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7821 HOUSE HEALTH EDUCATION & SOCIAL SERVICES

Summary Of California's MICRA

The key provisions of MICRA are:

1. Limitation on Compensation of Injured Victims

MICRA places a cap of $250,000 on the amount of compensation paid to malpractice victims for their "non-economic" injuries.

Non-economic injuries include pain, physical and emotional distress and other intangible "human damages." Such damages compensate for severe pain; the loss of a loved one; loss of the enjoyment of life that an injury has caused, including sterility, loss of sexual organs, blindness or hearing loss, physical impairment, and disfigurement.[6]

The MICRA cap is not adjusted for inflation. In order to provide the same level of compensation in today's dollars, the cap would have to be approximately $630,000.[7] Put another way, the $250,000 MICRA cap has decreased in value since 1975, when compared to the Consumer Price Index, to approximately $91,000.[8] Though health care costs – hospital charges, medical fees, etc. – have risen dramatically since 1975, compensation for non-economic damages has been frozen by the statute.[9]

2. Abolition of the Collateral Source Rule

The collateral source rule prohibits defendants charged with negligence from informing the jury that the plaintiff has other sources of compensation, such as health insurance or government benefits, including social security and disability. The purpose of this long-established doctrine is to ensure that the jury holds the defendant responsible for the full cost of the harm the defendant caused by requiring the defendant to pay all the victim's expenses – even if a collateral source has already paid them.

Application of another legal doctrine, known as subrogation, ensures that the collateral source rule does not result in "double recoveries" for injured victims. Under subrogation rights – which are applicable to virtually all health insurance policies, government programs, and workers' compensation systems – the third-

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6 Economic damages, the other type of legal damages, compensate for wage loss, doctor bills, etc. Intangible values are routinely recognized, quantified and awarded by our courts. For example, courts have awarded monetary damages to protect the value of corporate good will, art work and the right to maintain the view from a penthouse apartment.

7 Based on the U.S. consumer index as published by the U.S. Dept. of Labor, Bureau of Labor Statistics.

8 Id.

9 Tom Dressler, "Unfreeze Pain-and-Suffering Damages," Los Angeles Daily Journal, Nov. 4, 1991.

If the defendant enters bankruptcy or simply ceases to pay, the victims are forced to return to court and engage in another lengthy legal proceeding. Another problem is that an inflexible payment schedule leaves the victim without sufficient resources in the event that unanticipated medical or other expenses arise. This is most likely to occur in the years immediately following the injury, when the periodic payments are unlikely to cover the aggregate costs.

4. Mandatory Arbitration

MICRA provides that any contract for medical services may contain a provision for arbitration of any dispute regarding malpractice so long as it is disclosed. The malpractice victim's right to a jury trial may be completely foreclosed by such clauses, which are now routinely inserted in agreements patients must sign before receiving treatment. Most consumers are completely unaware of this restriction when they sign the legal forms in the doctor's office or at the hospital.

5. Statute of Limitations

MICRA imposes a short statute of limitations for medical malpractice cases. Victims must file a malpractice suit within three years after the date of injury, or one year after the discovery or when the injury should have been discovered, whichever occurs first. Actions by a minor under the age of 6 years must begin within 3 years or before his/her 8th birthday, whichever provides a longer period. Minors are required to bring suit while they are still minors (under 18).

There have been many instances in which malpractice involving children has not readily been detected or for which no action is taken initially because the family is unfamiliar with the legal system. Such cases are precluded by the statute of limitations.

6. Attorney's Fees

MICRA sets a sliding contingency fee schedule for plaintiffs' attorneys representing victims of medical malpractice. The fees are limited to 40% of the first $50,000 recovered; 33 1/3% of the next $50,000; 25% of the following $100,000, and 15%[10] of any amount exceeding $200,000. MICRA does not limit the fees of the defendant's lawyers.

This provision of MICRA discourages attorneys from taking the most severe malpractice cases. Combined with the cap on damages -- which proportionately reduces the plaintiffs' attorneys' fees -- medical malpractice cases have become prohibitively expensive for plaintiffs' attorneys to accept on a contingency basis.

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10 As originally enacted, MICRA limited attorneys fees to 10% of any amount over $200,000. This provision was amended in 1987 as part of a "truce" between the California Medical Association and the California Trial Lawyers Association, during which period no further amendments to MICRA were to be permitted.

Growth in health care costs in California has been nearly identical to national growth rates. Appendix A also contains data which permit comparison of the growth in the California and national consumer price indices since the passage of MICRA.

Between 1975 and 1991, the California medical CPI rose 286%, 5% more than the national medical CPI, which grew 273%. The annual growth rate of the national medical CPI averaged 8.6%, while California medical CPI growth averaged 8.8%.

Per capita health care expenditures have been higher in California than in the nation since the passage of MICRA. Health care costs for California and the nation can also be compared by considering per capita health care costs and their growth. Based on expenditures and per capita cost data developed in Appendix B, Appendix C displays a comparison of California and U.S. health care expenditures on a per capita basis.

Per capita health care expenditures in California exceeded the national average every year between 1975 and 1991, by an average of 13% per year. California per capita expenditures were, on the average, $186 higher than in the United States as a whole each year between 1975 and 1991.

Hospital patient costs are higher in California than in other major states. Another accurate indicator of health care expenditures is the average hospital patient cost per adjusted day, which reflects outpatient as well as inpatient services. Hospital patient data is displayed for California and other industrial states in Appendix D.

In 1990, the most recent year for which data is available, California's average hospital patient cost per adjusted day was the second highest of the state's studied; in 1985 and 1989, California's hospital patient costs were the highest.

Conclusions. The health care consumer price index in California has increased since the passage of MICRA in 1975. Indeed, most indicators show that California's health care costs are as high or higher than the national average and that the rate of growth of these costs has outpaced the nation since 1975.

This conclusion is confirmed by other studies. The General Accounting Office has noted that personal health care expenditures per capita in California were second highest in the nation in both 1982 and 1990, 18.9% and 19.3% percent higher than the national average, respectively.[12]

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12 "Health Care Spending: Nonpolicy Factors Account for Most State Differences," US GAO, GAO/HRD 92-36, February 1992, p. 16-17.

Between 1985 and 1990,[16] medical malpractice incurred losses as a percentage of health care costs averaged only 0.53% in California. Medical malpractice losses were only 0.24% of the state's health care costs in 1990.

These data explain why MICRA has not affected overall health care costs in California, as documented in the preceding section. The amount which malpractice insurers expect to pay out for malpractice claims is a minuscule portion of California's total health care bill.

The ratio of malpractice payments to California's total health care expenditures is similar to the national average. Appendix E also shows the "incurred losses" reported by national malpractice insurance carriers as a percentage of the nation's overall health care expenditures since 1976.

The extremely small percentage of California health care expenditures for which malpractice incurred losses are responsible is very similar to corresponding national data. The total amount of claims paid by insurance companies each year from 1976 through 1990 for medical malpractice averaged 0.57% of national health care costs – about 6/100 of a point more than in California (0.51%).

Medical malpractice incurred losses in California are consistent with national trends. Appendix E permits consideration of loss trends in California and the nation.

The amount of compensation insurers estimated they would have to pay for medical malpractice in California and nationally grew until the mid-1980's. Incurred losses then began to fall, both in absolute terms and as a percentage of health care costs.

Incurred losses associated with medical malpractice as a percentage of national health care costs decreased by more than 50% from their high of .82% in 1986 to .39% in 1990. This data tracks a similar study by the National Insurance Consumers Organization.[17] The decrease was more pronounced in California – incurred losses as a percentage of state health care costs fell by about 68% from 1986 (.76% of state health care costs) to 1990 (.24%).

These data reveal that estimated malpractice losses, already a tiny fraction of health care costs nationally and in California, are now shrinking. As a percentage of health care costs, they have dropped dramatically since the mid-1980's.

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16 As noted in Appendix E, the California data reflects an unusually large drop in the incurred losses reported by insurers for the last available year, 1991. For the reasons noted, we have excluded the 1991 data in making these comparisons between premiums and losses.

17 "Medical Malpractice Insurance: 1985-1991 Calendar Year Experience," The National Insurance Consumer Organization, (NICO), March 1993. The NICO study obtained incurred loss data from 1986 through 1991 from a recent NAIC report which made adjustments to previously reported annual data. To present consistent data from 1976, the data presented here was obtained directly from annual reports.

After 1986, insurers' estimates of payments they will make to malpractice victims began to fall. However, MICRA is not responsible for the reduction, which has occurred nationally as well. The reason for this trend is uncertain. However it is likely related to the insurance companies' actions in the mid-1980's, which precipitated the insurance "crisis" experienced throughout the nation during that period. We will return to the subject of the insurance industry's role in the next section.

In any case, MICRA itself has not reduced, in absolute terms, insurers' estimates of payments they will make to malpractice victims in California. At most, MICRA may have lowered the insurers' estimates of payouts in California compared to the national average, as would be expected.

Finally, it must be noted that there is no data publicly available which would permit analysis of the size or kind of claims made by victims in the years after the passage of MICRA. The U.S. General Accounting Office, which has published the only available data on the subject, has noted that malpractice claims increased in California between 1980 and 1984 (the study was published in 1986).[18] While we have aggregate information on losses expected by insurers, we do not know whether the number of claims rose or fell during these periods.

III. Malpractice Premiums and MICRA'S Impact on Health Care Costs

As noted previously, MICRA was enacted in 1975 in response to rapid increases in the price of malpractice liability coverage sold to medical providers by insurance companies. Insurance carriers told physicians' groups that rates had increased because of the growth of lawsuits. Medical providers supported the measure as a way to lower health insurance premiums.

Today, advocates of placing similar restrictions on medical malpractice suits throughout the nation make the same claim. They say that malpractice premiums are a critical factor in skyrocketing health care costs, and that MICRA would lower insurance premiums throughout the nation, thus reducing overall health care costs.

Implicit in these assertions are two assumptions: first, that insurance companies will pass-through to their policyholders the savings which result from reductions in the compensation insurers must pay to victims under such restrictions. If insurers experience fewer claims and their payouts to malpractice victims are reduced, premiums paid by medical providers should be reduced as a result. Otherwise, only insurance company balance sheets benefit from tort restrictions.

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18 Medical Malpractice: Case Study on California, General Accounting Office (GAO), December 1986.

expenditures in both the United States and California after reaching all-time highs in the late 1980's.

In absolute terms, earned malpractice premiums in California rose 191% from 1976 before reaching their high point in 1988. However, between 1988 and 1991, premiums dropped by 20%. The same pattern emerges nationally: premiums increased 331% between 1976 and 1989, the all time high, but by 1991 had dropped 5% from 1989.

Malpractice premiums as a percentage of health care costs fell 58% in California – from the high of 1.26% of state health expenditures in 1976 to 0.53% in 1991.

Nationally, malpractice premiums as a percentage of health care costs fell from a record high of 0.93% in 1988 to 0.65% in 1991, a drop of 30%.

As noted in Section II, insurance company losses on malpractice claims have fallen significantly in California and the United States. Theoretically, premiums would be expected to drop commensurably, and the drop would be expected to be reflected in the percentage of health care costs attributable to malpractice premiums. The data bear out some of these expectations, but reveal other trends worthy of comment.

The reduction in premiums has not been commensurate with the reduction in incurred losses. Comparison between the premiums charged by insurers and the incurred losses reported under the malpractice coverage they wrote reveals that insurers have not fully passed through to policyholders the savings that resulted from the reduction in incurred losses reported nationally and in California.

As noted in the preceding section, the insurers' estimates of payouts under malpractice liability policies have fallen since the mid-1980's, a phenomenon present both in California and national data and thus not a result of MICRA.[19] In California, incurred losses dropped 38% between 1988 and 1990,[20] while earned premiums fell only 9% from their 1988 high to 1990.

Nationally, incurred losses fell 31% from 1988 to 1990. However, malpractice premiums fell only 3% during the same period.

Thus, insurers do not appear to be passing through to policyholders more than a small portion of the savings reflected in the reductions in losses. However, a greater percentage has been returned to California policyholders. The

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19 See Section II for the discussion of this point.

20 As noted previously and in Appendix E, the California data reflect an unusually large drop in the incurred losses reported by insurers for the last available year, 1991. For the reasons noted, we have excluded the 1991 data in making these comparisons between premiums and losses.

The per capita malpractice premium in California has been higher than the national average in most years since the passage of MICRA. Another way to compare medical malpractice insurance premiums between the U.S. and California is to consider the per capita malpractice premium, using the population size. Appendix H shows that per capita medical malpractice premiums in California have been consistently higher than the U.S. since the passage of MICRA, falling below the national average in 1991 by $2.02.

Premiums of insurance companies are excessive in California and nationally. Appendix I displays the profits of insurers, as a percentage of premiums earned, for California and the United States.

As noted above, the recent drop in malpractice losses has not been accompanied by a commensurate drop in malpractice premiums. Appendix I confirms the suspicion raised by the prior data. It shows that insurance carriers writing medical malpractice liability policies in California -- many of them non-profit carriers[24] -- are charging excessive premiums. A strong indication that medical malpractice premiums are overpriced is revealed by the loss ratios -- the amount estimated as losses shown as a percentage of premiums sold. Carriers which sell medical malpractice policies in California had an average loss ratio of 36% in 1990. Put another way, these carriers paid out only 36 cents for every $1 in premiums they took in.[25]

Profits of the national carriers are also excessive. However, California carriers' profits are more excessive.

Conclusions. The data presented show that medical malpractice premiums are a negligible component of overall health care costs in California and in the nation. Regardless of MICRA's impact on premiums, imposition of such restrictions would be irrelevant to the total costs of the system.

