined 20 percent from 1986.
- Across Florida, the number of malpractice awards and settlements totaling $1 million or more fell to 19 last year, from 24 in 1987, according to the Florida Department of Insurance. Damages paid out plus defense costs dropped to $143.58 million in 1988 from $153.92 million the year before.
- Nationally, malpractice costs — jury awards and settlements plus defense costs — dropped $100 million in 1988 after soaring from $1.1 billion in 1978 to $4.2 billion in 1987, according to the Insurance Information Institute, a compiler of statistics for the insurance industry. St. Paul Cos., the nation's largest underwriter of medical malpractice coverage, dropped its rates by an average of 14 percent this year.

"A couple of years ago, most actuaries thought the trend line was going up," said Marc Rosenberg, vice president for federal affairs at the Insurance Information Institute. "Over the last couple of years, looking at experience, we realize we may have reached a plateau."

Doctors still see problems

But while the crisis has ebbed, serious problems remain, some doctors say. Though insurance rates have leveled off, many doctors say they still cannot afford to buy enough insurance to protect them against big-bucks lawsuits.

"Even though rates have fallen a small amount for the high-risk specialties, they've increased for the low-risk specialties," said Dr. Richard Glatzer, former president of the Dade County Medical Association. "We still have a major problem."

That's because most malpractice suits these days stem from the failure of front-line doctors such as family practitioners and internists to diagnose illnesses quickly and accurately, not from botched surgical procedures, said Robert White, director of claims and loss prevention at the Physicians Protective Trust Fund in Coral Gables.

"We have a lot of high-risk people [such as surgeons] who can't afford to carry coverage," White said. "The low-risk physicians [such as family practitioners] generally carry coverage and carry higher limits of coverage. The attorneys try to work the case around to where the coverage is."

In 1988 Dade and Broward neurosurgeons insured by Physicians Protective paid $174,452 a year for a policy that insures them up to $1 million per claim with a $3 million annual cap. As of Jan. 1, the high-risk specialists will pay $139,020 for the same coverage. Cardiologists, classified by insurers as lower risks, will pay $15,592, up from $15,063 in 1989.

"It's like having a critically ill patient, and he's still alive," said Marc Singer, a North Miami Beach financial planner who handles money matters for local doctors. "It's not like he's recovering and walking around."

Have yet to cut fees

Meanwhile, Florida doctors, who claim that 30 percent of medical costs are linked to malpractice premiums and defensive medicine, say they have yet to cut their fees. Few physicians who dropped their coverage have renewed their policies now that rates are lower.

And doctors like Glatzer continue to press for tort reform. Among his proposals: capping damages for pain and suffering at $250,000, stretching out malpractice settlements for a period of years, funding a statewide trauma system and limiting lawyers' contingency fees.

"We cannot become apathetic," he wrote in the latest issue of Miami Medicine, the DCMA's magazine. "We must look at what we've already accomplished and continue to fight."

MALPRACTICE JUDGMENTS

FEWER AWARDS . . .

Here are jury verdicts in medical malpractice cases in Dade County, which at one time was the hotbed of medical malpractice cases:

Year	Damages Awarded To plaintiff	No Damages Awarded
Jan. '85-March '86	44 percent	56 percent
April '86-March '87	47 percent	53 percent
April '87-Dec. '87	32 percent	68 percent
Jan. '88-March '88	29 percent	71 percent

SOURCE: Dade County Circuit Court

. . . FOR FEWER DOLLARS

The number and size of settlements and jury awards in malpractice cases are on the wane. Here are settlements and jury awards in Florida medical malpractice cases since 1983:

Year	Damage Awards	Million-Dollar Awards	Average Award
1983	620	14	$121,748
1984	673	20	$149,320
1985	773	12	$116,880
1986	863	20	$127,363
1987	893	24	$139,606
1988	832	19	$136,875

SOURCE: Florida Department of Insurance

Malpractice claims take nose dive

By RICK DESLOGE

Remember the medical malpractice insurance scare of 1986? The one where doctors had a hard time affording coverage — when they could find it; the one where Missouri jumped in with more than 40 other states to place caps on medical malpractice insurance judgments.

Three years later, the number of malpractice insurance claims has fallen in Missouri, as has the dollar amount of liability coverage for most doctors. And the insurance companies that write medical malpractice insurance are making money.

But don't give any credit to the damage caps — one that limited non-economic damages to $350,000 in 1986 and to $391,000 in 1989.

If credit goes anywhere, it's to another provision of the law, one that requires an attorney filing suit against a health care provider to include an affidavit from a medical expert that the case has merit.

"We know lots of cases are being dismissed because the attorneys can't get a statement from a qualified medical expert," said Jim Holloran, a personal injury attorney and former president of the Missouri Association of Trial Attorneys, the advocacy group of plaintiff attorneys.

Holloran is one of the first attorneys to test the new law. That case in St. Louis City Circuit Court went to trial July 31. The result: a hung jury.

The limits on non-economic damages — things like pain, suffering, disfigurement and loss of consortium — did not come into play in that case, Holloran said, primarily because his client died as a result of the alleged malpractice.

Holloran and other plaintiff attorneys said they were not pleased with the caps, but pointed out the limits affect few cases. Defense attorneys, who represent the medical insurance firms, generally thought the limits did not go far enough, but conceded the number of medical malpractice claims had dropped since the new law.

"We did not want to see any loss of victims' rights," said James Bartimus of Kansas City, president of the Missouri Attorneys Trial Association. On the other hand, he estimated "in less than 5 percent of the cases will it have any affect."

Under the new law, medical malpractice claims brought after Feb. 3, 1986, must have the medical affidavit, but also are subject to the non-economic caps. Missouri has a two-year statute of limitations to file such claims, and circuit courts in St. Louis and St. Louis County have a 2½-year backlog to bring the cases to trial. So only now are medical malpractice cases affected by the new law reaching the courts.

What is happening, said attorneys on both sides of the issue, is compromises hammered out in 1986 seem to be working.

That compromise covered three areas:

• Accountability — which resulted in the medical affi[illegible]avit.

• Predictability — which led to the limits on non-economic damages and gave insurance carriers for doctors and hospitals a better yardstick to measure losses.

• Affordability — which was to keep insurance for doctors and hospitals from skyrocketing.

Missouri was one of many states that limited damage awards in 1986 in the midst of the so-called "liability crisis," a label insurance firms gave the issue. Many of those firms ran public relations campaigns then blaming the lack of insurance and higher rates on a legal system bent on generating more medical malpractice cases and higher judgments, claims the plaintiff attorney groups denied.

In fact, the medical underwriters in Missouri are making money, according to the State Division of Insurance. About a dozen insurance firms underwrite 90 percent of the medical malpractice premiums in Missouri, said Lew Milahn, director of the Division of Insurance.

The main medical malpractice underwriters in Missouri are MOMEDICO in Springfield and Medical Defense Associates in St. Louis, both physician malpractice underwriters, and the Missouri Hospital Plan in Jefferson City, which carries insurance for hospitals. According to state records, medical malpractice premiums to those and other firms totaled $60.9 million in 1985 while they paid out $73.4 million. The situation reversed in

68

Missouri Medical Malpractice Premiums

Year	Total Premiums* (in millions)	Total Claims Paid (in millions)	Percent above(below) Total Premiums
1985	$60.9	$73.4	(20.6%)
1986	$95.8	$99.9	(4.2%)
1987	$94.5	$95.2	(0.7%)
1988	$123.0	$83.4	32.2%

*Total paid by doctors and hospitals to insurance firms

Source: Missouri Division of Insurance

1988, the most recent year statistics are available. That year the underwriters took in premiums totaling $123 million, but paid out $83.4 million.

Those familiar with the insurance industry point out the industry cycle leads to periods where insurance firms' premiums are most competitive when the firms' other financial investments are strong, but rise as the return on those investments fall off.

That cycle led to the insurance turnaround more than the damage cap, plaintiff attorneys said.

The limits also raise a constitutional question: Whether a state legislature can limit damages to a victim.

"I can assure you there are cases that would have doubled the value if it were not for this statute," said Paul Passanante, an attorney with Grey & Ritter in St. Louis. "For the legislature to say nobody's pain and suffering is worth more than a certain amount, I question." //

Health Care

FOR ASSOCIATION OF TRIAL LAWYERS OF AMERICA

PROGRAM News 4 STATION WRC-TV

DATE February 5, 1990 6:00 P.M. CITY Washington, D.C.

SUBJECT "Deadly Mistakes: The Broken Promise," Part One

DOREEN GENTZLER: Two years ago, News 4's investigation of the mistakes being made in medical laboratories caught the attention of the nation. After Lea Thompson's report, there were hearings, then new laws, and, most important, new hope that deadly mistakes would never happen again.

But tonight Lea begins another special report called "Deadly Mistakes: The Broken Promise," about some of the same problems that she reported on two years ago.

LEA THOMPSON: Well, you know, most of us have no idea where our doctors send our lab work. Most of us, most doctors, take it for granted that lab tests are done by people who know what they are doing on machines that don't make mistakes. Nothing could be further from the truth.

JANET COLEMAN (Nov. 1987): I'm going to die because the laboratory.

THOMPSON: Janet Coleman's Pap smear was read wrong. That mistake allowed her cancer to spread for eight months. She died at age 42.

Sandra Magruder. A lab her doctor used advertised low prices and quick service. Two errors in nine months. Dead at 36.

Janice Johnson. Her lab work was misread twice by a person who worked all day in one lab and then went to work for another. She was 35 when she died.

Erica Hayden. The lab misdiagnosed the seriousness of

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her cancer. Another mistake. She died at 28.

Two years ago, we told you that most labs were not tested for accuracy in this country, and those that were only had to get a 70 to pass some tests. 70! Barely a passing grade.

Today? Nothing has changed. **Our investigation uncovered the fact that nearly a third of the commercial labs in Virginia are never inspected. They still aren't.** We told you while a whole lot of lab work is being done in doctors' offices, almost none of them have ever been licensed or inspected. Not much has changed. **We told you nearly 40 percent of the people doing tests in D.C. doctors' offices had no laboratory training at all,** that hairstylists in most states are required to know more than the people who do your medical tests. Nothing has changed.

REP. RON WYDEN (Nov. 1987): The current self-policing system in the laboratory area is not working.