This conclusion is confirmed by other observers. The National Insurance Consumers Organization (NICO) concluded that, since 1976, "the cost of malpractice insurance, nationwide, has actually been steadily declining as a percentage of total health care costs."[26] Similarly, a recent report by the Congressional Budget Office (CBO) noted that the total cost of malpractice

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24 Non-profit, doctor owned companies control virtually the entire malpractice insurance market in California, in contrast to the dominance of private for-profit insurers before 1975.[24] These "bed-pan" mutuals, as they are called, were established by medical providers several years after the passage of MICRA, when the reduction in malpractice premiums promised by the private insurers did not materialize. The mutuals are capable of offering lower rates than the private insurers because they are not run for profit, and because they emphasize risk avoidance procedures which encourage safe medical practices.

25 Note that 1991's unusually low losses, mentioned elsewhere, allowed California malpractice insurers to achieve a 9% loss ratio.

26 Medical Malpractice Insurance: 1985-1991 Calendar Year Experience," The National Insurance Consumer Organization, (NICO), March 1993.

IV. Defensive Medicine

Supporters of MICRA contend that the data on premiums, claims and health care costs addressed above do not provide a full picture of the impact of malpractice claims on health care costs. They say that the real impact of malpractice suits on the health care system is the practice of "defensive medicine," that is, procedures, tests or even surgeries, otherwise unnecessary, but undertaken by practitioners solely to avoid malpractice suits by patients.[30]

Recently, the cost of "defensive medicine" was estimated to be $36 billion nationally.[31] Proponents of MICRA argue that tort restrictions will save billions of dollars by making "defensive medicine" unnecessary.[32]

If the proponents of tort restrictions are correct concerning the application of laws to restrict malpractice victims' rights, the practice of "defensive medicine" in California should have been sharply reduced, if not eliminated, by the passage of MICRA.

It must be noted preliminarily that "defensive medicine" is virtually impossible to quantify. The AMA itself has defined "defensive medicine" as "doing more diagnostic tests, sticking with the safest possible treatments, telling patients more about treatment risks, and keeping more complete records."[33] Obviously, such practices could equally be used as the definition of "high quality medical care." Indeed, the most recent report on the subject released by the AMA noted that estimating the cost of "defensive medicine" is "subjective" and "dependent on a variety of assumptions."[34]

MICRA has not limited "defensive medicine" in California, according to the most reliable indices. An empirical way to measure "defensive medicine" is to look at high-profile, costly procedures that are acknowledged by medical authorities to be susceptible to overutilization.

Cesarean sections are an excellent procedure to study because of the breadth of the data and the cost impact of a c-section compared to a vaginal delivery. In 1991, for example, the average costs for cesarean and vaginal deliveries were $7,826 and $4,720, respectively.[35]

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30 "Malpractice: A Straw Man," Consumer Reports, July 1992, p. 44.

31 Mike Snider, "Defensive Medicine adds $36 billion to Bill," USA Today, February 3, 1993.

32 "Estimating the Costs of Defensive Medicine," Lewin-VHI, Inc., January 27, 1993.

33 "Malpractice: A Straw Man," Consumer Reports, July 1992, p. 44.

34 "Estimating the Costs of Defensive Medicine," Lewin-VHI, Inc., January 27, 1993, p. 1.

35 Reuters News Service, April 23, 1993.

"defensive medicine," MICRA has not deterred the practice of such "defensive medicine" in California.

The c-section rate is no different in states with or without MICRA-type caps on malpractice damages. Data in Appendix K confirm this conclusion. The data compare c-section rates in states with and without caps on awards for pain and suffering arising from medical malpractice. Additionally, the Appendix utilizes data provided by the Public Citizen Health Research Group to determine the number of "unnecessary" c-sections. In the Public Citizen report, researchers used 10-12% as a proper c-section rate for a state and designated as unnecessary those c-sections occurring above this 12% rate.[40]

First, the data show that states which have imposed a cap on pain and suffering have as high a rate of cesarean sections as those states that do not have restrictive caps.

Second, the data show that the rate of unnecessary c-sections is virtually identical in states with or without caps on awards.

Conclusions. Proponents of MICRA assert that "defensive medicine" is a direct result of the tort system. They claim that restrictions on malpractice suits will lower health care costs by obviating the need for "defensive medicine."

However, this contention is without merit, according to a review of data associated with one procedure which is often said to reflect physicians' fears of malpractice suits: the cesarean section. Data show that tort restrictions in California and other states do not reduce the use – or misuse – of c-sections compared to other states.

As the claims of medical providers are subject to greater scrutiny, the validity of the concept of "defensive medicine" has been questioned.

It has been pointed out that what may be termed defensive medicine may simply be high quality care,[41] which saves consumers money in the long run and avoids malpractice. The Congressional Budget Office concluded that much of what is dubbed "defensive medicine" is standard medical care that would be provided anyway.[42]

> Physicians have always sought to provide patients with the best possible medical care at the lowest risks and would continue to do

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40 Sidney Wolfe, "Cesarean and Hysterectomy Statistics," Women's Health Alert, Public Citizen Health Research Group, 1991, p. 96.

41 "The Problem of Defensive Medicine, Science Magazine, May 1978, Vol. 200. p. 879.

42 Economic Implications of Rising Health Care Costs, Congressional Budget Office, October, 1992, p. 27.

The CPI v. Health Care Costs in California and U.S., 1975 TO 1991, (1982-84 = 100)

Year	CA CPI All Items	% Growth CA CPI All Items	Cum. Growth CA CPI All Items	CA CPI Medical*	% Growth CA CPI Medical	Cum. Growth CA CPI Medical	U.S. CPI Medical	% Growth U.S. CPI Medical	Cum. Growth U.S. CPI Medical
1975	52.3	—	—	46.6	—	—	47.5	—	—
1976	55.6	6.31%	6.31%	51.8	11.16%	11.16%	52.0	9.47%	9.47%
1977	59.6	7.19%	13.96%	56.8	9.65%	21.89%	57.0	9.62%	20.00%
1978	64.4	8.05%	23.14%	61.8	8.80%	32.62%	61.8	8.42%	30.11%
1979	71.3	10.71%	36.33%	67.7	9.55%	45.28%	67.5	9.22%	42.11%
1980	82.4	15.57%	57.55%	75.2	11.08%	61.37%	74.9	10.96%	57.68%
1981	91.4	10.92%	74.76%	83.2	10.64%	78.54%	82.9	10.68%	74.53%
1982	97.3	6.46%	88.04%	93.8	12.74%	101.29%	92.5	11.58%	94.74%
1983	98.9	1.64%	89.10%	100.7	7.36%	116.09%	100.6	8.76%	111.79%
1984	105.2	6.37%	101.15%	105.5	4.77%	126.39%	106.8	6.16%	124.84%
1985	108.6	3.23%	107.65%	111.4	5.59%	139.06%	113.5	6.27%	138.95%
1986	112.0	3.13%	114.15%	119.6	7.36%	156.65%	122.0	7.49%	156.84%
1987	116.6	4.11%	122.94%	129.2	8.03%	177.25%	130.1	6.64%	173.89%
1988	121.9	4.55%	133.08%	139.5	7.97%	199.36%	138.6	6.53%	191.79%
1989	128.0	5.00%	144.74%	152.1	9.03%	226.39%	149.3	7.72%	214.32%
1990	135.0	5.47%	158.13%	165.7	8.94%	255.58%	162.8	9.04%	242.74%
1991	140.6	4.15%	168.83%	179.8	8.51%	285.84%	177.0	8.72%	272.63%
Avg. % Growth:		6.43%			8.82%			8.58%	

*Source: U.S. Dept. of Labor, Bureau of Labor Statistics, All Urban Consumers; California Statistical Abstracts; *California Medical CPI derived from an average of Medical Care CPI for Los Angeles, San Francisco, and San Diego metropolitan areas.*

APPENDIX A

Method #2. Use a 1986 estimate published by the California Almanac as a baseline for extrapolation. According to The California Almanac (5th Edition, 1991), California's personal health care expenditures amounted to $52.5 billion. During that same year, personal health care expenditures in the nation were estimated to be 88.1% of total health care expenditures for the nation.

To calculate total health care expenditures in California for each year under this method:

1. Assuming that the national ratio of personal/total health care expenditures (88.1%) applies to California, California's total health care expenditures for 1986 were $59.5 billion.

2. Next, using population data for California and the nation, California's total health care expenditure figure for 1986 is translated to a per capita basis. This will allow us to develop the percentage by which California's total health care expenditures exceed the nation's in that year. Estimated total per capita health care expenditures in California in 1986 were 116.29% of the nation's per capita expenditures, or about 16% higher.

3. Assuming that California's total per capita health care expenditures are 116.29% of the nation's each year, California's total health care expenditures each year can be calculated by multiplying the national per capita amount by 116.29%. (In other words, the national total expenditures are adjusted for population growth and then multiplied by 116.29%).

4. Finally, the per capita numbers are translated back into total dollar expenditures by multiplying the per capita figures by the population for each year.

Note: This calculation depends on one key assumption: that California's per capita health care expenditures are always 116.29% of the national figure. Since costs have been increasing in California in recent years (see the CPI data in Appendix A), this assumption probably yields a liberal estimate for years prior to 1986, and a conservative estimate for subsequent years.

Method #3. Use the average of the medical CPI available for three metropolitan areas in California to estimate the medical care CPI for California. Using the method described under #2 above, the total and personal per capita expenditures can be calculated for each year. Then use CPI data to adjust the figures each year for inflation.

To calculate total health care expenditures in California for each year under this method:

1. Utilize the Medical CPI data contained in Appendix A to adjust the per capita data each year.
2. Translate the per capita numbers back into total dollar expenditures by multiplying the per capita figures by the population for each year.

APPENDIX B -- Con't.

Comparing the Annual Dollar and % Growth in Per Capita Health Care Expenditures, U.S. and CA, 1975 to 1991

Year	US Health Care Expend. Per Cap.	US Actual Growth Annually (in $)	CA Health Care Expend. Per Cap.	CA Actual Growth Annually (in $)
1975	$617	—	$731	—
1976	$700	$83	$822	$92
1977	$783	$83	$913	$91
1978	$872	$89	$1,008	$95
1979	$967	$95	$1,113	$105
1980	$1,101	$134	$1,255	$142
1981	$1,265	$164	$1,423	$167
1982	$1,408	$143	$1,591	$168
1983	$1,534	$126	$1,724	$133
1984	$1,652	$118	$1,839	$115
1985	$1,776	$124	$1,964	$126
1986	$1,894	$118	$2,100	$136
1987	$2,039	$145	$2,264	$164
1988	$2,233	$194	$2,466	$203
1989	$2,448	$215	$2,699	$232
1990	$2,706	$258	$2,968	$269
1991	$2,981	$275	$3,253	$285

Source: See Appendix B for California health care expenditures; California Statistical Abstract; U.S. Bureau of the Census.

APPENDIX C

Medical Malpractice Losses and Health Care Costs
California, 1976 to 1991

Year	[1] Health Care Costs* (000)	[2] Med Mal Incurred Losses (000)	[2]/[1] Losses as a % of Health Care Costs
1976	$18,039,288	$139,308	0.77%
1977	20,406,705	88,303	0.43%
1978	23,022,674	102,837	0.45%
1979	25,883,146	100,619	0.39%
1980	29,851,396	101,890	0.34%
1981	34,537,409	132,057	0.38%
1982	39,456,555	172,598	0.44%
1983	43,680,210	324,597	0.74%
1984	47,466,100	347,625	0.73%
1985	51,863,717	363,600	0.70%
1986	56,804,376	428,978	0.76%
1987	62,737,857	399,420	0.64%
1988	70,030,126	347,412	0.50%
1989	78,651,303	249,402	0.32%
1990	88,980,440	215,736	0.24%
1991	99,695,910	47,610*	0.05%
Average:			0.45%

Source: See Appendix B for estimate of California health expenditures; National Association of Insurance Commissioners, Profitability Results, 1976- 1991.

Medical Malpractice Losses and Health Care Costs
United States, 1976 to 1991

Year	[1] Health Care Costs (000,000)	[2] Med Mal Incurred Losses (000)	[2]/[1] Losses as a % of Health Care Costs
1976	$152,200	$557,890	0.37%
1977	172,000	529,240	0.31%
1978	193,700	824,457	0.43%
1979	217,200	943,888	0.43%
1980	250,100	1,037,074	0.41%
1981	290,200	1,397,562	0.48%
1982	326,100	1,724,380	0.53%
1983	358,300	1,925,136	0.54%
1984	389 600	2,382,125	0.61%
1985	422,600	3,235,776	0.77%
1986	454,900	3,750,880	0.82%
1987	494,200	3,903,900	0.79%
1988	546,100	3,831,408	0.70%
1989	604,300	2,693,120	0.45%
1990	675,000	2,657,809	0.39%
1991	751,800	2,708,134	0.36%
Average:			0.54%

Source: Health Care Financing Administration; National Association of Insurance Commissioners, Profitability Results, 1976 - 1991.

***Note on incurred losses in California in 1991.** The unusually large reduction in estimates of incurred losses in 1991 probably resulted from decisions by insurers to reduce reserves which were inflated in excess of requirements during the mid-1980's. Such reductions, including reserves built up over many years, may be taken in one year as appears to have occurred here. Regulatory activity mandated by Proposition 103 may have led insurers to take this action. Because of this anomaly, 1991 is omitted from certain calculations in the report, as noted.

APPENDIX E

Growth in Medical Malpractice Premiums, United States and California 1976-1990

Year	[1] U.S. Earned Premiums (000,000)	[2] CA Earned Premiums (000,000)	[3] U.S. Number of Physicians	[4] CA Number of Physicians	[1]/[3] U.S. Estimated Average Med-Mal Premium	[2]/[4] CA Estimated Average Med-Mal Premium
1976	$1,187	$228	(NA)	(NA)	(NA)	(NA)
1977	1,310	' 227	362,043	45,611	3,618	4,977
1978	1,381	249	381,122	47,891	3,624	5,199
1979	1,384	239	398,735	50,653	3,471	4,718
1980	1,333	230	417,758	54,082	3,191	4,253
1981	1,429	219	425,117	55,041	3,361	3,979
1982	1,526	211	443,467	57,225	3,441	3,687
1983	1,844	287	460,036	59,151	4,008	4,852
1984	2,125	375	(NA)	(NA)	(NA)	(NA)
1985	2,661	450	489,523	63,009	5,436	7,142
1988	3,803	629	497,473	64,066	7,655	9,818
1987	4,550	634	512,946	66,184	8,870	9,579
1988	5,068	683	(NA)	(NA)	(NA)	(NA)
1989	5,120	633	577,605	76,272	8,864	8,299
1990	4,931	606	592,166	78,285	8,327	7,741

Sources: National Association of Insurance Commissioners, Profitability Results; 1991-1992 Hospital Fact Book, California Association of Hospitals and Health Systems. * Data was not collected in 1984 and 1988, thus the 1985 and 1989 information reflect a two-year period.
(NA) = Not Available

APPENDIX G

Profit and Losses of Insurance Companies: Medical Malpractice, California, 1976 to 1991

Year	[1] Premiums Earned (000,000)	[2] Losses Incurred (000)	[2]/[1] Loss Ratio: Losses Incurred/ Premiums Earned	[3] Profit (000)	[3]/[1] Operating Profit: Profit as a % of Premiums Earned
1976	228	139,308	61.1%	3,192	1.40%
1977	227	88,303	38.9%	50,621	22.30%
1978	249	102,837	41.3%	53,286	21.40%
1979	239	100,619	42.1%	59,511	24.90%
1980	230	101,890	44.3%	61,180	26.60%
1981	219	132,057	60.3%	31,098	14.20%
1982	211	172,598	81.8%	19,201	9.10%
1983	287	324,597	113.1%	-90,979	-31.70%
1984	375	347,625	92.7%	18,375	4.90%
1985	450	363,600	90.8%	37,350	9.30%
1986	629	428,978	68.2%	89,318	14.20%
1987	634	399,420	63.0%	63,933	10.10%
1988	663	347,412	52.4%	137,904	20.80%
1989	633	249,402	39.4%	232,311	36.70%
1990	606	215,736	35.6%	241,794	39.90%
1991	529	47,610	9.0%	354,959	67.10%

Source: "Report on Profitability, By Line, By State," National Association of Insurance Commissioners, 1976 to 1991.

Profit and Losses of Insurance Companies: Medical Malpractice United States, 1976-1991

Year	[1] Premiums Earned (000,000)	[2] Losses Incurred (000,000)	[2]/[1] Loss Ratio: Losses Incurred/ Premiums Earned	[3] Profit (000,000)	[3]/[1] Operating Profit: Profit as a % of Premiums Earned
1976	$1,187	558	47.0%	239	20.1%
1977	1,310	529	40.4%	316	24.1%
1978	1,381	824	59.7%	175	12.7%
1979	1,384	944	68.2%	119	8.6%
1980	1,333	1,037	77.8%	91	6.8%
1981	1,429	1,398	97.8%	11	0.8%
1982	1,526	1,724	113.0%	-65	-4.3%
1983	1,844	1,925	104.4%	44	2.4%
1984	2,125	2,382	112.1%	187	8.8%
1985	2,661	3,236	121.6%	-513	-19.3%
1986	3,808	3,751	98.5%	-99	-2.6%
1987	4,550	3,904	85.8%	86	1.9%
1988	5,068	3,731	75.6%	415	8.2%
1989	5,120	2,693	52.6%	1,428	27.9%
1990	4,931	2,658	53.9%	1,450	29.4%
1991	4,862	2,708	55.7%	1,420	29.2%

Source: "Report on Profitability, By Line, By State," National Association of Insurance Commissioners, 1976 to 1991

APPENDIX I

Cesarean Section Rates in States With Cap on Non-Economic Damages

State	[1] Cesarean Rate - %	[2] Total Deliveries	[3] Total C-Sections	[4] # of Unnecessary C-Sections	[4]/[3] % of Unneces. C-Sections Out of Total C-Sections	[4]/[2] % of Unneces. C-Sections Out of Total Deliveries
CA	25.00%	479,902	119,975	62,388	52.00%	13.00%
CO	19.40%	23,058	4,473	1,706	38.14%	7.40%
HI	21.20%	19,123	4,054	1,759	43.39%	9.20%
ID	19.20%	15,830	3,039	1,139	37.47%	7.20%
IN	21.30%	80,895	17,231	7,524	43.67%	9.30%
ME	21.50%	16,292	3,503	1,548	44.19%	9.50%
MD	24.50%	65,980	16,160	8,245	51.02%	12.50%
MA	24.40%	89,433	21,822	11,090	50.82%	12.40%
MICH	24.80%	140,466	34,836	17,933	51.48%	12.77%
MI	23.40%	35,663	8,345	4,065	48.71%	11.40%
NM	19.20%	26,686	5,124	1,922	37.51%	7.20%
OR	22.00%	38,103	8,383	3,811	45.46%	10.00%
SD	17.40%	11,108	1,933	601	31.09%	5.41%
UT	20.00%	31,610	6,322	2,529	40.00%	8.00%
WV	25.40%	18,767	4,767	2,515	52.76%	13.40%
Avg.	21.91%				49.54%	11.76%

Source: Sidney Wolfe, Cesarean and Hysterectomy Statistics, Women's Health Alert, Public Citizen Health Research Group, 1991.

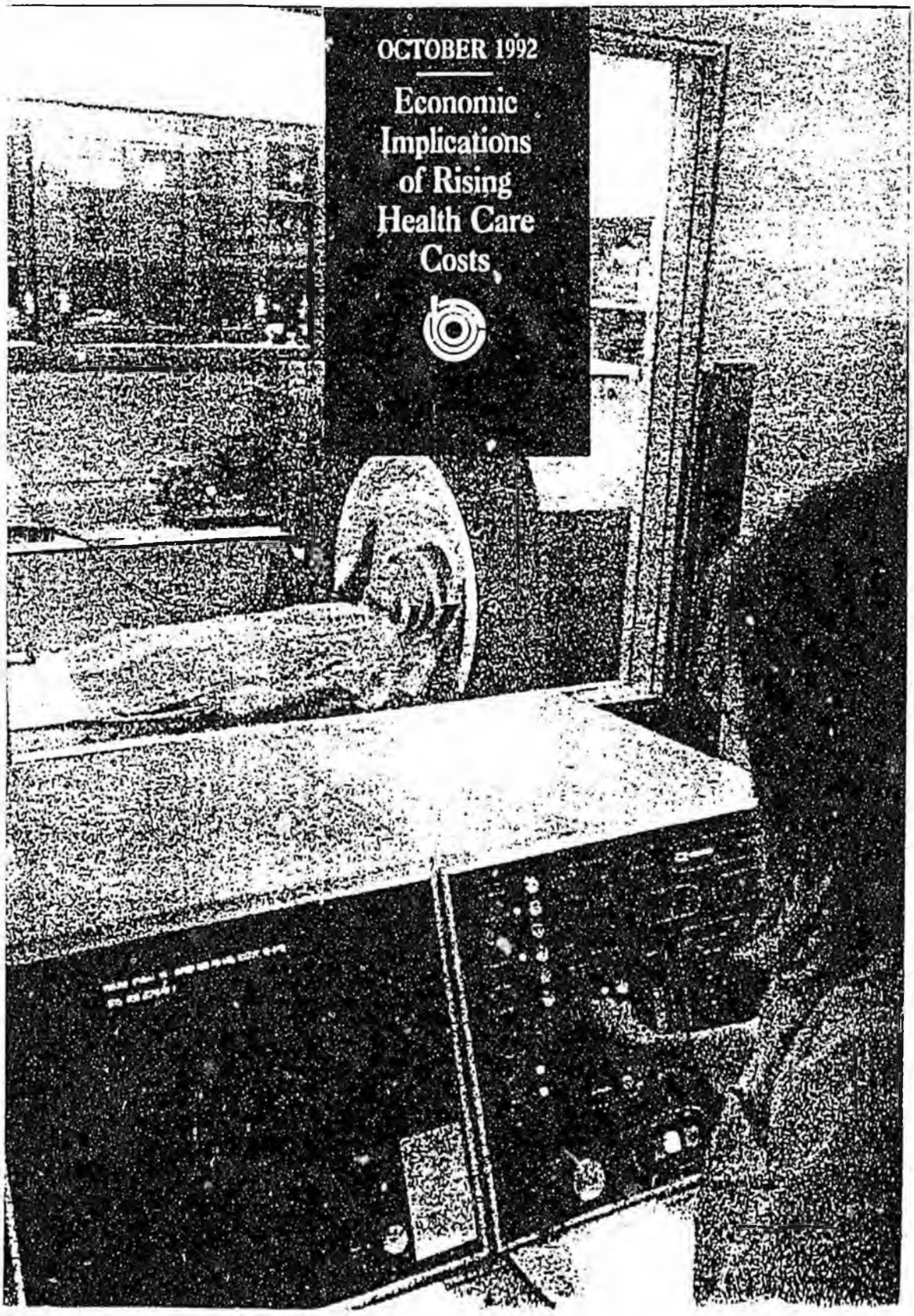
APPENDIX K

CONGRESS OF THE UNITED STATES
CONGRESSIONAL BUDGET OFFICE

A

CBO

STUDY



OCTOBER 1992

Economic Implications of Rising Health Care Costs

The Malpractice Issue

Some analysts believe that the possibility of malpractice lawsuits has substantially increased health care expenditures, not only by raising malpractice insurance premiums but also by inducing physicians to adopt "defensive" medical practices aimed at reducing the risk of lawsuits.[13] For several reasons, however, CBO infers from the available evidence that the larger published estimates are too high and that restructuring malpractice liability alone would not generate large savings in U.S. health care costs.[14]

First, malpractice premiums amount to less than 1 percent of national health expenditures. Thus, these premiums directly contribute little to the nation's overall health costs. Second, much of the care that is commonly dubbed "defensive medicine" would probably still be provided for reasons other than concerns about malpractice. Physicians have always sought to provide patients with the best possible medical care at the lowest risks and would continue to do so even without the threat of lawsuits. Because much of this "defensive care" helps to reduce the uncertainty of medical diagnoses, it seems unlikely that physicians would change their practice patterns dramatically in response to malpractice reform.

Conclusions

Health care spending is propelled upward by powerful forces. Dramatic technological breakthroughs have improved medical care, but at a very high cost. Moreover, the presence of insurance and heavy government involvement has eased the pressures on consumers to reject high-cost treatments. This means that new medical technologies do not have to meet the usual market tests that face other goods and services. As a result, when the boundaries of science are pushed out, medical breakthroughs that increase costs are not discouraged. Although several other factors--rising incomes, demographic changes, and higher medical malpractice costs--have been blamed for increasing the nation's health care bill, they do not appear to account for much of the increase.

12. See David Parkin and others, "Aggregate Health Care Expenditures and National Income: Is Health Care a Luxury Good?" *Journal of Health Economics*, vol. 6, no. 2 (1987), pp. 109-127; and Newhouse, "Medical Care Costs: How Much Welfare Loss?"

13. Roger A. Reynolds, John A. Rizzo, and Martin L. Gonzalez, "The Cost of Medical Professional Liability," *Journal of the American Medical Association*, vol. 257, no. 20 (May 22-29, 1987), pp. 2776-2781.

14. See Statement of Robert D. Reischauer, Director of the Congressional Budget Office, before the House Committee on Ways and Means, March 4, 1992.

Coalition for Consumer Rights

a center for public interest research and education

THE MYTH OF MEDICAL MALPRACTICE SAVINGS:

The Nothing for Nothing Trade Off in Indiana's Health Care System

The Coalition for Consumer Rights

February, 1992

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THE MYTH OF MEDICAL MALPRACTICE SAVINGS:

The Nothing for Nothing Trade Off in Indiana's Health Care System

Medical malpractice suits and the costs associated with them are often blamed for soaring health care costs. However, trends now show double digit health care inflation continuing into its fifth year despite declines in medical malpractice claims. This has cast doubt on the relationship between the two. The Coalition for Consumer Rights decided to further test the relationship between medical malpractice and health care costs with a comparative study on specific health care costs in two states.

Contrasting Two Systems: Illinois v. Indiana

Illinois and Indiana have vastly different compensation systems for victims of medical malpractice. Illinois has a tort based system which gives judges and juries the responsibility to decide if a doctor is guilty of negligence and to award compensation as they see fit, without limits.

Indiana has a review system, where medical malpractice cases are not heard by a judge and jury, but by a Medical Review Panel. Compensation is limited to $750,000, (only $100,000 is paid by the doctor's insurance), regardless of the extent of the injury and its impact on the person or their family.

These two systems have resulted in very different medical malpractice premiums for their doctors. Illinois doctors pay more for malpractice insurance. Indiana consumers have forfeited more rights under their system, but Indiana doctors pay lower malpractice premiums. This trade off has sometimes been justified by the suggestion that lower malpractice premiums are passed on to Indiana consumers in the form of lower health care costs.

Our surveys were designed to answer this question: What economic benefits do Indiana consumers realize by giving up their right to full recovery? Does the Indiana's 'rights trade off', which saves doctors money on malpractice premiums, result in lower costs to health care consumers?

Indicators: Room Rates and Childbirth Fees

Our first survey tested the hospital room fees in Indiana and Illinois, to provide a benchmark for differences between the two states. Since room fees alone could not be expected to reflect all differences between the states, a second survey was designed to incorporate more data.