SENATOR WILLIAM COHEN (Nov. 1987): We're talking about life and death.

JOHN WILSON [D.C. City Council; Nov. 1987]: The system we take for granted has gone virtually unchecked.

STATE SENATOR IDA RUBEN [Montgomery County, Md.; Nov. 1988]: And I think that something should be done.

THOMPSON: There were hearings.

REP. WYDEN (Nov. 1988): The regulation of medical labs in this country is dangerously inadequate and haphazard.

DELEGATE LARRY LAMOTTE [Baltimore; Dec. 1987]: For all intents and purposes, there has been no regulation.

THOMPSON: There were studies.

RICHARD KUSSEROW [**Inspector General,** Dept. of Health and Human [illegible], 1988]: **Roughly two-thirds of the** indiv[illegible] **actually performing the tests in the physician office laboratories have little or no formal laboratory training.**

THOMPSON: **Laws were passed very quickly.** In the **District**, the Clinical Laboratory Act of 1988. In **Maryland**, the Medical Laboratory Act of 1988. In Congress, the Clinical Laboratory Improvement Amendments of 1988.

SENATOR BROCK ADAMS (Oct. 1988): This bill will do a lot to overcome the terror and the horror that comes from misdiagnosis.

THOMPSON: President Reagan signed the federal lab law November 1st, 1988, less than one year from the date of our original story.

SENATOR BARBARA MIKULSKI (Oct. 1988): Labs will be regulated by a proficiency test; inspections, unannounced and announced; and we're going to set up workload standards for Pap smear testing.

THOMPSON: There was elation. There was hope, even from the families of the victims.

GLEN COLEMAN [husband; Nov. 1988]: Well, it doesn't make her dying any easier. But if she had to die, I'm glad that she had a part in changing the thing, so maybe not -- so maybe more people won't have to die.

SENATOR ADAMS (Nov. 1988): Within the year, the licenses will be sent out, then the testing will start on a quarterly basis.

THOMPSON: That was Senator Brock Adams in November 1988, when the federal lab law passed. He said within the year, the rules and the regulations, the nuts and bolts needed to make that new lab law work, would be written and in place, and people could finally have some confidence in their lab work. But that deadline passed a long time ago, and:

SENATOR MIKULSKI (Jan. 1990): Those regs are not ready. They've gotten bogged down in bureaucracy. They've missed their deadlines.

THOMPSON: So, we wait and wait. And deadly mistakes by medical laboratories continue, and people continue to die.

SALLY COX: I [unintelligible] my yearly checkup.

MAN: They were just screwed-up all the way around, doctors, laboratories, and everything. I mean it seemed like nobody was on top of their job.

SALLY COX: It just makes me sick that they didn't find it earlier. It really makes me mad.

MAN: I think she really got cheated out of her life, really. I mean that's what it all boils down to.

MAN: From the last three years that she was alive, her slides were misread for three years in a row.

WOMAN: It's difficult. It's very difficult.

MAN: This shouldn't have happened. This woman should not have died. She should be here. She should be a mother with

her boys and she should be my wife here in this house.

THOMPSON: Bitter? Yes. Angry? You bet.

These women are victims. They depended on their doctors. Their doctors depended on the lab. The lab made an error, sometimes two or three errors. As a result, these very young women died horrible deaths and left husbands and small children behind.

Strange, so much has happened, yet so little has been done.

For the **next three** nights on News 4 at 6:00 and at 11:00, we look at "Deadly Mistakes: The Promise Broken." We'll tell you why you need to be concerned, how a deadly mistake could happen to you. And we'll tell you how to protect yourself.

I'll see you again on News 4 at 11:00 tonight.

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4701 WILLARD AVENUE, CHEVY CHASE, MARYLAND 20815 (301) 656-4068

FOR ASSOCIATION OF TRIAL LAWYERS OF AMERICA

PROGRAM News 4 STATION WRC-TV

DATE February 5, 1990 11:00 P.M. CITY Washington, D.C.

SUBJECT "Deadly Mistakes: A Promise Broken"

JIM VANCE: Tonight a News 4 special report we hoped we wouldn't have to do. More deadly mistakes in medical labs.

Good evening. I'm Jim Vance.

DOREEN GENTZLER: And I'm Doreen Gentzler.

Two years ago, News 4's investigation of medical laboratory errors caused an uproar, an uproar that caused new laws to be passed. But two years later, Lea Thompson says, we still can't have confidence in our lab system.

Tonight Lea begins a special series of reports, "Deadly Mistakes: The Promise Broken."

LEA THOMPSON: You know, most of us take it for granted that lab tests are done by people who know what they are doing on machines that don't make mistakes. Nothing could be further from the truth.

JANET COLEMAN [Nov. 1987]: I'm going to die because the laboratory.

THOMPSON: Janet Coleman's Pap smear was read incorrectly. That mistake allowed her cancer to spread for eight months. She died at age 42.

Janice Johnson. Her lab work was misread twice by someone who worked all day in one job and nearly all night in another. She was 35 when she died.

Two years ago, we told you that most labs were not

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tested for accuracy in this country, that almost all lab work in doctors' offices was unregulated and done by people with now lab training, that in most states hairstylists are required to know more than the people who do your medical tests.

SENATOR WILLIAM COHEN [Nov. 1987]: We're talking about life and death.

JOHN WILSON [D.C. City Council/Nov. 1987]: The system we take for granted has gone virtually unchecked.

THOMPSON: There were hearings.

DELEGATE LARRY LAMOTTE [Dec. 1987]: For all intents and purposes, there has been no regulation.

THOMPSON: There were studies. Laws were passed very quickly. In the District, the Clinical Laboratory Act of 1988. In Maryland, the Medical Laboratory Act of 1988. In Congress, the Clinical Laboratory Improvement Amendments of 1988, signed into law November 1st, 1988.

There was elation. There was hope.

SENATOR BROCK ADAMS [Nov. 1988]: Within the year, the licenses will be sent out, then the testing will start on a quarterly basis.

THOMPSON: That was Senator Brock Adams in November 1988, when the federal lab law passed. He said within the year, the rules and the regulations, the nuts and bolts needed to make that new lab law work, would be written and in place, and people could finally have some confidence in their lab work. But that deadline passed a long time ago, and:

SENATOR BARBARA MIKULSKI [Jan. 1990]: Those regs are not ready. They've gotten bogged down in bureaucracy. They've missed their deadlines.

THOMPSON: But while we wait, deadly mistakes continue.

SALLY COX: It just makes me sick that they didn't find it earlier. It really makes me mad.

ROGER COX [Sally's husband]: I think she really got cheated out of her life, really. I mean that's what it all boils down to.

LINDA ANDAHAZY: It's difficult. It's very difficult.

JOE ANDAHAZY: [Linda's husband]: This woman should not

have died. She should be here. She should be a mother with her boys and she should be my wife here in this house.

THOMPSON: You do have to wonder if these recent victims of laboratory mistakes would be alive today if all the promises had been kept.

Fo the next three nights on News 4, both a 6:00 o'clock and at 11:00, we will tell you what went wrong, how a deadly mistake could happen to you. And we're also going to tell you how to protect yourself.

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FOR ASSOCIATION OF TRIAL LAWYERS OF AMERICA

—885-4111.

PROGRAM News 4 STATION WRC TV

DATE February 6, 1990 6:00 PM CITY Washington, DC

SUBJECT Part 2: Deadly Mistakes: A Promise Broken

JIM VANCE: Two years ago Lea Thompson related case after case of unnecessary surgery and death because of laboratory errors in this country. That story, which we called "Deadly Mistakes", got the nation's attention. **It led to the passage of new federal and state laws.**

Tonight though, we bring you an update. It is a story we wish we didn't have to tell, because Lea says you are not much safer today than you were two years ago.

"Deadly Mistakes: A Promise Broken". Lea?

LEA THOMPSON: Well, there were studies, and there hearings. And the more the legislators probed the worse the lab situation appeared. So laws were passed. But a law on the books doesn't mean that you are protected. Tonight we find out why people are still dying because of laboratory mistakes.

Linda Andahazy, an all-American girl. Captain of the cheerleading team, and homecoming queen at Thomas Edison High School in Alexandria, Virginia. Wife and mother of two young boys. Runner in ten kilometer races. Accomplished water skiier.

JOE ANDAHAZY (Husband): People were very impressed. She was an excellent athelete. There's nothing that she couldn't do.

THOMPSON: Except protect herself from a laboratory mistake.

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LINDA ANDAHAZY: My worst fear is confirmed. I have a malignant tumor.

THOMPSON: Linda took good care of herself. She had annual checkups and pap smears. When she was told her pap test was normal, like the rest of us she breathed a sigh of relief. Imagine her horror when only six months later she was told she had inoperable cervical cancer.

LINDA ANDAHAZY: It's just been a nightmare. Everything has changed. I can't [word inaudible], I can hardly walk.

I know that I'll never be cured.

THOMPSON: Linda Andahazy, yet another recent victim of a laboratory error. Experts say Cytopath Associates, which used to be in this building in the District, but since has moved to Virginia, misread her pap smears not just once, Cytopaths made mistakes three years in a row.

1985. Linda's pap report came back "abnormal". It said she had an infection. We know now she already had a serious pre-cancerous condition. 1986, normal. In reality, that pre-cancerous condition was much worse but still treatable and curable. 1987. Again the report said "normal". But by then Linda had full-blown cancer.

JOE ANDAHAZY: To see this situation, something that could have been prevented, it's totally unreal.

THOMPSON: The **technologist** who read Linda Andahazy's slides was working two full-time jobs, one at Cytopath and the other National Health Labs in Virginia. **It is estimated he was reading 40,000 pap smears a year. That's double what experts say is safe if you're going to catch signs of disease.** And, he worked alone, with nobody to double check his work to make sure it was accurate.

And the lab itself? This is what Linda Andahazy told lawyers she saw when she went to Cytopath Associates seeking answers.

LINDA ANDAHAZY: I've never been in a lab before but the slides were just laying around randomly. I saw a white table cloth on the table but it wasn't clean, it was stained and it was dusty. The place was just dusty and dingy. It was an old building and it was -- it seemed like it was dimly lit, it seemed dark.

THOMPSON: Shortly after we broadcast our original story two years ago, the D.C. City Council unanimously passed lab legislation.

COUNCILMAN JOHN RAY (May 1988): The purpose of the bill is to license and provide standards for the operation of clinical

laboratories in the District of Columbia.