Baby delivery fees were expected to show a greater responsiveness to malpractice costs because malpractice rates for obstetrical procedures have often been cited as a reason for soaring health care costs. Therefore we decided to test the hospitals fees associated with baby delivery.

Methodology

Calls were made on September 17, 1991 to hospitals in similar municipalities in Indiana and Illinois asking for the basic room rates for private and semi-private rooms. Calls were made in December, 1991 and January, 1992 to hospitals in the same municipalities asking for the average cost of baby delivery in a normal birth, and the average length of stay for a normal birth mother and baby.

Findings

Neither of the two separate surveys of the major hospitals in selected municipalities in Indiana and Illinois found any variance in fees that could be attributed to differences in medical malpractice costs.

In the four sets of similar municipalities surveyed, Illinois residents paid approximately the same rate or less per room. For the same municipal areas, there were only modest differences in hospital fees for baby delivery. In fact, for two sets of comparable municipalities, reported average fees were higher in Indiana.

Do Malpractice Premiums Make a Difference?

A brief review of the two indicators of health care costs -- baby delivery costs and hospital room rates -- shows that lower malpractice costs do not lead to lower health care costs.

If lower medical malpractice costs are saving anyone money in Indiana, it is not the health care consumer. Although the Indiana medical compensation system requires consumers to forfeit their legal rights, it gives them nothing in return.

APPENDIX A

COMPARISON OF HOSPITAL ROOM RATES BETWEEN INDIANA AND ILLINOIS COMMUNITIES

Bloomington, Indiana Population 51,646

Hospital	$ for Semi-Private	$ for Private
Bloomington	$371.50	$431.50
Bloomington Meadows	Closed for Construction	

Bloomington, Illinois Population 44,189

Hospital	$ for Semi-Private	$ for Private
Brokow	$258	$276
St. Joseph	$261	$288
Mennonite	$240	$258

Muncie, Indiana Population 77,216

Hospital	$ for Semi-Private	$ for Private
Ball Hospital	$240	$250

Moline/Rock Island, Illinois Population 92,000

Hospital	$ for Semi-Private	$ for Private
United Medical Center	$237	$253
Franciscan	$235	$245

Springfield, Illinois Population 99,637

Hospital	$ for Semi-Private	$ for Private
Memorial Med Ctr	$270	$290
St. Johns	$305	$325

South Bend, Indiana Population 109,727

Hospital	$ for Semi-Private	$ for Private
Memorial	$405	$455
St. Joseph Med Ctr	$420	$455

Evansville, Indiana Population 130,496

Hospital	$ for Semi-Private	$ for Private
St. Mary's	$327	$348
Deaconess	$317	$357
Wellborn	$335	$378

Rockford, Illinois Population 139,712

Hospital	$ for Semi-Private	$ for Private
Rockford Memorial	$305	$330
St. Anthony Med Ctr	$285	$300
Swedish American	$324	$374

Estimated 1986 population figures.
Research conducted in September 1991 by Kim S. Gray
Coalition for Consumer Rights

APPENDIX B

COMPARISON OF DELIVERY COSTS IN THE CASE OF A NORMAL DELIVERY BETWEEN INDIANA AND ILLINOIS COMMUNITIES

TOWNS UNDER 100,000

Bloomington, Illinois	Population 44,189
Hospital	**Average Reported Delivery Charge**
Brokow	2,900
St. Joseph	2,531
Bloomington, Indiana	Population 51,646
Hospital	**Average Reported Delivery Charge**
Bloomington	2,500
Terre Haute, Indiana	Population 61,125
Hospital	**Average Reported Delivery Charge**
Terre Haute	2,600
Union	2,500
Muncie, Indiana	Population 77,216
Hospital	**Average Reported Delivery Charge**
Ball Hospital	2,500
Aurora, Illinois	Population 81,293
Hospital	**Average Reported Delivery Charge**
Copley Medical Ctr.	3,200
Mercy Health Ctr	1,400-2,000
Moline/Rock Island, Illinois	Population 92,000
Hospital	**Average Reported Delivery Charge**
United Medical Ctr.	3,000

Franciscan	2,000-2,500

Champaign/Urbana,Illinois Population 93,000

Hospital	**Average Reported Delivery Charge**
Carle Foundation	2,500
Covenant	2,700-3,500
FINDINGS:	Average cost for Indiana: $2,525 Average cost for Illinois: $2,647 A difference in cost of only $122.62

TOWNS OF COMPARABLE SIZE:
SPRINGFIELD, IL AND SOUTH BEND, IN

Springfield, Illinois Population 99,637

Hospital	**Average Reported Delivery Charge**
Memorial Med Ctr.	2,000
St. Johns	1,500-2,400

South Bend, Indiana Population 109,727

Hospital	**Average Reported Delivery Charge**
Memorial	3,500
St. Joseph Med Center	1,982
FINDINGS:	Average cost for Indiana: $2,741 Average cost for Illinois: $1,975 $766 higher costs in Indiana

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TOWNS OF COMPARABLE SIZE:
EVANSVILLE, IN; ROCKFORD, IL; AND GARY, IN

Evansville, Indiana Population 130,496

Hospital	**Average Reported Delivery Charge**
St. Mary's	2,258
Deaconess	2,875
Welborn	1,600

Rockford, Illinois	Population 139,712
Hospital	**Average Reported Delivery Charge**
Rockford Memorial	1,886
St. Anthony's	2,500
Swedish American	1,600-2,500
Gary, Indiana	Population 151,953
Hospital	**Average Reported Delivery Charge**
Methodist	2,500
FINDINGS:	Average cost for Indiana: $2,308 Average cost for Illinois: $2,145 Difference in cost of $163

TOWNS OF COMPARABLE SIZE:
FORT WAYNE, IN AND PEORIA, IL

Fort Wayne, Indiana	Population 172,196
Hospital	**Average Reported Delivery Charge**
Parkview Memorial	2,538
St. Joseph	2,500
Peoria, Illinois	Population 200,466
Proctor Community	2,500
Methodist Medical Ctr.	3,400
St. Francis	1,848
FINDINGS:	Average cost for Indiana: $2,519 Average cost for Illinois: $2,582 Difference in cost of only $63

Estimated 1986 population figures.
Research conducted in December 1991 and January 1992 by Kim S. Gray, Coalition for Consumer Rights

DRAFT Comments to: Larry Weiss (907) 333-5862 - 5862 Kennyhill Dr. Anchorage AK 99504 (Professor of Sociology, UAA)

A Few Comments About Tort Reform and Medical Negligence

By Lawrence D. Weiss December 1993

MEDICAL MALPRACTICE

Medical malpractice involves the negligent treatment of patients by a variety of health care providers including physicians. Negligent physicians may be drunk, drug impaired, incompetent, or otherwise unable to exercise adequate judgement or skill in the treatment of patients. The consequences of physician negligence range from no effect to full permanent disability or death. From a public health perspective the key issues involve the negligence of the physician and the consequences for the patient. In other words, what social structures or processes detect and deter medically negligent physicians from harming their patients, and what structures act as obstacles to the detection and deterrence of negligent physicians? What patients are at risk as victims of malpractice, and what are the consequences for those patients?

The media image of medical malpractice has been predominantly formed and conditioned not by the public health perception of malpractice, but rather by the institutions involved with the financial consequences of medical malpractice. These social institutions include primarily the private insurance industry and physicians through their professional organizations. As a result medical malpractice is commonly discussed in the context of the high cost of malpractice insurance premiums and the issue of tort reform rather than the effective control of negligent physicians and the toll they take in medical injury and human suffering.

Public health institutions in both the private and public sectors are starved for resources and have minimum access to the powerful media machines that churn out public opinion. On the other hand the $1.6 trillion insurance industry (Weiss 1992, 17) and the American Medical Association engage legions of public relations flacks, hundreds of lobbyists and scores of millions of dollars each year to influence the media and public opinion. This uneven access to the media during the last couple of decades has resulted in a highly skewed public perception of the various issues related to medical negligence and malpractice. As a result the public discussion has been heavily weighted by vested interests wielding ideological arguments. The bright light of non-ideological research and analysis has been noticeably absent from most public discussion.

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Magnitude of The Medical Negligence Problem

Until the last few years the only major piece of research addressing the relationship between medical negligence, patient injuries, and malpractice claims was a study conducted in the mid-1970s published by the California Medical Association (Mills 1977). In that study a convenience sample of nearly 21,000 medical records was analyzed for evidence of medical negligence. This study revealed a negligence rate of 0.8 percent, or about eight injuries due to medical negligence for every 1,000 hospitalizations. It was estimated that only about ten percent of those injured as a result of medical negligence ever filed a claim for damages (Danzon 1985, 19).

A more recent and methodologically stronger study confirms the magnitude of the medical negligence problem and suggests that a much smaller fraction of those injured seek compensation than was indicated in the California study. The Harvard Medical Practice Study (Hiatt 1989) selected a random sample of approximately 31,000 records from 51 hospitals in the state of New York in the year 1984. Teams of physicians evaluated these records to uncover injuries caused by medical negligence, i.e. "the failure to meet standards reasonably expected of the average physician, other provider, or institution..." (Hiatt et al. 1989, 481).

The Harvard study revealed a medical negligence rate of 10 in every 1,000 hospitalizations, somewhat higher than the California study (Localio et al. 1991). The injuries included in the study were [illegible] serious enough to result in a longer hospital stay, disability upon discharge, or death. Further, projecting their findings to the entire state of New York in the year of the study, the researchers estimated over 27,000 serious injuries due to medical negligence among 2.6 million patients discharged from acute care hospitals. These projected injuries included nearly 7,000 deaths and almost 900 cases of permanent and total disability. Table 4.1 summarizes the relationship between adverse events (injuries or illnesses caused by medical intervention) not resulting from negligence, adverse events resulting from negligence, and the resulting litigation.

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Table 4.1 Negligent Injury and Resulting Litigation
Of Every 10,000 Hospital Patients

9,630 will experience no adverse events and
370 will suffer adverse events, but
270 of those will be without negligence. Of the
100 negligent adverse events, in
98 no claims for compensation will be made. Of the
2 claims made, only
1 will receive any compensation.

Source: Saks 1993, 9. (Based on findings of the Harvard Medical Practice Study)

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People 65 years of age and older were particularly likely to be victims of medical negligence regardless of the severity of their initial illness (Brennan et al. 1991, 373) indicating a greater propensity among the elderly to be treated by substandard medical practitioners. In addition, "[t]here was more negligence among the Medicaid patients than the privately insured, and much, much more among the uninsured." (Hiatt 1992, 258) In other words, there is an inverse relationship between wealth and negligent medical treatment.

While the California study (Danzon 1985) found that an estimated 90 percent of those injured by medical negligence never filed a claim, the Harvard Medical Practice Study found that more than 98 percent of all the injuries caused by medical negligence were not followed by a malpractice claim (Localio et al., 1991). In summary the investigators observed that:

> the civil-justice system only infrequently compensates injured patients and rarely identifies and holds health care providers accountable for substandard medical care....The abandonment of malpractice litigation is unlikely unless credible systems and procedures, supported by the public, are instituted to guarantee professional accountability to patients (Localio et al. 1991, 250).

Detection and Deterrence

There is an extensive array of institutional structures across the nation with the nominal purpose of deterring, limiting, or terminating the practices of negligent physicians. Nevertheless, nationwide projections based on the Harvard Medical Practice Study (Brennan et al. 1991) as well as other studies (Wolfe 1992) indicate that physicians cause 100,000 to 300,000 serious injuries and deaths every year resulting from medical negligence. Clearly these facts put in serious question the actual effectiveness of institutional safeguards.

Hospital Peer-review Committees Hospital peer-review committees have the benefit of knowing the professional strengths and weaknesses of physicians with whom they share hospital privileges. The intimacy of the hospital setting, however, makes effective self-regulation among friends and colleagues unlikely. The threat of suits against individuals sitting on the peer-review committees adds to the obstacles inhibiting effective detection and deterrence of negligent physicians by these committees (Schwartz and Mendelson 1989, 1342). In 1991, for example, American hospitals sanctioned only 750 physicians with restrictions lasting longer than one month (Wolfe 1992, 1). This

is the equivalent of 1.25 such sanctions for each 1,000 physicians. Contrast this rate to physician-owned malpractice insurance companies which terminated insurance for 6.6 physicians per 1,000 due to medical negligence (Schwartz and Mendelson 1989:1345). In the latter case physicians are personally liable for a colleague's malpractice, in the former case they are not.

State Licensing Boards At the state level licensing boards have the authority to investigate and discipline physicians for medical negligence as well as other problems relating to their practice of medicine. A maximum of 5 per 1,000 physicians nationally have been disciplined by state boards in a any recent year, and the figure is a fraction of that for serious disciplinary actions such as license revocation or suspension. Moreover, only about 12 percent of all disciplinary actions actually relate to medical negligence. The rest have to do with criminal behavior, overprescribing drugs, ethics issues, etc. The most aggressive states discipline about 10 per 1,000 physicians annually, while the most reticent discipline about one per 1,000. In 1991 state medical boards disciplined only 3,034 physicians, whereas in that same year an estimated 150,000 to 300,000 serious injuries or deaths occurred due to physician negligence in hospitals. These figures do not include estimates of medical negligence that occur in physician office settings outside the hospital (Wolfe 1993c).