THOMPSON: By now, under that law, every lab, including those in doctors' offices should be licensed and inspected to make sure things are done properly and accurately. And work load limits should be set on pap smear readers, although the D.C. City Council caved in and decided not to test those people to see that they're reading them accurately.

It's been two years since the Council passed the D.C. lab law. The Mayor finally got around to appointing an advisory panel to work out the details and get the law going in November. And that group has only met once. So who knows when D.C. will have real lab protection.

And you have to wonder, if D.C. had had strong regulation in effect whether Joe Andahazy's wife might still be alive today.

JOE ANDAHAZY: This shouldn't have happened. It was stupid.

TOM MORFORD (Health & Human Services): Some of the technologists screening these slides read too many every day, read so many to the point that they're not doing a good quality job, in fact, they're doing no job at all.

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475-4843

THOMPSON: Up until recently, only one state, New York, has tested the technologists who do pap smears to make sure they know what they are doing. And if studies done for the Federal Government and by the state of Maryland last year are any indication, those of us who do not live in New York have reason to worry.

The survey done for the Feds looked at 18 labs across the country that regulators were worried about. It found half of the 18 at one time or another reported pap smears as normal when those slides clearly showed signs of infection, pre-cancers, or cancer. Forty-four percent of those labs went ahead and issued reports on pap smears that had not been done well enough by the doctor to even be evaluated. A third reported paps as showing some kind of problem when in fact there wasn't any problem at all, the slides were normal. [illegible] 18 labs, one in California and the other in Illinoi[illegible]t study found things so bad the Feds had no choice [illegible] labs out of the Medicaire program.

Researchers were also very surprised to learn that when labs did find mistakes on their own, they did not always discuss the errors with the people who made them.

PAT ASHTON (American Society for Cytotechnology): They may not have been going the next step and working with their technologists to improve their overall performance.

THOMPSON: In the Maryland study, one out of every four labs the state looked at failed the pap smear test, 25%. One in

every four pathologists -- Mds, doctors -- flunked. One in every eight cytologists flunked -- those are the technolgists who read pap smears.

But in Maryland, thanks to the brand new and working Medical Laboratory Act of 1988, things should get better. Maryland introduced its lab law early in 1988. It was signed into law three months later. As of last July, all labs in Maryland, including all doctors' office labs, regardless of the test performed, are coming under stricter review. People reading pap smears are being tested, and limits have been set on the number of pap smears they can read in a 24 hour period.

What D.C. has not been able to do, Maryland seems to have done very well. And Virginia? Virginia merely inspects Medicaire and interstate labs, the labs that the Federal Government forces it to look at. That leaves one-third of the commercial labs and all of the doctors' offices labs in Virginia unregulated. Nobody ever inspects or tests anybody in those labs.

LINDA ANDAHAZY: At bedtime every night they pray that my cancer will go away. I don't think they understand completely. I think that they think they're praying and I might get better, and that I'll return to do the things with them that I always did.

JOE ANDAHAZY: That rocking chair out there was her chair. She used to sit out there and wait for me to come home.

It's tough. It's a very quiet house now.

THOMPSON: Linda Andahazy died last April. Cytopath Associates, who turned down an interview for this report, settled for an undisclosed sum.

Tomorrow on News 4 at 6, we'll meet another victim of a laboratory mistake. Her story proves it's not just commercial labs you have to worry about. There are tremendous problems right there in your doctor's office. And later, we'll of course talk about how you can protect yourself.

I'll be back on News 4 at 11.

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FOR ASSOCIATION OF TRIAL LAWYERS OF AMERICA

PROGRAM News 4 STATION WRC-TV

DATE February 6, 1990 11:00 P.M. CITY Washington, D.C.

SUBJECT "Deadly Mistakes: The Promise Broken"

JIM VANCE: It's been two years since our report we called "Deadly Mistakes," News 4's investigation of unneeded surgery and death because of laboratory errors. That story led to state and federal law. But tonight Lea Thompson has another story to tell, a News 4 special report this time we call "Deadly Mistakes: A [sic] Promise Broken."

LEA THOMPSON: You know, the more legislators probed after our story, the worst the lab situation appeared. So, laws were passed. Why, then, two years later, are people still dying because of laboratory mistakes?

Linda Andahazy, all-American girl, captain of the cheerleading team, homecoming queen at Thomas Edison in Alexandria, wife and mother, runner, water skier.

JOE ANDAHAZY [Linda's husband]: People were very impressed. She was an excellent athlete. There's nothing that she couldn't do.

THOMPSON: Except protect herself from a laboratory mistake.

LINDA ANDAHAZY: My worst fear is confirmed. I've got a malignant tumor.

THOMPSON: In April 1987, Linda's annual Pap smear came back marked "normal." Imagine her horror only six months later when she learned she had inoperable cervical cancer.

LINDA ANDAHAZY: It's just been a nightmare. Everything has changed.

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THOMPSON: Experts say a person at Cytopath Associates, then in the District, who worked two full-time jobs misread Linda's Pap smears three years in a row. Court papers also show he also read double the number of slides to be accurate.

If a study done for the Federal Government last year on Pap smears is any indication, we all have reason to worry. Eighteen suspect labs were looked at. In half, Pap smears were reported as normal when they clearly showed signs of disease. A third told women there was a problem when there was none. Two were so bad, they were kicked out of the Medicare program.

In a Maryland study done last year, one out of every four labs failed the Pap smear tests. One-in-four doctors flunked. One-in-eight technicians failed.

Maryland moved quickly in 1988 to clean up its labs. By last July, it was licensing and inspecting every lab in the state. It now tests Pap smear workers and limits the amount of work they can do.

In Virginia, one-third of commercial labs and all doctors' office labs are never inspected or tested.

D.C. has a new lab law. Labs should be licensed and inspected. Pap smear readers should be regulated. But the law is worthless. No rules have been written to make it work.

And if D.C. had had a strong regulation, who knows if Joe Andahazy's wife might still be live today?

JOE ANDAHAZY: That rocking chair out there was her chair. She used to sit out there and wait for me to come home.

It's tough. It's a very quiet house now.

THOMPSON: Linda Andahazy died last April. Her family sued Cytopath Associates -- which, by the way, refused an interview with us -- and settled for an undisclosed sum.

On the subject of Pap smears, cervical cancer, if caught early, is curable. Those at particular high risk are smokers and people who were very young when they first had intercourse. Hardest hit, the elderly, especially poor black women.

In an effort to save a lot of elderly lives, starting in July, Medicare will start helping to pay for Paps in the elderly. They really are something every woman has to get, but they have to be taken and read right.

Tomorrow on News 4 at 6:00 and 11:00, another victim's story that proves you need to worry not only about mistakes in

commercial labs, but things going wrong right there in your doctor's office.

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FOR ASSOCIATION OF TRIAL LAWYERS OF AMERICA

PROGRAM News 4 STATION WRC-TV

DATE February 7, 1990 6:00 P.M. CITY Washington, D.C.

SUBJECT Deadly Mistakes: The Promise Broken, Part Three

JIM VANCE: Lea Thompson all this week has been investigating the state of our laboratory tests. Her findings are startling, especially when you consider there were laws passed two years ago to stop the deadly mistakes being made in labs. Now Lea reports on deadly mistakes once again, the promise broken.

LEA THOMPSON: You know, labs without rules are like cars without gas. They just don't go anywhere. The legislators did what had to be done. It's the administrators, the bureaucrats, who've made all of these new laws worthless. And people, as a result, continue to have unnecessary surgery and radiation and medicine. People continue to die.

For Roger Cox, it's another day behind the counter at the Bethesda Women's Farm Cooperative: cakes, pies, jams, jellies. It used to be a family affair. Now he sells alone.

ROGER COX: She was something to keep up with, you know. I mean it took everything for me just to keep up with her. She was always on the go.

There's things that my wife provided for me and provided for my kids that I'm not going to be able to replace in any way. There's times that -- there's things that, you know, she could do for them that I really can't do them. And that makes it hard.

THOMPSON: Roger's wife, Sally Cox, mother of eleven-year-old Josh and nine-year-old Jarrett, died 15 months ago. She was only 28. She and they are the victims of another medical laboratory mistake. A system which has few checks and balances killed her. The charge is both the medical laboratory and her

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doctor were negligent, were not careful enough. And as a result, Sally Cox is dead.

COX: By the time they did finally get around, you know, probing and finding out exactly what was the matter, I mean it was just -- you know, that's too far gone now.

THOMPSON: In 1986, Sally's doctor sent her Pap smears to the Medpath Laboratory in Rockville. Medpath sent it back with a notation "abnormal." Experts now say that slide shows a more serious condition than that.

Sally's doctor, who had delivered her children and treated her for 12 years, did send a letter saying to return to his office for a repeat Pap test. But the letter never went to Sally A. Cox in Monrovia, Maryland. It went to Shirley A. Cox in Walkersville. Sally never got the message.

COX: We never heard anything. So, as far as we knew, everything was, you know, fine.

THOMPSON: So Sally did not have another Pap test for 15 months. This time Med,ath said it showed signs of inflammation, nothing more. But expert review of that Pap smear slide showed a serious pre-cancerous condition; a condition, though, that was still treatable and curable.

But nine months later:

SALLY COX: [Unintelligible]...that's how bad I was bleeding.

THOMPSON: Sally had cancer

MRS. COX: I need to know why they couldn't find this cancer earlier than they did.

COX: There was not much I could really explain to her, you know. I mean 'cause -- well, actually the doctors and the Medpath and stuff, they never, you know, explained it to us beforehand. So there was no way that I could, you know, explain to her why such a thing would happen.

THOMPSON: Sally's case brings home the point that kings can go wrong not just in a commercial lab, but also in a doctor's office. In fact, 25 percent of all medical tests are done in doctors' offices, offices which are virtually free of licensing or inspection, places where the doctor's wife might be doing the test.

RICHARD KUSSEROW [HHS Inspector General/July 1988]: I

think that's very serious. I think that we have a real quality problem in that setting.

HOMPSON: Sixteen states claim they have some type of regulation of physician office labs. The Inspector General found most of those laws worthless.

Enter the Federal Government. For over 20 years, it has had some regulation of interstate and Medicare/Medicaid labs. But after hearing one horror story after another:

BARBARA ARBUCKLE [victim/Jan. 1988]: And I also pray to God that something can be done about this problem, so another person does not have to go through it.