Apart from the periodic situation of friends and colleagues reluctant to enforce sanctions against each other, most of these boards face a number of additional obstacles. A most difficult one is the standard of proof state boards are required to use to identify and manage negligent physicians. "'Clear and convincing evidence'" must be produced rather than the less stringent "'preponderance of evidence'" that is typically used in other settings such as state courts (Schwartz and Mendelson 1989, 1345). Another serious obstacle is the widespread shortage of investigators and resources necessary for boards to effectively conduct investigations. As a result boards often have backlogged cases numbering in the hundreds. A third obstacle is that state boards generally do not have extensive peer-review capabilities, inhibiting the quantity and quality of information received during an investigation. Finally, the case of an accused physician who fully contests State licensing board charges typically drags on six to eight years. The physician may remain in practice that entire time. One public interest lawyer wryly noted that '"This system is so slow, so meager, and so trivial that death is weeding out incompetent physicians much faster than is the board."' (Chesteen and Lally 1991)

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Medicare Peer Review Organizations Medicare Peer Review Organizations (PROs) were created in each state by the federal government in 1982 to monitor the quality and cost of hospital care reimbursed by Medicare. Theoretically these organizations wield a big stick. They can discipline problem physicians and hospitals by denying them participation in Medicare, refer serious quality of care problems to the state medical licensing board, or "educate" the offender. A review of their work in the mid-1980s indicates that the rate of PRO recommendations for exclusions from Medicare and Medicaid declined dramatically. The trend corresponds with an emerging policy revision in the Health Care Financing Administration (HCFA) which oversees the PROs. HCFA has decided to adopt the strategy of "educating" errant physicians rather than disciplining them.

A study of eight randomly selected PROs by the Department of Health and Human Services (HHS) Office of the Inspector General (OIG) during a six month period in 1990 found 131 physicians responsible for serious medical negligence or other breaches of quality of care. Despite the fact that these problems had led to hospital readmission, disability, or death; and despite the fact that 30 percent of these physicians had multiple infractions, only two were ever referred to the OIG for termination with Medicare, and three were referred to the state licensing board. The rest of the physicians were notified that a problem had been discovered and were monitored more closely by the PROs to a greater or lesser extent. Most of the physicians also received a phone call or brief letter from the PRO, and that served as the additional "education" they were supposed to receive.

> In fact, the study reveals that PROs squander opportunities for genuine improvement of substandard physicians' skills. And by categorically rejecting more punitive measures in favor of ineffective education, they fail to deter repetition of serious problems by the same--or other--incompetent doctors. (Wolfe 1991)

Physician-owned Insurance Companies Approximately 40% of all physicians in patient care are insured against medical negligence claims through physician-owned insurance companies (Schwartz and Mendelson 1989). Unlike the alternative of commercial insurance, and unlike either state licensing boards or hospital peer-review committees, members of physician-owned insurance companies are personally liable for claims made against any of their co-owners. As a result of this financial accountability, applicants to physician-owned insurance companies are often carefully screened for competence by a committee of members prior to admission. Once admitted, members who have had

claims for malpractice filed against them may be rigorously evaluated by peers, outside consultants, and underwriters.

Sanctions against negligent physicians may include additional surcharges on their insurance premiums, deductibles in the event of successful claims, restrictions on practice, additional training, or the termination of insurance. In about a third of the cases, however, the latter sanction takes the form of a resignation from part ownership in the insurance company (and therefor termination of coverage) under pressure from the insurance company. Schwartz and Mendelson (1989, 1345) estimate that in 1985 state boards suspended or revoked the licenses of about 0.08% of all practicing physicians, less than one per 1,000, because of incompetence or negligence. During the same year physician-owned insurance companies terminated coverage for 6.6 per 1,000 member physicians due to medical negligence. In other words the maximum sanction was applied by the physician-owned insurance companies over eight times more frequently than the maximum sanction applied by state boards.

Certainly it can be argued that suspension of license is considerably more serious than loss of insurance so that the penalties are not comparable. However, lesser sanctions for negligence were levied by the physician-owned insurance companies at a rate about thirteen times more frequently than lesser sanctions applied by the boards. There is a strong suggestion in these research findings that structurally the physician-owned insurance companies, characterized by personal financial liability, are far more effective at weeding out negligent physicians than are the state licensing boards.

The occasional revocation of a physician's license by the state board due to negligence, the board's ultimate sanction, may effectively prevent a physician from endangering the people of a particular state. However, that same negligent physician is free to start a practice in another state whose licensing board may be entirely unaware of the physician's history of incompetence. Physician-owned insurance companies administer their ultimate sanction, termination of insurance, far more frequently than boards revoke or suspend licenses, however the social result is the protection of member-physicians' finances rather than protection of the public's health. The sanctioned physician is relatively free to continue his or her flawed practice of medicine with commercial insurance or without insurance coverage at all. In addition he or she may be accepted to practice in the military, or in a state or municipal hospital.

National Practitioner Data Bank In the fall of 1990 the Department of Health and Human Services initiated the National

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Practitioner Data Bank. The nominal purpose of this data bank is to collect and disseminate information about medical malpractice payments and a range of adverse professional actions involving physicians and other health care practitioners:

> This system...was created to help meet a national need to restrict the ability of incompetent practitioners to move from state to state without disclosure or discovery of the practitioner's previous damaging or incompetent performance. The data bank contains information on adverse actions taken against a practitioner's license, clinical privileges, and professional society memberships, as well as information on malpractice payments resulting from judgements or settlements (U.S. General Accounting 1992b, 2).

Unfortunately, the political compromises made during the formation of the data bank legislation have seriously flawed the use of this information to protect the public's health. Congress refuses to allow disclosure to consumers of any information that might reveal the identity of an individual practitioner. The only organizations allowed to obtain this information are hospitals and other health care entities, professional societies, state licensing boards, and individual practitioners. Of these, only hospitals are actually required to query the data bank when hiring, granting clinical privileges, or evaluating physicians. Despite the stated major purpose of the data bank, state licensing boards are not required to evaluate data bank information prior to granting new licenses. A recent study by the U.S. General Accounting Office (1993) found that the data bank's effectiveness is further hampered by long delays in providing requested information, lax security regarding sensitive information, inadequate federal monitoring of the data bank contractor, and poor planning for the data bank's future.

<u>Verifying Physicians' Credentials</u> There is no single, public source for information about physicians who have been disciplined because they were drug impaired, incompetent, negligent, unethical, or engaged in criminal behavior. Most state medical societies will release a list of names of physicians that they have disciplined, but that list will not contain the names of physicians who have been disciplined by a myriad of federal agencies, other state medical boards, hospital peer review boards, or a number of other institutions. The closest thing to such a list that may be as accessible as the local library is a book updated every couple of years under the title *Questicnable Doctors* (Van Tunen 1991), produced by Public Citizen Health Research Group, a consumer advocacy Ralph Nadar spinoff group. This publication lists in one source physicians

who have been disciplined by several federal agencies and most state medical societies.

While it is almost impossible to find out if a particular physician has been disciplined by all of the institutions that potentially might do so, it is even more difficult for a person seeking health care to verify that a physician has the training and experience that he or she claims. In a study conducted by Reade and Ratzan (1989) their conclusion was that "obtaining access to complete, up-to-date, and verified information about physicians is all but impossible."

> Physicians listed in the yellow pages of the phone book typically are free to list just about whatever they want. The phone companies typically run no independent checks on state licensure or specialty credentials listed.
>
> Many state or county medical societies do not independently verify biographical information given to them by physicians such as medical school, residencies, or board certification. Whether they verify such information or not, often medical societies will not release crucial information to the inquiring public such as whether or not the physician is board certified.
>
> The 23 specialty and subspeciality boards of the American Board of Medical Specialities (ABMS) are wildly inconsistent to public inquiries about board certification and other information concerning the qualifications of member-physicians. Some released all pertinent information over the phone, but most did not. Some would release such information only to hospitals, or only to mailed inquiries. Some would only release information with a signed release from the physician, and some boards referred inquiring members of the public to the library, often to a copy of Marquis' *Directory of Medical Specialists* (American Board of Medical Specialities 1991-92)
>
> The *Directory of Medical Specialists* in theory only lists physicians who are board certified. A serious problem with this compendium is that, for a number of reasons, a physician who is board certified in a specialty area may not be listed in here. Finally, only board certification is independently certified. Other biographical information, for example regarding residency and fellowship training, simply reflects what the physician indicated, and is not independently verified.

> The American Medical Association directory does contain verified information about state licensure, medical school, and specialty-board certification, but the directory is not easy to find, is heavily coded making it quite user unfriendly, and can be quite misleading to the lay person. In addition the directory provides no information on advanced training or certification in subspecialties.
>
> State licensing boards verify training and certification information to a greater or lesser degree initially, but may not verify additional information given during licensure renewal, for example about advanced training. State boards vary in terms of how much information they will release to the public, and under what circumstances.

Sleep-Deprived Medical Residents. Residents are typically recently graduated medical students who are doing one to four years of additional clinical training, usually on the house staff of a hospital. Residents are terribly exploited, working 100 to 120 hours per week or more, and often working up to 36 hours straight with no sleep or only a quick nap (U.S. General Accounting Office 1992a). A substantial body of research dating back to the early 1970s supports the common sense assumption that fatigued residents are likely more prone to medical negligence than well rested physicians.

The Accreditation Council for Graduate Medical Education (ACGME) accredits the nearly 7,000 residency programs across the United States. For several years during the late 1980s ACGME, the AMA, and the Association of American Medical Colleges (AAMC) worked together to develop accreditation standards that would limit the excessive hours typically worked by medical residents. These efforts were opposed by the American Boards of Medical Specialities (ABMS), in particular the six surgical specialty areas of the 24 medical specialities in the ACGME. Only one of these six surgical specialities restricted the maximum number of hours a resident could work per week, only one of them limited the number of days per week a resident had on-call duty, and only one of them required a minimum of one day per week off (U.S. General Accounting Office 1992a, 45). The surgical specialities wanted virtually no restrictions on their exploitation of medical residents.

Nevertheless, as a compromise ACGME finally adopted the following language the end of 1991:

> 'It is desirable that residents' work schedules be designed so that on the average, excluding exceptional patient care needs, residents have at least one day out of

> seven free of routine responsibilities and be on-call in the hospital no more often than every third night.' (U.S. General Accounting Office 1992a, 3)

This sounds like a mushy equivocating statement because it is. Under these guidelines residents can still work 96 hours or more per week. The guidelines are the result of opposition to a more meaningful policy by the surgical specialties of the ACGME, the American Board of Surgeons, and the American College of Surgeons. Surgeons objected to any ACGME regulations on the basis that "such limits interfere with the development of the resident's sense of commitment to the patient and impede the continuity of care necessary for patient safety." (U.S. General Accounting Office 1992a, 3). Apparently severe fatigue and stress, and the resultant increased risk of medical negligence was not thought to interfere with "patient safety" to a significant degree.

New York State is the only state that attempts to regulate the number of hours residents work. The impetus for this regulation arose from a 1986 New York county grand Jury investigation of the suspicious death of a teenager admitted to New York Hospital who was treated by two overworked and undersupervised residents. New York limits residents to 80 hours per week, averaged over a four week period. The state also requires one full day off each week, a minimum of eight hours off between scheduled on-duty assignments, and a specific level of supervision. The additional personnel required to replace the medical residents now limited to "only" 80 hours per week cost the hospitals of the State of New York an estimated $227 million the first year. This cost projection along with others indicates how widespread the exploitation of cheap, abundant medical resident labor is to the current practice of hospital-based health care nation-wide (U.S. General Accounting Office 1992a, 32-36.

Unfortunately there have been no published studies regarding why surgeons and possibly other groups of physicians are so resistant to allowing residents to have reasonable working conditions, thereby reducing medical negligence caused by fatigue, stress, and sleep deprivation. The additional costs may be a factor, but presumably that is the worry of the hospital administrator and not physicians with training responsibilities or hospital privileges. Perhaps the systematic overwork of the residents is seen as a kind of hazing ritual that functions to bond the residents to the profession while simultaneously loosening ties with patients, family, and non-physician friends. Surely an important impetus to the gross exploitation of the residents' time is fear by the physician-educators that their own

time would be severely impacted by additional work if residents were allowed to cut back. In any case these questions need additional research because the medical and social consequences of the systematic overwork of residents are so serious.

Tort Reform

The American Medical Association and its state affiliates, insurance companies, and the media have combined to make the issues of medical malpractice and tort reform almost inseparable in the public consciousness. A tort is a legal action specifying:

> ...allegations of injury or wrong committed either against a person or against a person's property by a party or parties who either failed to do something that they were obliged to do or did something that they were obligated not to do (Ostrom et al., 1993, 19).

Torts include a wide variety of court actions such as product liability, automobile torts, personal injury, libel, etc. A medical malpractice suit is a particular type of tort requiring a patient to show that he or she was injured during medical treatment, that the physician's treatment (or lack of appropriate treatment) caused the injury, and that the physician failed to provide the generally accepted standard of care. In 1991 an estimated 1.2 million tort cases of all kinds were filed in state courts, a figure which has been fairly stable for several years (Ostrom et al., 1993, 19). However, only about 10% of all torts decided at trial are medical malpractice cases (Ostrom et al., 1992, 81).

Organized Physicians' groups and the insurance industry take the lead in arguing that there is need to reform the legal structure as it pertains to torts, and in particular to medical malpractice cases. Some of the commonly cited reasons include:

> There is an explosion of medical malpractice litigation, and much of it is trivial or unwarranted.
>
> Lawyers' contingency fees are the cause of the high cost of medical malpractice insurance.
>
> Enormous, unfair settlements are the cause of the high cost of medical malpractice insurance.
>
> The high and rising cost of health care can in large part be attributed to the high cost of medical malpractice insurance.

DRAFT Comments to: Larry Weiss (907) 333-5862 - 5862 Kennyhill Dr. Anchorage AK 99504 (Professor of Sociology, UAA)

> Defensive medicine, the ordering of largely unnecessary tests and procedures by physicians trying to avoid malpractice suits, is driving up the cost of health care.
>
> High medical malpractice insurance premiums are forcing physicians to stop delivering babies, to reduce or eliminate other medical procedures, and to quit the practice of medicine altogether.