THOMPSON: In October 1988, Congress decided to go a whole lot further.

SENATOR BARBARA MIKULSKI: We are being medically mugged by these laboratories.

THOMPSON: It passed the Clinical Lab Improvement Amendments, CLIA. It calls for the regulation of every test in every lab in the country.

TOM MORFORD [Health Care Financing Administration]: Before the new legislation was passed, we regulated about 12,000 clinical labs in the United States, primarily under Medicare/Medicaid or interstate commerce. The new Clinical Lab Amendments, in effect, make us responsible for every lab in the United States, whether it be in a physician's office, a small private lab. And the numbers increased astronomically, from, as I said, about 12,000 to somewhere between 300 and 600 thousand labs.

THOMPSON: Congress passed a tough law, one that would give people some guarantees on safety and accuracy. Congress ordered rules and regulations to be written by the Health and Human Services Administration to implement that law: how to test people in labs, what fees to charge labs for inspection, what penalties they would face if they didn't do the job right. Congress expected the Health Care Financing Administration to have those rules and regulations written a long time ago. It expected the law to be up and running by now. It is anything but.

MORFORD: Both the Congress, as well as those of us in the Executive Branch, I assure you, did not realize the size and complexity of the task.

SENATOR MIKULSKI: We gave them an enormous job. But

one of the reasons the job is so enormous was they weren't doing their job in the first place.

MORFORD: We're working as diligently and as quickly as possible to do the kind of regulation that the public merits.

SENATOR MIKULSKI: We need someone in charge of the Health Care Finance Agency on a permanent basis that's moving these regs through in the kind of quickstep that Congress wanted.

MORFORD: It's better to do it right than to do it quickly in some slipshod fashion.

MIKULSKI: We will be holding national oversight hearings on this. We're going to ask, "Where are those regs?"

THOMPSON: But while the politicians and the bureaucrats fight it out, families like the Coxes have to live with the consequences.

SALLY COX: When they told me it was so big [unintelligible], you know, I knew that, you know, this is it, you know.

COX: I do blame the doctor. I do blame the labs. When you come down to a job that you're doing that concerns life and death, you just can't hire that are going to make those mistakes. They just can't be doing that.

My kids and, I guess, myself too, they took her from us.

THOMPSON: Sources tell us proposals to make that medical lab law work are written, but are stuck in the Secretary of Health and Human Services' office over arguments on what kind of qualifications lab workers should have.

Congress is anger. Congressman John Dingell, just yesterday, sent a letter to HHS complaining about the delay. And Barbara Mikulski and Senator Brock Adams say they will pull HHS into oversight hearings next month to put some folks' feet to the fire.

We'll be there.

Sally Cox's doctor has no comment on all of this.

The lab, Medpath, would not talk to us on-camera, but did issue this statement: "We at Medpath feel great sympathy for the Cox family. However, the simple truth remains that Medpath is not responsible for the death of Sally Cox. The matter is now in the hands of the judicial system, where it properly should be

resolved. Therefore it's not appropriate for Medpath to discuss the matter further." Unquote.

Tomorrow on News 4 at 6:00 and 11:00, the bottom line of all of this: How are you going to protect yourself?

3/18/90

Sitting on tort reform

EFFORTS TO achieve tort reform — legalese meaning that the state needs to clean up its act when it comes to damage suits and malpractice actions — have been stalled in Juneau for years.

The move is trapped again, as time begins to run out in this 1990 session, in the House Judiciary Committee.

The co-chairman of the committee is sitting on the latest version of a tort reform bill that he doesn't want passed.

Indications are a majority of the House members want the bill enacted. The Senate has signaled it will pass the bill if the House will act on it.

But Judiciary Chairman Max Gruenberg, a Democrat from Anchorage, is a lawyer. And a lot of lawyers — especially those who love the rewards that now can be plucked relatively easily in Alaska from malpractice and other damage suits — don't want anybody tinkering with this ready source of Big Dollar claims.

IN THE last couple of years there have been endless legislative hearings — half a hundred in all — on tort reform.

House Judiciary Committee members have heard all the arguments, pro and con, on repeated occasions.

A preponderance of the testimony over and over again has urged the legislature to move ahead with tort reform proposals that are urgently needed. Various committee hearings have resulted in the current legislation being repeatedly amended, striking half of the original provisions and leaving more or less just a few bones on the skeleton.

But even though enactment of those provisions would be a step forward, the legislation remains mired because a lawyer — apparently with no concern about whether his position could be perceived to be a conflict of interest — so far has refused to move the bill to the Rules Committee, from which it could be brought to the floor for a vote.

Mr. Gruenberg was not elected to represent the trial lawyers of Alaska, yet they are the ones who stand to profit most from his refusal to let this bill out of committee.

The fact is that the general public has an enormous stake in this legislation.

The Citizens' Coalition for Tort Reform, the group which has worked for years to get this legislation enacted, represents a diverse interest that includes doctors, dentists, hospitals, construction companies, insurance companies and businesses of all kinds.

THEIR INTENT is not to deny injured parties access to financial relief through lawsuits arising from wrongful death or terrible harm and suffering that might have been caused by the careless or stupid negligent acts of others. Rather, the effort is to put some common sense rules in place that will put limitations on excessive damage awards and to otherwise introduce some sensible reforms into a system that now is bent out of shape.

As a consequence of the present order of things, for example, many doctors in Alaska are practicing without any insurance at all. Some have dropped their practices, and residents in some villages, towns and cities are without medical care in some specialties.

Other states have dealt with such crises by enacting tort reform legislation. Legislative action in Juneau is long overdue.

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Our purpose: To present a balanced, accurate, impartial news report; to watchdog government and other institutions depending on the public for support; to provide wholesome family entertainment; and to support on our editorial page environmentally sound development of our natural resources and a diversity of other economic opportunities.

HOW DOCTORS HAVE RUINED HEALTH CARE

To hold down costs, we must first find out what we are paying for.

BY LAUREN CHAMBLISS AND SHARON REIER

ABOUT 35% OF ALL SURGICAL DEATHS AND 50% of postoperative complications, such as infections, are probably preventable. As many as one-fourth of all patients who die in hospitals may have been misdiagnosed by physicians. Up to 35% of all hospital admissions are not needed. Some 15% to 30% of diagnostic tests don't help or aren't even looked at. Those shocking figures come from a study conducted by a bipartisan group backed by major corporations, headed by former Presidents Ford and Carter, and staffed by some of the brightest minds in the medical business today. (The data, culled from medical research and expert testimony, are contained in a confidential memo from the staff to the National Leadership Commission on Health Care members.)

Studies published in medical journals tend to confirm these findings. They report, for example, that 44% of bypass surgeries are unwarranted or questionable. For cardiac pacemaker implants, 20% of procedures are not necessary and another 36% ambiguous. And the California-based think tank, Rand Corp., found that, in one particular surgical procedure, carotid endarterectomies—the delicate procedure surgeons perform to clear the major neck artery to prevent strokes—32% were done, if not capriciously, then without much justification.

"One-fourth of hospital days, one-fourth of procedures and

of Minnesota's HMO: "We have a historic inequity that favors procedural processes. We pay the doers more than the thinkers."

Americans also seek instant gratification when it comes to new medical technology. Banks goes on: "Americans have an appetite for consuming high-tech health care. But there isn't evaluation of the new technology. Lots of evaluation is done in real time with real dollars."

Meanwhile, the cost of American health care continues to soar. We will spend $650 billion in 1990, about 12% of GNP. Growing at today's double-digit annual clip, health care will suck up 15% of GNP by the year 2000. Already the U.S. spends more on health care per person than France and West Germany, and nearly twice as much as Britain (see table, page 48).

And if you think we get more for our money, think again. Infant mortality and life expectancy statistics—indicators of just how good our medical system is—lag behind Japan, England, Canada, West Germany and Sweden.

Why is the system out of control? Certainly not for lack of corrective initiatives. Private insurance companies and the government have taken steps to cut costs and increase competition. Diagnostic-related groupings (DRGs), imposed by Medicare, limit payment for procedures so that hospitals have an incentive to hold down costs. In November, Congress made an attempt to corral doctor's fees by, among other things, limiting payments for expensive diagnostic tests that could have been done the less-expensive, old-fashioned way—by physical exam. Insurance companies and employers are pushing cost sharing.

two-fifths of medications could be done without," wrote Rand fellow Dr. Robert Brook in a recent article in the *Journal of the American Medical Association*. "Almost every study that has seriously looked for [hospital] overuse has found it, and virtually every time at least double-digit overuse has been found."

A truly astonishing percentage of the $650 billion annually spent on health care in this country is wasted; the result of unnecessary surgery, unneeded diagnostic procedures and puffed-up bills. The incidence of operating room incompetence is chilling.

Even the average layman is beginning to learn about the overuse of common procedures such as hysterectomies and cesarean sections. (By the time they reach 70, about two-thirds of the women in the U.S. have had their uterus removed.)

What is causing this outrageous medical overkill? A biased reward system has a lot to do with it. Says Mark Banks, medical director and head of quality control at Blue Cross/Blue Shield

But most of these initiatives have backfired. "Faced with efforts to hold down costs, doctors have responded partly by increasing services. And doctors do control demand, much more so than the patient. Even with the freezes, income from Medicare to doctors increased 31% from 1980 to 1986," reported the National Health Care Campaign, a coalition of religious, charitable and union groups.

Ed Morton, chief operating officer of Health Care, Inc., a Naples, Fla.-based diversified health-care provider, also puts much of the blame on physicians and the physician-dominated health-care system: "You can't have these guys running around like the Lone Ranger. You think Ollie North was a loose cannon? You think the loss of S&L oversight caused problems? Without appropriate and timely review, you put yourself in a position where abuse can take place."

That can happen at outpatient surgery centers as well, especially when doctors own a piece of the action. Ford Motor, which spends $1.02 billion a year in employee medical benefits, refuses

to reimburse patients for facility charges done in outpatient centers not affiliated with a hospital. Why? Because there isn't sufficient scrutiny as to whether surgery is necessary.

Nor is the much-vaunted second opinion the panacea it was supposed to be. Medical politics and fear of malpractice suits make most doctors unwilling to openly contradict a peer.

Political problems aren't limited to doctors, of course. While studies show that hospitals specializing in a particular procedure do it better—a sort of practice-makes-perfect effect—most are reluctant to give up any department, even an underutilized one, for fear of losing prestige or physician support.

And the controls are inadequate to begin with. A recent study by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) revealed that more than a third of the 5,200 hospitals it surveyed lacked the sort of controls necessary to guard against inappropriate surgery, unnecessary blood transfusions and/or uncoordinated treatment of intensive-care patients.

"It's a major challenge to convince any organization in the delivery of service that quality is important and at the same time cost effective," says Dr. Dennis O'Leary, president of the JCAHO. "Generally speaking, American industry is ahead of the hospital field, well ahead, in applying quality improvement techniques."

Former Surgeon General C. Everett Koop wrote shortly before leaving office in October: "We have a system that is distinguished by a virtual absence of self-regulation on the part of those who provide care—hospitals and health-care workers, primarily physicians—but distinguished as well by the absence of such natural marketplace controls as competition in regard to price, quality or service."

"One-fourth of hospital days, one-fourth of procedures and two-fifths of medications could be done without."

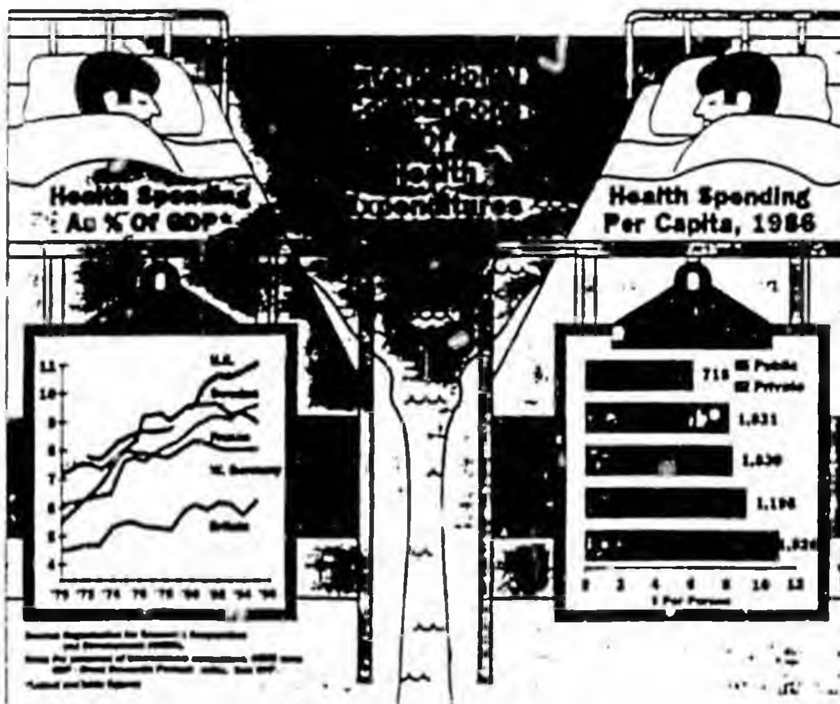
What all this means, for starters, is that there is a tremendous need for medical information. At present, a doctor tells the patient what surgery is needed and where to have it done. There is no way for a patient to participate in the process by judging cost or quality factors. If an employee's health-care plan points to a specific hospital, he has no way to check that the lower-cost provider is doing high-quality work. It's like having a Ford dealer tell you how many cars your family needs and where to buy them, too.

"If we don't have quality-of-care procedures in place, or quality assurance systems, such as exist in other industries, we're going to make a lot of mistakes, waste a lot of money and hurt a lot of people," says Dr. Henry Simmons, head of the National Leadership Commission on Health Care.

In Washington, there's growing talk of nationalizing health care to curb runaway costs and provide for the 37 million Americans with no health coverage at all. The proposals run the gamut from granting tax breaks to encourage citizens to buy their own insurance to forcing employers to provide basic coverage for workers.

The plans have one thing in common: They deal with the symptoms—exploding costs and the uninsured—without addressing the disease. We are still far from knowing which parts of the American medical system are worth saving and which should be discarded.

"We've got all the computers we need to analyze the data," says Representative Fortney "Pete" Stark (D-Cal.). "It's a crime more isn't being done. We've got 21st-century equipment but 19th-century procedures for looking at the data."



Here's what the government needs to do to generate the information the public badly needs.

• Spend a lot more for research. Washington has to get into the business of gathering and disseminating information to the public. In the area of technology, for example, less than 1% of the federal government's $108 billion health-care budget goes to figuring out the best, and most cost-effective, way to use the hundreds of high-tech products that flood the medical field every year.

• Set standards for medical care to stop surgical and diagnostic overuse. Think about it: The FDA demands that each new drug be subjected to rigorous testing, but less than 20% of the nation's medical procedures are put to any review, according to the Office of Technology Assessment (OTA). The Leadership Commis-

sion's Simmons estimates that a $500 million effort would be enough to study the most commonly performed procedures and come up with guidelines. Some doctors deride practice guidelines as "cookbook" medicine and worry that substandard physicians might be tempted to simply follow the recipe regardless of a particular patient's needs. But the American Medical Association and others are working vigorously to develop quality checklists that could at least provide a patient, and doctor, with an outline of options. And the savings could be enormous: up to $22 billion a year if there was only a 5% reduction in unnecessary surgery for 11 of the most commonly performed operations. And that doesn't even count savings from overused diagnostic tests.

• Start a national data bank that would contain information about doctors—including disciplinary action—and hospitals, with cost and quality measures. Measuring "quality" isn't easy. The JCAHO, which accredits hospitals, is just now developing statistical measurements to evaluate a hospital's treatment record, such as whether there's a high postsurgical infection rate. The government should use the JCAHO guidelines to do the same for the public. That may mean more hospitals will go out of business. But that may not be a bad thing: Beds today are still only about 60% occupied. In a 1988 report, OTA advised setting up a "consumer affairs" agency within the department of Health and Human Services to begin the process of providing information to patients.

The special interest groups—doctors, hospitals, and even the insurers—all agree on the need for health-care reform in general and more quality information in particular. But that's where the harmony ends and the backbiting begins.

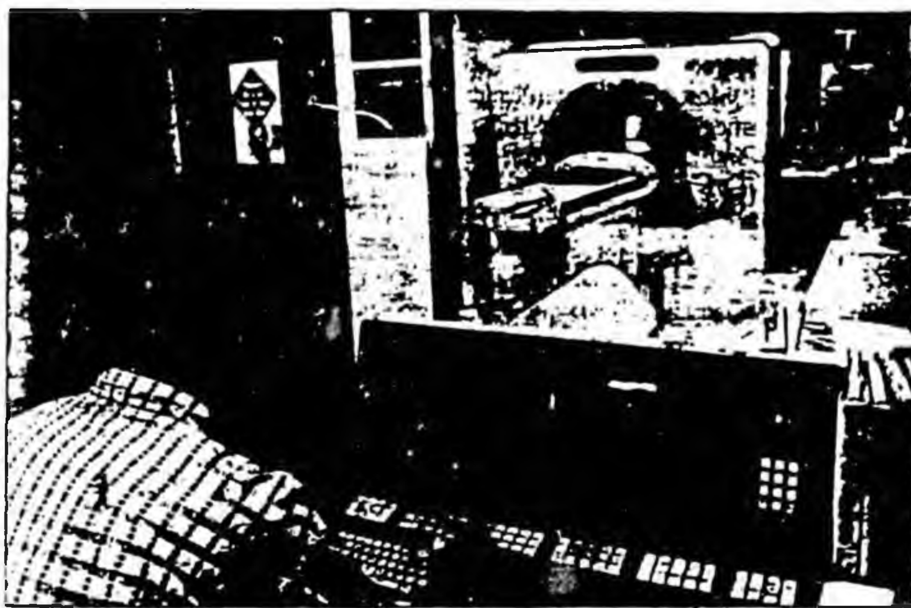
"I hear lots of slogans and can imagine the placards about the proper structure of health-care reform, but I don't hear many people out there saying, 'Yes, we are willing to forgo some of our income for the public good,' " says William Roper, President Bush's domestic policy adviser. Roper indicates that Bush won't make health-care reform a priority unless and until some sort of consensus is reached by the big boys: the American Medical Association, the American Hospital Association and the insurance lobbies.

Good luck.

The mighty AMA, a big source of congressional campaign money, has never been wild about giving the public access to data on doctors. HHS, for example, has a new data bank that will keep a national scorecard of such things as disciplinary actions and malpractice awards against the nation's 500,000 physicians. The data bank is supposed to help hospitals and other health-care agencies check a physician's background. At present, a doctor may get into trouble in one state and set up shop in another with little danger his poor record will follow him. But largely because of AMA objections, the national data bank can't be tapped by the general public. The new doctor in town may have a blacklist 50 pages long, but there will be no way for his patients to find out.

And hospitals aren't any better. Three years ago, when the Health Care Financing Administration, which administers Medicare, began publishing data on hospital mortality rates, the hue and cry from the nation's health-care providers was deafening. The idea behind HCFA's data was to help doctors and patients make decisions about where to go for care. If Bob Smith was about to go in for, say, heart surgery, a quick review of local hospitals would show which institution had the best record of success, or at least the lowest level of ultimate failure: patient deaths.

The AHA says the data is so misleading it's of little benefit to patients. True, the data isn't properly indexed for severity of illness at admission. But consumer groups argue that even less-than-perfect information is better than no information at all. And HCFA's mortality data, as limited as it is, has given the industry a strong incentive to develop data the public can understand.



A CAT scan in progress

"A historic inequity that favors procedural processes."

"It's simply not acceptable to say that because the data is imperfect, we'll do nothing," says Bush aide Roper, who, as HCFA's former chief, first released mortality data for public scrutiny. "There's too much at stake to sit on our hands until something better comes along."

There are other signs the government is edging in the right direction. In the 1990 budget, Congress allocated $32 million—up from $5 million the previous year—for studies on the effectiveness of four extremely common ailments whose surgical solutions are now being questioned: heart attacks, lower back pain, cataracts and prostate problems. Says administrator Norm Weisman of the National Center for Health Services, a subsidiary of HHS: "What we are trying to do is determine what outcomes there are so we can say to physicians and to patients, 'Here are the risks and here are the benefits.' "

One of the problems in setting policy, according to Dr. David Eddy, a Duke University specialist, is that up until now the analysts and policymakers have assumed that the scientific base

of medicine was solid.