These allegations provide important ideological ammunition for their respective adherents. The AMA has an interest in diverting attention from the responsibility of physicians in committing widespread medical malpractice, and the insurance industry has an interest in diverting attention from the fact that its profits are derived from increasingly higher premiums. In other words, the insurance industry has historically had little reason for taking an active role in reducing the incidence of malpractice because it has been able to cash in on it (Peck 1986). Nevertheless, two decades of frequently unproven, ideologically-driven allegations pumped up by massive media campaigns and political lobbying efforts have resulted in wide spread tort reform across the United States.

Some of the tort reforms have been aimed at creating barriers to legal suits (Spernak and Budetti 1991). Many states, for example, have "frivolous suit" penalty statutes requiring the party with an allegedly weak claim or defense to pay court costs and attorney fees for the other party. Some states have shortened various statutes of limitation applying to medical injury claims, and a number of states have "good samaritan" statutes giving immunity to negligent physicians who provide emergency care at the scene.

Many states have initiated tort reforms intending to alter the plaintiff's burden of proof. Some of these have increased the plaintiff's burden of proof beyond the standard "preponderance of the evidence." Others, such as *res ipsa loquitur* greatly ease the burden of proof on the plaintiff by allowing the judge to instruct the jury in certain very self-evident cases that negligence did in fact cause the injury. These cases typically settle out of court.

Finally, a major category of tort reform involves laws designed to reduce damage awards. In its most direct form, states have enacted caps on the economic, non-economic, and punitive damages a plaintiff may receive from a jury. Some states allow defendants to pay out large awards in installments rather than all at once. For the defendant this has the added

benefit that the plaintiff may die, perhaps saving the defendant a considerable sum of money.

The consequences of these reforms have varied considerably. (Spernak and Budetti 1991, 13-15). Several studies indicate that limits on damage awards are associated with slightly or modestly reduced insurance premiums, and reduced amount paid per claim. Many of the reforms seem to have had no measurable effect on insurance rates, claims filed or damages paid. Some of the reforms have had consequences opposite those anticipated. For example, the establishment of mandatory pre-trial screening panels has increased average claim payments by over 50 percent.

Most importantly, however, there is no evidence that any of the tort reforms have actually helped to detect or deter the widespread incidence of malpractice known to exist. Further, there is no evidence that any of the tort reforms have made the attainment of compensation easier for the overwhelming majority of victims of medical negligence who never file a claim, who never make a settlement, and who are never paid a penny by the negligent physician or medical facility. These, however, are not the goals of tort reform.

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Box 4.1

MEDICAL MALPRACTICE INSURANCE IN CANADA: MUCH CHEAPER

Canadian physicians are sued about one fifth as often as U.S. physicians despite the lack of evidence that the incidence of medical negligence is significantly less in Canada than in the United States. Moreover, their malpractice insurance costs about one ninth as much as it does for U.S. physicians. The medical malpractice insurance premium in Canada costs on average a mere 1.5% of a physician's net professional income. There are a number of factors that may account for why this is so:

In most Canadian provinces the limitation period, that is the period during which the plaintiff may file a malpractice claim, is considerably shorter than in the U.S.

In Canada punitive damages are rarely awarded, and damages for pain and suffering are considerably less than in the U.S., due in part to a nation-wide cap.

Since there is universal access to health care in Canada, estimated costs for past and future health care needs are a minimal component in the decision to sue, and a smaller part of any award or settlement compared to the United States.

Social security programs in Canada are generous and relatively comprehensive compared to the U.S., minimizing the incentive to sue primarily for these kinds of benefits.

Contingent fee systems are not typically used by lawyers in Canada. This may reduce speculation, but it may also reduce access to compensation by low income people.

Under the Canadian legal system losers must pay a large portion of the winner's legal costs.

Over 95 percent of all medical malpractice claims are defended by one professional liability association, the Canadian Medical Protective Association, in contrast to hundreds of associations and insurance companies in the U.S. This concentration of resources and experience more effectively protects physicians and inhibits marginal claims.

Despite the above facts, the growth of malpractice actions in Canada is comparable to that in the United States. Between 1971 and 1989 the number of malpractice claims against Canadian Physicians grew nearly 700 percent, however only about one third

of those claims resulted in payments. The average malpractice award was $150,640 in 1989 (expressed in 1991 Canadian dollars), and had grown at the rate of 9.7 percent per year between 1971 and 1989, adjusted for inflation. The Average malpractice insurance premium increased nearly 15 percent per year between 1976 and 1988, adjusted for inflation.

In summary, Canadian physicians pay much lower medical malpractice premiums than their U.S. counterparts in large part because Canadian physicians are sued far less often. This appears to be the case due to obstacles in the legal system to the pursuit of compensation, and due to more encompassing health care and social security programs in Canada. The negative consequences of the Canadian system are that low income people and people with legitimate but difficult to prove cases are discouraged from seeking compensation. Furthermore, the Canadian system does not appear to be any more likely to identify and deter negligent physicians from practicing in the first place. Finally, the rate of growth of malpractice claims and payments is comparable to that in the U.S.. This portends controversy in the future for Canadians.

Source: Coyte, Peter C. et al. Medical Practice--The Canadian Experience. *The New England Journal of Medicine* 324 no. 2:89-93.

MEDICAL MALPRACTICE:

PERCEPTIONS AND MISPERCEPTIONS

March 1993

Developed by
The American Bar Association
Special Committee on Medical
Professional Liability and the
ABA Governmental Affairs Office

MEDICAL MALPRACTICE:
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Cost of Health Care in the United States

U.S. health care outlays, accounting for approximately 14 percent of the GNP, totaled $838.5 billion in 1992, up about 11.5 percent from $738 billion in 1991.[1] The medical-legal component in the same period appears to have decreased, since health care costs greatly increased during this period and malpractice premiums declined slightly.[2]

Factors Contributing to Cost

Among the factors cited as contributing to the rising cost of health care:

* Reliance on sophisticated and expensive treatment;
* Innovative treatment of such illnesses as heart disease, AIDS and cancer;
* An aging population which adds to Medicare and Medicaid expenditures; and
* High administrative costs of the health care system.

Some cite the cost of defensive medicine. However, no one has reliably measured what, if anything, defensive medicine costs. An October 1992 study of the Congressional Budget Office concluded that health care spending is propelled upward by high cost technological and medical breakthroughs. The study finds that rising incomes, demographic changes, and medical malpractice costs do not appear to account for much of the increase in the nation's health care bill. The report states that malpractice insurance premiums account for less than one percent of the dollars spent annually on the nation's health care.

Factors Contributing to Cost continued

The report also concluded that "much of the care that is commonly dubbed 'defensive medicine' would probably still be provided for reasons other than concerns about medical malpractice. Physicians have always sought to provide patients with the best possible medical care at the lowest risks and would continue to do so even without the threat of lawsuits. Because much of this 'defensive care' helps to reduce the uncertainty of medical diagnosis, it seem unlikely that physicians would change their practice patterns dramatically in response to malpractice reform."[3]

"Defensive Medicine"

Varying figures for the cost of "defensive medicine" have been estimated.[4] To address the subject of "defensive medicine," there must be agreement upon the meaning of the phrase. There is no agreement upon the definition. That uncertainty has resulted in the inability to statistically measure the cost.[5] In published studies, "defensive medicine" has included erroneously the cost of the consequence of physicians' financial incentive to direct patients for tests and examinations in facilities in which physicians have a proprietary interest.[6] Some have considered the cost of new technology and advancements in medical knowledge, care, and treatment. In that regard, patients expect the use of very modern, sophisticated and expensive technology to refine diagnosis and eliminate uncertainties.

Therefore, to examine the impact of the medical-legal system, the necessary inquiry is to what extent physicians direct medical expenses that are unwarranted for the treatment or diagnosis of patients, and are not motivated by personal financial interests. In other words, an expense is only attributable to the medical-legal system when the sole reason for that expense is concern by the physician about a medical malpractice claim. There is no study to measure that cost, and there is no basis for assuming that competent and reputable physicians impose such expenses upon their patients without a justifiable medical reason.

To the extent that physicians' concern about liability results in more conscientious medical care, then "defensive medicine" is certainly desirable.[7] When the fear of tort liability deters medical injuries, then health care costs are lowered by avoiding the costs associated with medical injury.[8] Thus, if liability concerns are a deterrent, statutory provisions that relieve physicians of concern regarding negligent practices can actually result in an increase of health care cost.

Because no reliable studies have been done to determine the cost of so-called defensive medicine, the Office of Technology Assessment has been asked to study the issue and is expected to complete its study before the end of the year.

Number of Malpractice Claims

The number of malpractice claims peaked in 1985. Since 1985, the overall rate has declined at an average annual rate of 8.9 percent.[9] As an aside, one should note that even when the number of claims does grow, it is not clear precisely what this signifies, as different insurance companies define a "claim" differently. Some, for example, require their insureds to be covered for an occurrence, to notify them whenever an occurrence might lead to a lawsuit. Each such notice then becomes a "claim" whether or not a lawsuit, or any other claim by the patient, is ever filed. In addition, when there is initial uncertainty about liability, parties who are potentially liable are listed as parties to a lawsuit to avoid a bar under a statute of limitations. After further investigation, those determined not to be liable are dropped from the suit before trial and without any indemnity being paid.

Costs of Malpractice Coverage

The cost of medical malpractice insurance, for the most part, reflects the cost of the medical-legal system. In contrast to the increase in health care costs, medical malpractice costs have decreased slightly.[10] Medical advances have made many severe injuries more survivable, particularly for the newborn, as well as for others. What might have been a wrongful death case is now more often a case brought by a living plaintiff who has a lifetime of actual economic costs. These cases result in larger overall awards.

In 1989, malpractice insurance premiums were less than three-quarters of one percent of the total health care costs in the United States, and premium cost decreased by about four percent for 1990. The Physician Payment Review Commission agrees that the cost of malpractice insurance is "probably not excessive."[11] In comparison to other components of health care costs, administrative costs, for example, are 10 to 24 times the cost of all medical malpractice claims.[12]

General Claims Information

A February 1989 report of the Department of Commerce of the State of Minnesota reviewed all claims filed with two insurers in Minnesota, North Dakota and South Dakota against physicians from January 1, 1982, through December 31, 1987. Among its conclusions are the following:

* With the exception of self-insured groups, the St. Paul Companies and Minnesota Medical Insurance Exchange insure nearly 100 percent of Minnesota's physicians. This report represents the only known comprehensive study of physician loss experience for any jurisdiction over the time period of the study.

* The frequency of claims per year did not materially change over the time period of the study.

* The severity of the claims payment did not materially change over the time period of the study.

* Claims determined by the insurer to be frivolous did not increase over the time period of the study.

* The likelihood of receiving compensation as a result of filing a malpractice claim was approximately 25 percent. The rate did not materially change over the time period of the study.

* No punitive damages were awarded against a physician.

General Claims Information continued

* The average cost of investigating and defending a claim changed little over the time period of the study. Indeed, the amount appeared to be decreasing.

* Despite unchanging claims frequency and declining loss payments and loss expenses, physicians, on average, paid approximately triple the amount of premiums for malpractice insurance in 1987 than in 1982.

Additionally, the Harvard Medical Study Group estimated that, in 1984, eight times as many patients suffered an injury from negligent medical treatment as filed a malpractice claim in New York State. About 16 times as many patients suffered an injury from negligence as received compensation from the medical malpractice system.[13]

Juries

A recent study of medical malpractice cases suggests that unjustified payments to plaintiffs are probably uncommon. In cases in which "physician care was deemed to meet community standards," the physician typically won. The study found that "[t]he defensibility of the case and not the severity of patient injury predominantly influences whether payment is made. Even in cases that require a jury verdict, the severity of the patient injury has little effect in whether any payment is made." The study is based on 8,231 New Jersey medical malpractice cases from 1977 to 1992.[14]

Empirical research done on medical malpractice juries leads to the conclusion that there is no support for claims that medical malpractice juries are biased against defendants or unjustifiably generous in determining awards.[15]

Obstetricians/Gynecologists

Physicians enter the field of obstetrics in large numbers and obstetricians continue to maintain a profitable field of practice. The mean-net income of obstetricians/gynecologists, after expenses (and including liability premiums) and before taxes, was $207,300 in 1990.[16] To become a recognized obstetrician/gynecologist, a person with a medical degree becomes certified by the American Board of Obstetrics and Gynecology. Before 1980, there were 18,663 board certified obstetrician/gynecologists. In the period between 1980 and 1989, 10,153 new obstetrician/gynecologists received certificates. As of July 1991, there were 25,043 board certified physicians obstetrician/gynecologists.[17]

The percent of obstetrician/gynecologists who incur claims annually dropped at an average annual rate of 22.7 percent between 1985 and 1990.[18]

Research suggests that only a "small proportion of injury causing medical errors ever lead to a claim against the physician, and fewer result in a jury trial. Of the small portion of obstetrics and gynecology errors that result in a jury trial, physicians win most of the time. When physicians lose, it is likely to be in situations that do not involve specific procedures but that do involve severe injuries and in situations involving older, well-established technologies... The fact that it is older established technologies rather than newer, frontier technologies that are generally involved suggests that targeted attempts at quality assurance may be more appropriate than radical tort reform in reducing obstetrics and gynecology malpractice litigation."[19]

AMA's Tort Proposals: Impact on Health Care Costs

The Congressional Budget Office states that medical-legal costs, as measured by medical malpractice insurance premiums, account for 0.74 percent of the nation's health expenditures.[20] The pending proposals would result in a negligible impact on health care costs. A recent study funded by the Texas Medical Association, the Texas Trial Lawyers Association and the Texas Hospital Association reported that its findings indicated that "changing the medical professional liability system will have minimal cost savings impact on the overall health care delivery system in Texas."[21]

A recent study examined the relationship between medical malpractice tort "reform" and health care costs and found there to be "no indication that enacting major tort 'reforms' is positively correlated with lower health care costs." In fact, the study found that "states with the lowest per capita expenditures are more likely to have enacted fewer tort 'reforms' overall than the average."[22]

- **Collateral Source Rule**

  The collateral source rule forbids evidence from being introduced to show that a patient's costs, such as medical bills, have already been paid by another source, such as their own insurance. (Note that the collateral source has a right of "subrogation" -- that is, the right to recover from the successful plaintiff whatever monies the collateral source laid out that are recovered by the plaintiff from the tortfeasor.)

Collateral Source Rule continued

Elimination of the collateral source rule solely favors physicians by passing on the cost of the medical injury to another health care provider or to other providers of benefits to the injured person as a result of his injury. For example, often an injured person has the benefit of health or disability insurance which pays for a portion of the additional medical or other costs attributable to the injuries caused by a physician's negligence. Typically, the insurer will assert a lien against its insured's recovery or pursue a subrogation claim. Under some proposals, to change the collateral source rule, it has been suggested that health care costs would be saved if the negligent physician would get a credit for the insurer's payment, and the insurer could not recover from the person who injured its insured. An obvious consequence of the loss of lien and subrogation rights by a health insurer will be an increase in those premiums. The net result is no reduction in health care costs but a windfall benefit to the defendant physician or more precisely to his or to her insurer at the expense of the injured person.

o **Limiting Non-Economic Damages**

The total cost of medical malpractice, including awards, is less than one percent of health care spending.[23] Limiting awards in medical malpractice suits as a means of containing those costs is clearly an ineffective solution. In addition to being ineffective, such legislation falls hardest on those who have been the most grievously harmed -- the most severely injured victims of medical negligence who are prevented from being made whole.

There is also a question as to whether this type of proposal would be legally effective if enacted. There is some experience at the state level regarding caps on damages. Although there are variations in the legislation that has been enacted at the state level, some states have held that different types of proposals to cap damages violate various provisions of their constitutions.[24]

ENDNOTES

1 See the 1993 U.S. Industrial Outlook, U.S. Department of Commerce, page 42-1.

2 1989 Profitability Study (By Line By State) and 1990 Profitability Study (By Line By State), National Association of Insurance Commissioners, 1990 and 1991.

3 Congressional Budget Office, Economic Implications of Rising Health Care Costs (October 1992) page 27.

4 The American Medical Association has estimated the cost of defensive medicine based upon a survey of physicians who were asked, for example, whether they ordered more tests because of the perceived risk of a medical malpractice claim. Its estimate was $15.1 billion dollars for 1989. The AMA, moreover, recognized other reasons contributed to an affirmative response, stating, "like other defensive measures, all defensive medicine cannot be characterized necessarily as overuse but can reflect necessary improvements in patient care." Statement on behalf of the American Medical Association to the Senate Finance Subcommittee on Medicare and Long Term Care Regarding Medical Liability Reform, October 18, 1991, page 6.

5 The Physician Payment Review Commission (PPRC) has questioned such figures, noting that "Studies that use physicians' estimates of the amount of defensive medicine they practice are not sufficiently reliable to make quantitative estimates." Physician Payment Review Commission 1991 Annual Report to Congress, page 374.

See also Patricia M. Danzon, "Liability for Medical Malpractice," Journal of Economic Perspectives, Vol.5, no.3, Summer 1991, pages 51-69.

6 Mark N. Cooper, "Physician Self-Dealing for Diagnostic Tests in the 1980s: Defensive Medicine vs. Offensive Profits," Consumer Federation of America, October 3, 1991, reported that the rapid spread of physician ownership of diagnostic testing facilities is a much more likely cause of rising diagnostic costs than fear of malpractice liability.

A January 1991 study by the State of Florida's Health Care Cost Containment Board looked into physician ownership of health care facilities. It found that joint ventures among health care providers resulted in higher health care costs due primarily to the over-utilization of services.

A study of radiation centers in Florida found that doctor-owned centers appeared to result in a substantial increase in use and cost of the services. See Mitchell, Jean M.; Sunshine, Jonathan H.; "Consequences of Physicians' Ownership of Health Care Facilities - Joint Ventures in Radiation Therapy, The New England Journal of Medicine, Vol.327, No.21, Nov. 19, 1992, pages 1497-1501.

[6] continued
Another study examined workers' compensation claims in California and found that self-referral increases the cost of medical care covered by workers' compensation for physical therapy, psychiatric evaluation services and MRI Scans. Swedlow, Alex; Johnson, Gregory; Smithline, Neil; and Milstein, Arnold, "Increased Costs and Rates of Use in the California Workers' Compensation System as a Result of Self-Referral by Physicians," The New England Journal of Medicine, Vol.327, No.21 Nov. 19, 1992, pages 1502-1506.

[7] Patricia M. Danzon, "Liability for Medical Malpractice," Journal of Economic Perspectives, Vol.5, No.3, Summer 1991, pages 51-69. Ms. Danzon concludes that liability concerns have brought about some efficient changes in practice.

The Physician Payment Review Commission Annual 1991 Report also discusses other possible causes of inefficient and inappropriate defensive medicine.

* Physicians and hospitals often benefit financially by delivering more care.

* Insurance does not deter physicians from ordering additional tests because insurance provides funding for that which a patient could not otherwise afford.

* So-called defensive medicine practices often have become the standard of care adopted by the medical community, and reflect an advancement in technology or care.

[8] Testimony, Robert D. Reischauer, Director, Congressional Budget Office, Statement before the Committee on Ways and Means, U.S. House of Representatives, March 4, 1992, Appendix F, page 32.

[9] Martin L. Gonzalez "Medical Professional Claims and Premiums 1985-1990," Socioeconomic Characteristics of Medical Practice 1992, page 23.

[10] 1989 and 1990 Profitability Studies, see endnote 2.

[11] Physician Payment Review Commission 1991 Annual Report to Congress, page 372.

[12] See Woolhandler S., Himmelstein D.U., "The Deteriorating Administrative Efficiency of the U.S. Health Care System," The New England Journal of Medicine, 1991; 324; 1253-1258. Administrative costs are estimated to range between 10 percent and 24 percent of health care costs.

13 Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York, a report by the Harvard Medical Practice Study to the State of New York (1990).

14 Mark I. Taragin et al, "The Influence of Standard of Care and Severity of Injury on the Resolution of Medical Malpractice Claims," Annals of Internal Medicine, November 1992; Vol.117, No. 9, page 780.

15 Neil Vidmar, "The Unfair Criticism of Medical Malpractice Juries," Judicature, October-November 1992, Vol.76, No.3., page 118.

16 Martin L. Gonzalez, "Medical Professional Liability Claims and Premiums, 1985-90," Socioeconomic Characteristics of Medical Practice 1992, published by the American Medical Association, at page 132.

17 ABMS Compendium of Certified Medical Specialists, 3rd Edition, 1990-91, Vol.1, at page vii, published by the American Board of Medical Specialties; 1991 ABMS Compendium Supplement, at page viii.

18 Gonzalez, Supra endnote 16 at page 24.

19 Steven Daniels & Lori Andrews, "The Shadow of the Law: Jury Decisions in Obstetrics and Gynecology Cases," Medical Professional Liability and the Delivery of Obstetrical Care, Volume II, 161 published by the National Academy Press, for the Institue of Medicine (Victoria P. Rostow & Roger J. Bulger, eds, 1989, at page 91.

20 Testimony, Robert D. Reischauer, Director, Congressional Budget Office, Statement before the Committee on Ways and Means, U.S. House of Representatives, March 4, 1992, page 18.

21 "Medical and Hospital Professional Liability," a report prepared for the Texas Health Policy Task Force by Tomm and Associates, July 1992.

22 Andrea Dubin, False Claims: The Relationship Between Medical Malpractice "Reforms" and Health Care Costs, prepared for the Coalition for Consumer Rights, March 1993, at page 2.

23 Testimony, Robert D. Reischauer. See endnote 20.

24 See Florida (Smith v. Department of Insurance, 507 So.2d 1080 (Fla.1987)); Illinois (Wright v. Central Du Page Hospital Association, 63 Ill.2d 313, 347 N.E.2d 736 (1976)); New Hampshire (Carson v. Maurer, 120 N.H. 925, 424 A.2d 825 (1980)); North Dakota (Arneson v. Olson, 270 N.W.2d 125 (N.D.1978)); Ohio (Morris v. Savoy, 61 Ohio St.3d 576 N.E.2d 765 (1991)).

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PATIENTS, DOCTORS, AND LAWYERS:

MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION IN NEW YORK

A Report By the Harvard Medical Practice Study
To the State of New York

PREFACE

Concern about the medical malpractice problem and the tort litigation system as it deals with that problem led the then Deans Howard Hiatt of the Harvard School of Public Health and James Vorenberg of the Harvard Law School to bring together certain members of their faculties to form the Harvard Medical Practice Study in 1984. The complexity of the issues confronting legislative and executive bodies of government as well as the courts, physicians, lawyers, and society itself, and the paucity of facts that could illuminate those issues required the participation of members of both faculties and others if a comprehensive research program were to be carried out. An equally important requirement for such work was the sponsorship of a state government prepared to open to investigators hospital records, insurance records, and the participation of administrative units of hospitals, physicians, and several state and municipal agencies.

Benjamin Barnes and Harvey Fineberg of the School of Public Health and Paul Weiler of the Law School were members of the original study group. Weiler, who is also Chief Reporter of the American Law Institute's Tort Reform Project, has continued to serve as a principal architect and investigator. After Fineberg replaced Hiatt as Dean, he asked Hiatt, who is Professor of Medicine and whose background included nine years as Physician-in-Chief at a Harvard teaching hospital, to become a member of the group in 1985.

As the scope of the Study broadened, several colleagues from a range of disciplines joined it. William Hsiao, an economist at the School of Public Health, helped in the planning phase. Russell Localio, a lawyer-statistician, then Director of Research at the Risk Management Foundation, was recruited to manage the project and to work on medical record review design and execution and claims data analysis. Ann Lawthers, a health policy analyst who was at Boston University, was initially administrative director and later

coordinator and designer of the provider studies. Troyen Brennan, a lawyer-physician, member of the Division of General Medicine and Primary Care at Brigham & Women's Hospital, and a Lecturer at the Law School, became a senior member of the physician-reviewer group and a contributor to the provider studies. William G. Johnson, an economist at the Maxwell School of Syracuse University, assumed responsibility for the patient interview phase of the study. Nan Laird, a statistician at the School of Public Health, took charge of statistical design and methodology. Ken Thorpe, an economist at the School of Public Health, joined in the deterrence studies. Sol Fleishman and Howard Frazier, both internists, and Lucian Leape, and Lynn Peterson, both surgeons, were recruited to serve as senior physician reviewers for the record review portion of the study. In 1988, Leape, formerly chairman of the Department of Pediatric Surgery, Tufts Medical School, replaced Barnes as leader of the record review, and Joseph Newhouse, a health economist, formerly Director of the RAND-UCLA Center for Health Financing Studies and the new McArthur Professor and head of Harvard's Division of Health Policy Research and Education, replaced Hsiao as leader of the econometric study. Liesi Hebert, an epidemiologist, joined the research team in 1989.

Consultants to the project included:

Floyd J. Fowler, Jr., Director of the Center for Survey Research, University of Massachusetts, who helped in planning the design of the hospital record survey.

Graham Kalton, Chairman of the Department of Biostatistics at the University of Michigan, who worked on the analysis of the survey sample.

Ruth Kilduff, Risk Manager at New England Medical Center, who helped design the survey on hospital injury prevention activities.

Donald Rubin, Head of the Department of Statistics at Harvard University, Alan Zaslavsky, Lecturer in Statistics, who assisted with the analysis of deterrence, and Theresa Dailey, who provided computational assistance for Chapter 10.

Members of the Medical Practice Study office who provided

invaluable assistance during all phases of the study included: Sybil Carey, who provided administrative direction; Elaine Gebhardt and Steven Marcus, who assisted with computation and data management; Chris Braudaway-Bauman, Wendy Vander Hart, and Robert Chaufornier, who provided secretarial assistance; and Roger Dempsey, who filed endless boxes of adverse event forms.

From the Metropolitan Studies Program, Maxwell School, Syracuse University, the following individuals assisted with the report: Bruce L. Riddle, academic computing specialist; Esther Gray and Martha Bonney, secretaries; Mary C. Daly, graduate research assistant; Linda McCarthy, research assistant; Robert Guell, programmer.

A team from Mathematica Policy Research, Inc, of Princeton, New Jersey, under the leadership of Richard Strouse, carried out the patient interviews -- often under extremely difficult conditions -- very skillfully.

Support for the exploratory stages of the research came from the Klingenstein Fund of New York and a grant from the Risk Management Foundation of the Harvard Medical Institutions.

The relationship with the New York State Legislature and Department of Health under its Commissioner, Dr. David Axelrod, has been especially important. The Department's impartiality and commitment were crucial to that relationship, for the areas of medical malpractice and tort reform have been in urgent need of facts gathered and analyzed with methods that are scientifically sound. Also essential was the State's grant of complete confidentiality of information collected and the protection by New York law against subpoena of data.

Members of our group began with different views of the most promising ways to achieve reform. Some so regarded increased tort litigation, while others favored "no-fault" or other approaches. But as is necessary for every scientific enterprise, all agreed

that our function was to gather the best possible empirical information. We emphasize this point for it has been suggested by some that the Study set out to prove that one approach was better than another. Rather, we believe we have succeeded in our goal--to gather unbiased information which will help inform and elevate the ongoing debate.