Eddy believes that premise is just plain wrong. "The wide variation in using procedures points to a soft intellectual basis," he comments. Eddy, who has degrees in both surgical medicine and mathematics, designs statistical models that assess just how well certain procedures really work.

"Outcomes research" like Eddy's poses a fundamental question: Are doctors practicing a kind of ritualistic medicine, not unlike the barber/doctors who did bloodletting in the Middle Ages?

Eddy believes doctors tend to use familiar homilies like a "stitch in time saves nine" or "an error of commission is to be preferred to an error of omission" to justify procedures. In a recent article, he notes: "Most of the simplifications and heuristics point in one direction, toward overutilization. When this happens the price is paid in terms of inconvenience, pain, distress, days in the hospital, unnecessary risks and money."

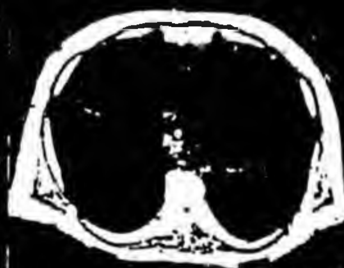
It may be ignorance rather than greed that leads to medical overkill. Many patients who are dissatisfied simply move on to a new doctor and never complain. Since complete medical records are only available for Medicare patients over 65, it is difficult for a doctor to get proper feedback.

While many organizations laud Eddy's work—he has been a consultant for Chrysler, Blue Cross/Blue Shield, HMOs and the AMA—some of his findings have caused a furor. Take his work on Pap smears. For 40 years, the American Cancer Society promoted the annual Pap smear to detect cervical cancer early. Then, Eddy's statistical analysis showed the test to be virtually as effective for screening cancer when given every three years. The ACS [illegible] recommendations, provoking a storm of controversy from the American College of Obstetricians and Gynecologists.

Eddy's work on outcomes [illegible] by the so-called "small area [illegible]" [illegible] Wennberg, a Dartmouth University medical professor. Using Medicare data, Wennberg discovered striking variations in the rates for certain surgical procedures from one community to another. In his landmark prostatectomy studies for the state of Maine, Wennberg not only found large regional variations in the number of surgeries used to treat benign urinary tract obstructions common in older men, but also that the risk of complications from the surgery was far higher than generally believed. Thanks to Wennberg's highly publicized research there are now 35% fewer prostatectomies done in Maine.

Wennberg's studies have demonstrated that knowledge leads to more conservative practice.

What all this suggests is that the biggest problem with health care isn't cost, it's waste. Eliminating that waste would save the nation untold billions, but how can that be done? Chiefly, by gathering the information and disseminating it to the consuming public, who have a right to know. And how can reluctant congressmen and senators be goaded into action? Through the mailbox.



"You can't have these guys running around like the Lone Ranger. You think Ollie North was a loose cannon?"

The "Show-Me" Days Are Here

With corporate health-care costs up another 9% this year to over $150 billion, more firms are taking a closer look at what they're getting for their money. Just last month, Georgia-Pacific raised its deductible from $200 to $300 and began charging $600 per employee per year for family coverage, up from $400. In some cases this has led to labor strife. Nynex and Bell Atlantic both underwent four-month strikes this year when they tried to institute larger health insurance copayments.

A group of around 20 major corporations including Alcoa, Hewlett-Packard, General Electric, Ford and Honeywell have pioneered in trying to hold down unnecessary health-care costs. "As companies kept complaining about rising costs, we began to hear from the providers: 'All you care about is costs; you don't care about quality,' " says Alcoa benefits manager Dick Wardrop. "So we said: 'Okay, tell us about quality.' We got silence. So we concluded: 'Either they know and they are keeping quiet for a reason, or they don't know.' "

Compounding the silence were biting articles by Dr. Arnold Relman, editor of the *New England Journal of Medicine*, arguing that 20% to 30% of medical procedures are inappropriate. Equally damning were studies showing surprisingly high variations in medical practices from one region to another. Gradually, says Wardrop, this "led large companies to [illegible] this is one of the reasons the Japanese are eating our lunch." Ford, for example, spends $305 per automobile on [illegible] costs, 50% more than their Japanese counterparts.

Dr. John Burns, an internist and kidney specialist, is Honeywell's vice president of health management. Burns believes [illegible] industry has gone through three phases in its attempts to cut health costs. First, it promoted health maintenance organizations. Firms hoped HMOs could shift the risk to a provider to cut costs. But, says Burns, a process of "adverse selection" emerged with younger and healthier employees joining the HMOs and older, sicker ones not joining them. That sabotaged the initiative.

Second, firms asked employees to shoulder larger deductibles or copayments. The hope was that this would give employees incentive to be more selective.

Finally, companies resorted to utilization agents who limit financial exposure by imposing a maximum payment per diagnosis, or by limiting the length of a patient's hospital stay.

But the last two "solutions" proved to be flops as well. "None of the above has resulted in any significant cost savings. Nothing has dented the system," says Burns. Why? The answer, he claims, is that the focus has been on attempting to control costs through benefit design without describing what is necessary and appropriate health care.

"Now," says Burns, "we are saying that, if in retrospect

they can determine cases not to be necessary, why can't we design a system where criteria are known and published and communicated? The answer," he asserts, "is that we can." In private conversations, says Burns, physicians will admit much of what they do is neither necessary nor appropriate. His conclusion: "The payment system incentivizes extra medicine."

The solution, then, he continues, is to go directly to a group [of physicians] and say "We will reward you by sending you more patients so that it will increase your market share, provided the standards of the medical literature are the determinant of the process." With $160 million in health payments last year, Honeywell has the clout to talk like that.

Burns says he goes to the medical director of a physician group or hospital and says: "We are interested in purchasing standard-based health care. Show me, department by department, what quality improvements you have instituted. What standards do you have for coronary artery surgery? Do you have a high-risk pregnancy program designed to minimize the incidence of premature birth? Some groups do. They may have data to show that their premature birthrate is 50% lower than the state average. And guess what? It is cheaper. And that is the new paradigm. The shift from cost control to quality control through health management." —*S.R.*

The Prototype

One interesting prototype of a national health information network can be found in Pennsylvania. Each of the Keystone State's 290 medical institutions is being ranked quarterly on how well it treats a variety of medical conditions, and how much it charges for them.

This one-of-a-kind consumer guide to hospitals is still in the development stage but the state has high hopes its new Health Care Cost Containment Council, which publishes the information, will boost competition to help curb Pennsylvania's skyrocketing health-care budget, now at $2 billion.

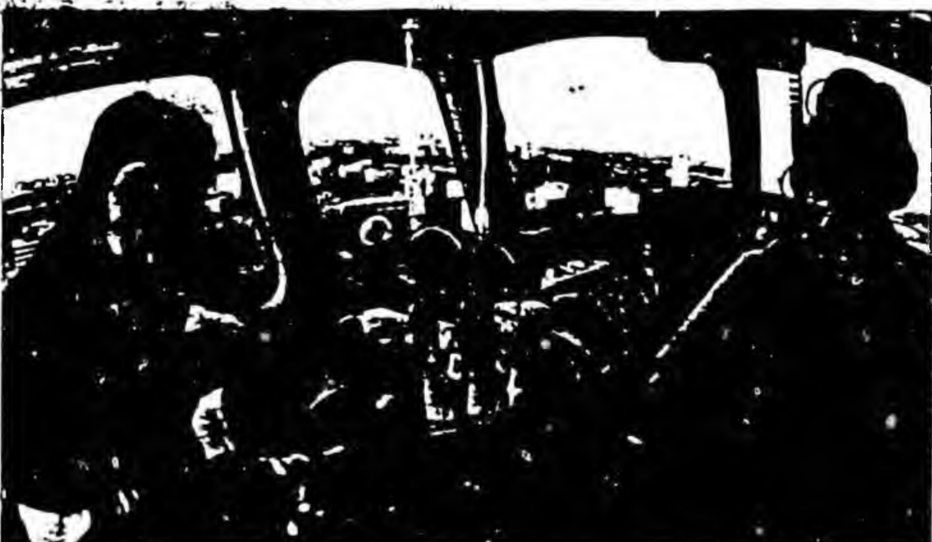
"We are trying to get good, reliable, consistent information that people can use to buy health care," says council director Ernie Sessa. "By disseminating this information we hope to create a truly competitive marketplace in health care."

The first trial run report, published in June, compared mortality rates and medical complications for 55 different conditions—from lower back pain to heart failure—at 15 south central Pennsylvania hospitals. What the consumer guide shows quite clearly is how much treatment and cost can vary from one facility to another. The average charge for hip and knee replacement at Lancaster Community Hospital, for example, was $7,300 while at nearby Hershey Medical the charge reached $12,500.

Pennsylvania's paying dearly to foster competition. The Health Care Cost Containment Council's annual budget is $2 million. On top of that, the hospitals had to lay out up to $200,000 to purchase computer systems.

And Pennsylvania's initiative is proving highly controversial. There have been complaints that the computerized screening program wasn't designed for hospital comparisons. Health-care experts say there are inconsistencies in how hospitals report the data, which may not accurately reflect how sick patients were upon admission, for example.

"No one knows whether what it's measuring is an accurate indicator of quality of care," says Dr. Norbert Goldfield, a New Englander who has written a book about the issue. He says the best indicator of a hospital's quality is probably pa-



Chopper medevac teams on the job.

"This is one of the reasons the Japanese are eating our lunch."

tient satisfaction, but the data collected in Pennsylvania doesn't include that human factor.

Director Sessa agrees that Pennsylvania's methodology isn't perfect but says it's a first step in providing the sort of comparative data that will enable employers and patients to seek out high-quality, low-priced care. Besides, he doesn't expect miracles. "Our goal is to hold down the escalation of the cost of health care to at least somewhere around the consumer price index level."

The next step: a similar type of consumer guide rating physicians. *—L.C.*

Finding A Good Doctor

"It would be nice if you could [find out] whether a doctor has ever been disciplined . . . but unfortunately that's a secret."

Most people find a doctor by asking family and friends. "It's better than nothing," says Dr. Lynn Soffer of the Public Citizen's Health Research Group in Washington, D. C. "But it really overemphasizes the personal, rather than technical, attributes of a physician."

How else is the average person supposed to pick a doctor? "Find out where and when they graduated from college," says Soffer. "Are they board-certified in a recognized specialty?" And how does one go about doing that? "One way is to look at the walls in their offices," she replies. "Another way is to consult the Directory of Medical Specialists at the library. To do that, you need to know the city where the doctor is practicing medicine or the city where he completed his residency.

"If you're moving to a new city," she continues, "call the head of the department at a medical school or university hospital in the area and ask for a recommendation. That will help your chances of getting a good doctor, one who keeps up with the latest medical procedures."

The Office of Technology Assessment, Congress's investigative arm, published a report in 1988 entitled *The Quality of Medical Care—Information for Consumers*, notes that "Formal disciplinary actions by the state medical boards provide the most valid information about poor-quality physicians." Unfortunately, such information is simply not available to the general public. "It would be nice if you could get information like whether a doctor has ever been disciplined or how often he has been sued," says Soffer. "But unfortunately, that's a big secret."

You can get some useful information about hospitals, however. The OTA recommends that patients review hospital mortality rates, published by the Health Care Finance Administration (HCFA). Another indicator is the volumn-outcome relationship for a specific operation. Research shows that the more often a specific operation is performed at a hospital, the higher the success rate. If you already know what type of illness you have, there are often specialized data banks on physicians or hospitals. For instance, the National Cancer Institute has introduced a data base called PDQ that combines updated information on cancer treatment, research protocols and physicians and organizations involved in cancer care. PDQ can be accessed by anyone who has a personal computer and a standard telephone line.

Dr. Dennis O'Leary, president of the JCAHO

"Quality is important and at the same time cost-effective."

Within PDQ, a directory provides the names, addresses and telephone numbers of more than 14,000 individual physicians who spend a major portion of their clinical practice in the care of cancer patients. Another PDQ directory lists approximately 1,600 health-care organizations with cancer treatment programs.

For more information, you can call 1-800-4-CANCER. In addition to PDQ, NCI will provide general information about various types of cancer treatments and locations of clinical trials research in the caller's regional area.

You can also call organizations like the American College of Obstetricians and Gynecology or the American Society of Plastic and Reconstructive Surgery for information on an illness or operation. The latter, for instance, will provide a caller with the names of 10 board-certified plastic surgeons in a specific region, as well as educational brochures and background on a particular doctor. The background check is cursory, however. *—H.H.*

MAC NEIL/LEHRER NEWSHOUR

Wednesday, February 28, 1990

WNET, New York, New York

SHOW #3678

ANCHORS:	ROBERT MAC NEIL
	JAMES LEHRER
NEWS MAKER:	DANIEL ORTEGA, President, Nicaragua
CORRESPONDENT:	KWAME HOLMAN, NEWS MAKER (Interview with Defeated Pres. Ortega)
FOCUS - EXXON - FACING CHARGES:	ROBERT ADLER, Environmental Lawyer
	RICHARD SAMP, Washington Legal Foundation
FOCUS - NEGLIGENT TREATMENT: (Medical Malpractice Debate)	DR. DAVID AXELROD, New York Health Commissioner
	DR. HARVEY WACHSMAN, Malpractice Lawyer

TRANSCRIPT BY:

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commissioned the Harvard Report today and is one o' the leading proponents of the no fault insurance solution. Harvey Wachsman is a physician and practicing lawyer. He is president of the American Board of Professional Liability Attorneys. He's on the faculty of Brooklyn Law School and the University of South Florida College of Medicine.
Dr. Axelrod, what is the surprising finding in your study, the large amount of negligence, or the small amount of claims?

DR. DAVID AXELROD, New York Health Commissioner: I think it was rather the small amount of claims. A previous study done at Stanford approximately 10 years ago identified roughly the same percentage of adverse events, that is injuries to patients that occurred that would lead us to have believed at least that the number would be approximately the same. There is a concern I have with the data that are being presented and that is that this is an extrapolation from the review of some 30,000 charts to over 2.7 million discharges in 1984. So to say that numbers of thousands of individuals who are identified as having died represents an extrapolation from 1,100 cases in which injury was identified in the Harvard study.

MR. MAC NEIL: I see. It's like a poll. In other words, you've taken a sample and you're saying that represents that reality?

DR. AXELROD: That is correct.

MR. MAC NEIL: Right, like a blood sample.

DR. AXELROD: Yes.

MR. MAC NEIL: Okay. Why do you believe there are so few malpractice claims arising out of so many cases of negligence?

DR. AXELROD: I think in many instances, the patient is not aware of the fact that any negligence has been committed. I think there are difficulties in accessing what is otherwise identified as an officious system with respect to the individual person. I don't think that the average person thinks that there is much chance of success. An individual who comes from a lower socii-economic background may not feel that he has the wherewithal or she has the wherewithal to purse a malpractice suit. There is no clear indication that our system is geared to one of social responsibility with respect to payment for medical injury and it leads more to an event that looks like entering a lottery with respect to a return with a medical malpractice suit.

MR. MAC NEIL: Do you share Pres. Bush's belief that fear of malpractice claims, that doctors hold of malpractice claims, is distorting the medical delivery system?

DR. AXELROD: Yes, I believe that there is a distortion which is occurring. I think it's occurring in a number of different areas. The most important of them may, in fact, be the unwillingness of physicians to participate in peer review of their own colleagues. That fear I think has removed an important element of maintaining the quality of healthcare within our institutions. Without full participation of physicians, it is not going to be possible to have a full review of what happens and the manifestation of quality that we would like to have. I do believe there is a cost impact associated with the practice of defensive medicine. I don't know what it is. It's been estimated to be 5 percent or 10 percent or 15 percent in various studies.

MR. MAC NEIL: How does that come about?

DR. AXELROD: Doctors because of their concern for their ultimate testimony in the event that they should be faced with a malpractice suit attempt to go to the nth degree with respect to the ruling out of diseases. There is an error of commission in many instances with respect to reaching the 99.9 percentile in terms of likelihood of a given disease by some very expensive tests. We have a broad armamentarium of diagnostic tests, valuative procedures that are available to the valuative

CORRECTION

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MR. ADLER: What worries me is that despite many years of civil enforcement of environmental laws we still have widespread non-compliance. Let me give you an example. According to the General Accounting Office, a recent study, four out of every ten industries who discharge toxic waste into the nation's sewer systems are violating their discharge permits despite civil compliance. Obviously, we don't have enough deterrence, and without this sort of action corporate America is not getting the message that it has to comply with environmental laws.

MR. LEHRER: Do you think this sends the new message though on those kinds of cases as well?

MR. ADLER: I think it does to all corporations who are responsible for complying with pollution laws if pursued aggressively.

MR. LEHRER: Your concern, Mr. Samp, is that it sends a double message, it may send a message to the bad guys, but it also sends the wrong message to the good guys as well?

MR. SAMP: Exactly, and it seems to me that, as I stated before, that this is not a reasonable environment in order to allow business to thrive in this country, that I would certainly agree that there are appropriate circumstances under which criminal law should be enforced. For example, it seems to me that any company that goes out in the middle night and takes drums full of toxic waste and dumps them in a park and does so knowingly and intentionally, that sort of corporation ought to be indicted. But we're not talking about that kind of case here. We're talking about a corporation which had no intention of spilling any oil, did so, perhaps through its own negligence, and now they're finding themselves in a criminal court.

MR. LEHRER: All right. Mr. Samp, Mr. Adler. thank you both for being with us.

MR. ADLER: Thank you.

MR. SAMP: Thank you.

FOCUS - NEGLIGENT TREATMENT

MR. MAC NEIL: Next tonight new facts and the new debate about medical malpractice. A major study released today found that thousands of hospital deaths and tens of thousands of injuries each year are the result of negligence but that relatively few victims ever file malpractice claims in courts. The study conducted by Harvard researchers examined one state, New York, that drew conclusions with implications for a malpractice insurance system nationally. The study was based on New York hospital patients in 1984. It found more than 27,000 patients were treated negligently in hospital, 6,630 deaths were due in part to negligence, but only one in eight of the patients injured by negligence actually sought compensation and filed malpractice claims. These figures fuel an already heated debate over what can be done to cut malpractice insurance costs and improve medical care. Pres. Bush spoke last week to doctors at Johns Hopkins University about the impact of malpractice lawsuits on medical care.

PRES. BUSH: (February 22) And I ask you today to avoid the understandable urge to practice defensive medicine, where doctors fearing litigation too often dictate treatment that is unnecessary, where the threat of lawsuits threatens the very research that is so desperately needed to save lives, and in return, we've got to restore common sense and fairness to America's medical malpractice system.

MR. MAC NEIL: Restoring common sense to the system is the subject of a proposal in this week's New England Journal of Medicine. The article calls for implementing a no fault malpractice insurance system. The no fault system would take cases out of courtrooms and set up expert panels to compensate victims. We turn now to reaction to today's study and a debate over the no fault solution proposal. Dr. David Axelrod is the New York State Commissioner of Health. He

commissioned the Harvard Report today and is one of the leading proponents of the no fault insurance solution. Harvey Wachsman is a physician and practicing lawyer. He is president of the American Board of Professional Liability Attorneys. He's on the faculty of Brooklyn Law School and the University of South Florida College of Medicine.
Dr. Axelrod, what is the surprising finding in your study, the large amount of negligence, or the small amount of claims?

DR. DAVID AXELROD, New York Health Commissioner: I think it was rather the small amount of claims. A previous study done at Stanford approximately 10 years ago identified roughly the same percentage of adverse events, that is injuries to patients that occurred that would lead us to have believed at least that the number would be approximately the same. There is a concern I have with the data that are being presented and that is that this is an extrapolation from the review of some 30,000 charts to over 2.7 million discharges in 1984. So to say that numbers of thousands of individuals who are identified as having died represents an extrapolation from 1,100 cases in which injury was identified in the Harvard study.

MR. MAC NEIL: I see. It's like a poll. In other words, you've taken a sample and you're saying that represents that reality?

DR. AXELROD: That is correct.

MR. MAC NEIL: Right, like a blood sample.

DR. AXELROD: Yes.

MR. MAC NEIL: Okay. Why do you believe there are so few malpractice claims arising out of so many cases of negligence?

DR. AXELROD: I think in many instances. the patient is not aware of the fact that any negligence has been committed. I think there are difficulties in accessing what is otherwise identified as an officious system with respect to the individual person. I don't think that the average person thinks that there is much chance of success. An individual who comes from a lower socii-economic background may not feel that he has the wherewithal or she has the wherewithal to purse a malpractice suit. There is no clear indication that our system is geared to one of social responsibility with respect to payment for medical injury and it leads more to an event that looks like entering a lottery with respect to a return with a medical malpractice suit.

MR. MAC NEIL: Do you share Pres. Bush's belief that fear of malpractice claims, that doctors hold of malpractice claims, is distorting the medical delivery system?

DR. AXELROD: Yes, I believe that there is a distortion which is occurring. I think it's occurring in a number of different areas. The most important of them may, in fact, be the unwillingness of physicians to participate in peer review of their own colleagues. That fear I think has removed an important element of maintaining the quality of healthcare within our institutions. Without full participation of physicians, it is not going to be possible to have a full review of what happens and the manifestation of quality that we would like to have. I do believe there is a cost impact associated with the practice of defensive medicine. I don't know what it is. It's been estimated to be 5 percent or 10 percent or 15 percent in various studies.

MR. MAC NEIL: How does that come about?

DR. AXELROD: Doctors because of their concern for their ultimate testimony in the event that they should be faced with a malpractice suit attempt to go to the nth degree with respect to the ruling out of diseases. There is an error of commission in many instances with respect to reaching the 99.9 percentile in terms of likelihood of a given disease by some very expensive tests. We have a broad armamentarium of diagnostic tests, valuative procedures that are available to the valuative

procedures that are available to the medical profession, and the physician may choose to utilize one or many of them or all of them in an effort to assure himself that he is not going to be subject to litigation by virtue of his failure to have done a single test.

MR. MAC NEIL: Okay. We'll come back in a moment.
Dr. Wachsman, do you dispute the findings of the survey?

DR. HARVEY WACHSMAN, Malpractice Lawyer: I think the survey's findings of enormous of amount of malpractice in this country is true. I think that there are numbers of physicians who are alcoholics, drug addicts, psychiatrically impaired. According to the AMA 7 to 9 percent, or thirty to forty thousand physicians in this country are impaired. Obviously, that would cause an enormous amount of malpractice which does cut across this country, and you extrapolate those numbers, that comes out to about 100,000 people a year die because of malpractice in hospitals alone. This was a study of hospitals, not even doctors' offices, and hundreds of thousands of people are injured. The reason for the great disparity between the numbers of lawsuits and the numbers of malpractice is clear. It's due to deception and fraud practiced by physicians and hospitals in this country, misleading patients, so that they do not know, and they are misrepresented to in a wholesale manner by physicians so that they cannot find out what exactly occurred. There's also changing of records, forgery that goes on on a national level, that's as significant as well.

MR. MAC NEIL: But for those patients who do find out and do know or suspect there's been malpractice, Dr. Axelrod said they don't claim because they think they're throwing themselves into a lottery.

DR. WACHSMAN: It's not so. First of all, those people who are significantly injured or, in fact, were injured, they win the cases because they're meritorious. In our office, we just heard before from Dr. Axelrod, there's very few wins by patients, not so. In our office, more than 90 percent of the patients who come to us, who we actually bring a lawsuit for, we win, and although we only take about 3 percent of those patients who actually call or contact our office in order to bring a suit.

MR. MAC NEIL: Do you agree with Dr. Axelrod and the President that doctors fearing malpractice are practicing defensive medicine and that that is raising the cost of healthcare?

DR. WACHSMAN: That's absolutely untrue. That's something that has been propagated by medicine and also obviously misled the President into thinking that there is so much defensive medicine going on. There is none essentially, because no test that does not help a patient or at least find the diagnosis or help elucidate the diagnosis for that patient in no way assists the physician in defending himself. And the truth of the matter is, that most malpractice is not due to the 99 percentile test but is due to three things, one, the physician not showing up, two, I'm talking about seeing the patient and evaluating him rather than over the phone or showing up some other time, two, is not taking a proper history, which takes time to evaluate a patient and 80 percent of diagnosis is made on history, and three, is not doing a proper, a physical examination. 70 percent of all malpractice cases across this country are due to a physician not showing up, not taking a proper history, examining, and if you look at that, I think any patient is entitled to those things and not due to some test that somehow he didn't do. Those cases we have wide experience, we've written three volumes in the area, it's not so.

MR. MAC NEIL: You say it's not so, but you wouldn't agree with the cartoon, with the sort of folk wisdom that's in the cartoon in the New Yorker recently where a doctor is saying to a patient, well, I think it's just a common cold, but let's run a full battery of tests just to be sure?

DR. WACHSMAN: No, because that's just not true. Again that's misrepresentation. There have been a lot of things in history, as you're aware of, that have occurred and knowledge that's pushed around and stated when, in fact, it's not true. The truth is that there is no great defensive medicine. The only defensive medicine that does exist, which I do agree with, is when a physician spends

more time with his patient, talks him and examines him over a longer period of time, and, therefore, can see less patients per hour and therefore, there's a cost to that physician because he can't make as much money. But it's certainly not due to tests.

MR. MAC NEIL: Two quite different points of view on this. Now, you are in favor of replacing the present system with a no fault system. Can you explain briefly how that would work and why it would improve things, in your view?

DR. AXELROD: I think the first difficulty is that you've been talking about the Harvard study dealing with medical malpractice. The Harvard study did not deal with medical malpractice. The Harvard study dealt with medical injury and the nature of that injury and the extent to which negligence was responsible for that injury. Only 1 percent of the cases that were reviewed by the Harvard study demonstrated negligence, so that what we have tried to do is to define our terms a little bit better. We are concerned with a social system which provides justice to those who are injured by virtue of their contact with the healthcare system. Our concern is that the medical care system is a hazardous one in terms of your entry into that system because of the nature of the interventions, and that there is a distinct possibility for injury. The no fault system which we are proposing would have a mechanism by which individuals would be paid on the basis of the nature of that injury if there was causality established, rather than fault assigned to a given physician. It would not be necessary for an individual to become a plaintiff within an adversarial system in order to be compensated for the injury which occurred.

MR. MAC NEIL: Well, who would decide whether they were at fault, the office or hospital --

DR. AXELROD: It would presumably be a panel of individuals who would be expert with respect to the nature of those injuries, it would work similar to worker's compensation where those who make decisions with respect to occupational health would make a judgment.

MR. MAC NEIL: Why would that be an improvement over the system now?

DR. AXELROD: Because as it currently stands, the Harvard study demonstrates that only 1 in 10, approximately 1 in 10 individuals, who have been injured as a result of negligence ever receive any kind of compensation. There is nothing to suggest that there is any equity, that it's an effective system with respect to compensation for medical injury. I think what we have to do is to separate what it is we're trying to do. Are we simply trying to provide a small number of individuals that has no relationship to the nature of the injury?

MR. MAC NEIL: In other words, big awards, millions of dollars?

DR. AXELROD: Big awards as opposed to providing everyone who suffers an injury that is significant with a level of compensation that is relevant to the nature of that injury.

MR. MAC NEIL: Why wouldn't that be an improvement on this system?

DR. WACHSMAN: I think first of all, all it does is grant immunity and that's what they're really interested in. The whole purpose of the study was not to see to it how they can compensate people better but to gain immunity. I can point to Virginia and New Zealand which has no fault. In New Zealand, since January 1, 1988, they have a brain damaged baby circumstance --

MR. MAC NEIL: No fault --

DR. WACHSMAN: -- no fault system, and they're going to compensate all these children, the total number of children in two years and two months that have been compensated is zero. In New Zealand, there's no fault system where a patient has to prove their case to an official of the government. That just doesn't occur, because they can't do it. One little comment that Dr. Axelrod mentioned in passing was the word "causation". The word "causation" means proximate cause under

the law. That is the most difficult thing for a malpractice lawyer who's capable to prove in any case. No patient will ever be able to prove it by themselves.

MR. MAC NEIL: In other words, this is just giving the doctors immunity because you'll never pay anybody because the doctors will never admit if they review themselves or a committee reviews them, they'll never admit that there was malpractice.

DR. AXELROD: But we've confused two very different things. We've confused physician discipline and deterrence with an equitable system for compensation for medical injury. Both Dr. Wachsman and I would agree that there needs to be a better disciplinary system. I do not believe that there is any data that would suggest that the existing malpractice system represents an effective deterrent. That was one of the elements of the Harvard study and I think that there is, if any presence of deterrence, it's very limited.

MR. MAC NEIL: But his point is that the system you're proposing would represent no deterrence at all.

DR. AXELROD: Oh, no, oh, no, hardly.

MR. MAC NEIL: I mean, he instances no compensation for birth damaged babies under the Virginia's no fault system and the inability of patients in New Zealand under their system to gain any admission of malpractice.

DR. AXELROD: Well, there's. I don't want to get into other systems, because I think that there are complexities about the New Zealand system which has been in place for 15 years that, in fact, has not had an effective deterrent system. The Virginia system has been in place for one year in which there has been any experience, and I don't know that that is an appropriate time frame in which to judge the effectiveness of the program. What I think you have to do is identify the fact that we have not been as good as we think we have been with respect to oversight of physicians. I think that there needs to be a whole new arena in which we evaluate the effectiveness of the oversight of government, the failures of the existing physician peer review process, the failures of the hospital review process, but I think that the most important thing of all that will challenge the effectiveness of any malpractice system, any no fault system even, will be the new information that is emerging. One of the major revolutions that has occurred is the availability of information with respect to outcome, with respect to procedures within institutions, procedures done by physicians. I am firmly convinced that it is the public, it is the advocacy of the public, it is the public requesting information that is going to change the medical practice in the most imaginative way possible.

MR. MAC NEIL: I'm sorry, gentlemen, but that is the end of our time. Thank you both for joining us.

RECAP

MR. LEHRER: Again, the major stories of this Wednesday, Nicaragua's Sandinista government declared a unilateral cease-fire in the war against the contras. On the Newshour, Pres. Ortega said if the contras refuse to disband, he will do what is needed to defend his nation. And after five previous attempts, NASA successfully launched the space shuttle Atlantis.
Good night, Robin.

MR. MAC NEIL: Good night, Jim.
That's the Newshour tonight and we will be back tomorrow night. I'm Robert MacNeil. Good night.