EXECUTIVE SUMMARY

Introduction

The Harvard Medical Practice 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. To do so, we had to understand and isolate the key issues and assumptions that divide the protagonists of the current tort system, a reformed tort system, and no-fault alternatives. We have not prejudged the feasibility of any such no-fault program for injured patients, nor have we endorsed the criticisms that are made about present day malpractice litigation. Rather, we believe we have provided relevant empirical data that will permit informed judgments and sound policy-making concerning this complex area.

The Study had four principal components:

1. A population based measure of the incidence of injuries resulting from medical interventions, which we 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, we obtained information about the numbers of claims and suits by patients in whose hospital records we found no evidence of injury.

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.

The following summarizes some of our methods and major findings.

1. The incidence of adverse events

The hospital medical record review was key to estimating the incidence of adverse events associated with medical management. The record review focused on two critical issues: causation and negligence. We asked, "Was the patient's condition attributable to medical management rather than to the disease under treatment (causation)? Was negligence involved?"

In addition to establishing causation and negligence, we determined where injuries occurred, the types of injury and then the magnitude of disability experienced.

The review was conducted by teams of trained medical record administrators and nurses for the screening phase, and board-certified physicians for the physician-review phase.

Methods were devised to resolve the logistic problems that arose because of the infrequency of adverse events: we found efficient and reliable ways to sift through thousands of medical records to find the few that indicated the patient disability caused by medical management. We also developed ways to deal with the methodologic problems that arose: the medical record administrators had to make valid judgments regarding the presence of screening criteria and physicians had to make valid and reliable judgments about whether a patient's injury resulted at least in part from medical management, and, if so, whether management failed to meet a standard of medical care.

In order to make our results generalizable to the entire population of hospital discharges in New York, we drew a probability sample of more than 31,000 hospital records. Our ability to obtain such a sample was made possible by the

availability of the Statewide Planning and Research Cooperative System (SPARCS) data system. The basic sampling design of the Study was an implicitly stratified, systematic, two-stage cluster sample of discharges. We first selected hospitals with probabilities proportional to the number of non-psychiatric discharges and then secured the cooperation of all 51 hospitals selected. Records within hospitals were selected with three different sampling frequencies determined by patient age and diagnosis-related group (DRG). Using SPARCS information on patient discharges, we drew a sample with a distribution that conformed closely to the population on important hospital and patient characteristics.

We analyzed 30,121 (96%) of the 31,429 records selected for the study sample. After preliminary screening, physicians reviewed 7,743 records, from which a total of 1,133 adverse events were identified that occurred as a result of medical management in the hospital or required hospitalization for treatment. Of this group, 280 were judged to result from negligent care. Weighting these figures according to the sample plan, we estimated the incidence of adverse events for hospitalizations in New York in 1984 to be 3.7%, or a total of 98,609. Of these, 27.6%, 27,179 cases, or 1.0% of all hospital discharges, were due to negligence.

Physician confidence in the judgments of causation of adverse events spanned a broad range, but only 1.3% of all discharges were in the close-call range (defined as a confidence in causation of just under or just over 50-50). An even smaller fraction, 0.7% of discharges were close-call negligent adverse events, but they constituted a larger proportion of total negligent adverse events.

The majority of adverse events (57%) resulted in minimal and transient disability, but 14% of patients died at least in part as a result of their adverse event, and in another 9% the resultant disability lasted longer than 6 months. Based on these

figures, we estimated that about 2,500 cases of permanent total disability resulted from medical injury in New York hospitals in 1984. Further, we found evidence that medical injury contributed at least in part to the deaths of more than 13,000 patients in that year. Many of the deaths occurred in patients who had greatly shortened life expectancies from their underlying diseases, however. Negligent adverse events resulted, overall, in greater disability than did non-negligent events and were associated with 51% of all deaths from medical injury.

Risk factors

The risk of sustaining an adverse event increased with age. When rates were standardized for DRG level, persons over 65 years had twice the chance of sustaining an adverse event of those in the 16-44 years group. Newborns had half the adverse event rate of the 16-44 years group. The percent of adverse events resulting from negligence was increased in elderly patients. We found no gender differences in adverse event or negligence rates. Although the rates were higher in the self-pay group than in the insured categories, the differences were not significant. Blacks had higher rates of adverse events and adverse events resulting from negligence, but these differences overall were not significant. However, higher rates of adverse events and negligent events were found in hospitals that served a higher proportion of minority patients. At hospitals that cared for a mix of white and minority patients, blacks and whites had nearly identical rates.

Adverse event rates varied 10-fold between individual hospitals, when standardized for age and DRG level. Although standardized adverse event and negligence rates for small hospitals (fewer than 8,000 discharges/year) were less than for larger hospitals, these differences were not significant. Hospital ownership (private, non-profit, or government) also was not associated with significantly different rates of adverse

events. The fraction of adverse events due to negligence in government hospitals was 50% higher than in non-profit institutions, however, and three times that in proprietary hospitals. These differences were significant. The standardized rate of adverse events in upstate, non-MSA hospitals was one-third that of upstate metropolitan hospitals and less than one-fourth that in New York City. These differences were highly significant. The percent of adverse events due to negligence was not significantly different across regions. Non-teaching hospitals had half the adverse event rates of university or affiliated teaching hospitals, but university teaching hospitals had rates of negligence that were less than half those of the non-teaching or affiliated hospitals.

The nature of adverse events

Nearly half (47%) of all adverse events occurred in patients undergoing surgery, but the percent caused by negligence was lower than for non-surgical adverse events (17% vs 37%). Adverse events resulting from errors in diagnosis and in non-invasive treatment were judged to be due to negligence in over three-fourths of patients. Falls were considered due to negligence in 45% of instances.

The high rate of adverse events in patients over 65 years occurred in three categories: non-technical postoperative complications, complications of non-invasive therapy, and falls. A larger proportion of adverse events in younger patients was due to surgical failures. The operating room was the site of management for the highest fraction of adverse events, but relatively few of these were negligent. On the other hand, most (70%) adverse events in the emergency room resulted from negligence.

The most common type of error resulting in an adverse event was that involved in performing a procedure, but diagnostic errors and prevention errors were more likely to be judged

negligent, and to result in serious disability.

The more severe the degree of negligence the greater the likelihood of resultant serious disability (moderate impairment with recovery taking more than six months, permanent disability, or death).

2. Litigation data

We estimated that the incidence of malpractice claims filed by patients for the study year was between 2,967 and 3,888. Using these figures, together with the projected statewide number of injuries from medical negligence during the same period, we estimated that eight times as many patients suffered an injury from negligence as filed a malpractice claim in New York State. About 16 times as many patients suffered an injury from negligence as received compensation from the tort liability system.

These aggregate estimates understate the true size of the gap between the frequency of malpractice claims and the incidence of adverse events caused by negligence. When we identified the malpractice claims actually filed by patients in our sample and reviewed the judgments of our physician reviewers, we found that many cases in litigation were brought by patients in whose records we found no evidence of negligence or even of adverse events. Because the legal system has not yet resolved many of these cases, we do not have the information that would permit an assessment of the success of the tort litigation system in screening out claims with no negligence.

Confining our analysis to the adverse events that involved strong or certain evidence of negligence, however, we estimate that 12,859 injuries from medical negligence did not lead to malpractice claims. Of these injuries, 22% (2,833) occurred in patients under age 70 years who suffered moderate or greater incapacity. Our projections suggest that if this group of

patients had litigated, the malpractice claims frequency for year 1984 would have increased by 75%.

3. Economic Consequences of Medical Injury

Having documented from the medical records survey which patients were injured, and from the litigation survey which patients filed tort suits, we used the patient survey to determine from the patients themselves what losses they suffered as a result of these injuries and what compensation they received from non-tort sources. For that purpose we divided our patient sample into five categories -- worker, homemaker, child, retired, and disabled -- and assembled data about lost wages and fringe benefits, medical costs, lost household production, and levels of physical and functional impairment. Our data for that final category have not been analyzed for this Report.

We faced two major difficulties in this survey. First, we had to locate, in 1989, people who had been hospitalized in 1984 in order to interview them about their experience since 1984. In fact, we were successful in finding and interviewing 71% of all injured patients, a response rate which is quite respectable for a survey of this type.

Our second problem was how to disentangle the effects of the adverse event itself from those that were properly attributable to the underlying illness, which itself would naturally be expected to entail considerable medical costs, time off work, and inability to perform normal household tasks. Two different strategies were devised for this purpose. One was to interview a control group of uninjured patients who were matched with our "experimental" group on the relevant dimensions, thus permitting econometric analysis of the precise difference which the iatrogenic injury made in the aggregate economic experience of the two groups. While we have collected all the data for the two groups, we have not completed this analysis for purpose of presentation in this Report.

Instead our primary focus has been on an alternative method -- estimating the compensable losses that might be paid under a hypothetical no-fault plan in which each patient's experience was assessed individually (as would have to be done in a real no-fault program), and then totaled. For that purpose we had to make a number of assumptions about program design: two important ones are noted here. First, all financial losses and compensation received during the first six months from hospital admission were deleted. These short-term losses are likely reimbursed from other sources (e.g., sick pay for time off work). Further, this reduces the number of cases in which disentangling the effect of the injury from the underlying illness may be very difficult. Second, we assumed that a no-fault patient compensation scheme would involve a second insurer, standing behind primary sources of general medical or disability insurance.

Our key findings with respect to these two criteria were that the bulk of disabilities were of short duration -- e.g., 42% of absences from work lasted for less than a month and 76% lasted less than six months. However, the average economic losses were much larger in the smaller number of more serious or fatal disabilities. With respect to these longer-lasting disabilities, more than 85% of the medical bills were covered by some form of health insurance, but only 20% of the lost earnings, and no detectable portion of lost household production.

Our ultimate finding is that the present discounted value of the net compensable losses (past and future) suffered by patients injured in New York hospitals in 1984 amounted to $894 million (in 1989 dollars). These compensable losses consisted of $285 million in lost wages and fringe benefits, $103 million in uninsured medical costs, and $506 million in lost household production (the latter having been valued at the market wages earned by the working women in our patient cohort).

To provide some perspective for these figures, the malpractice premiums paid by New York doctors and hospitals in 1988 amounted to $850 million. When one includes the amount spent by self-insured hospitals and the health care organizations, the total malpractice insurance burden is over $1 billion. However, these tort costs incorporate two major factors not reflected in our estimate. One is damage for pain and suffering, which typically are not compensated under no-fault programs. The other component is administrative and legal expenses which definitely would be a significant factor over and above the patient's economic losses. The administrative share of claims costs in no-fault workers compensation is usually estimated to be around 20%, though we believe it would be somewhat higher for no-fault patient compensation.

Since the sample of injured and interviewed patients in our different categories was rather small despite the relatively large sample of 31,000 hospitalizations, the confidence intervals surrounding our point estimates are large: the figures might be as much as 50% less or 100% more than those presented.. On the other hand, the estimate of net wage losses and medical costs -- these being the items typically covered by a no-fault scheme, and even then not in full fault - totalled just $335 million. Thus, there is considerable room within the current tort "envelope" to adjust even for an outcome at the highly improbable outer limit of these confidence estimates.

4. Malpractice Litigation and Deterrence

We examined the presumed deterrent effects of the tort system in two ways -- a series of physician surveys as well as an econometric study that compared the rates of adverse events and negligent adverse events, on the one hand, with the threat of a claim on the other.

The physician surveys revealed that the overall perceived risk of being sued in a given year was 20%, approximately 3 times the actual risk of being sued. The perceived risk of suit for

The final part of our study examined the relationship between variations in claims rates and variationsin cost and in injury rates in the sample of study hospitals. We found some evidence that total cost per discharge was greater in hospitals that faced higher claims rates, although the relationship that we estimated was sensitive to how we specified the relationship. Even conceding that there is an effect on cost, however, does not tell us whether the effect is good or bad. On the one hand, greater efforts to prevent injuries or ameliorate the consequences of those that occur may well require greater resources. On the other hand, additional resources in response to a greater threat may simply represent wasteful defensive medicine and not contribute to a reduction in patient injuries.

The important test, therefore, is whether hospitals that face higher claims rates actually do exhibit lower injury rates. We find no evidence that they do, but the precision of our estimates is not good, and we cannot rule out the possibility that there are in fact substantially reduced rates of injuries at the hospitals in our sample with higher claims rates. More specifically, the point estimate relating injuries to claims is actually positive in most specifications and never close to significantly negative. However, the confidence intervals around the coefficient include values that would demonstrate substantial deterrence.

We illustrate how our data cannot rule out a substantial deterrent effect by choosing one of the relationships we estimated, that for the probability that an adverse event is negligent, controlling for a number of other hospital characteristics. The point estimate of the claims variable is slightly positive; however, if we reduce the point estimate by approximately one standard error, it shows substantial deterrence. In quantitative terms, the reduced estimate would suggest that, other things equal, hospitals in the highest quartile of claims rates would have about 24% fewer negligent

negligent care was about 60%, a figure substantially greater than the actual risk of litigation from injuries caused by negligence. Additionally, perceived risk was significantly greater for high-risk specialties such as obstetrics, orthopedics and neurosurgery and for physicians in Nassau and Suffolk counties, lending credence to the responses.

Physicians who perceived themselves to be at greater risk of suit said that in the past ten years they had ordered more tests and procedures and reduced their practice scope more than had their colleagues with perceived risk.

The tort system's deterrence signal to physicians appeared mixed. For example, physicians often considered the severity of punishment to depend on whether a case went to trial or whether the media publicized it. The evidence was not clear, however, on whether the severity of the punishment and the actual transgression were related: most physicians perceived their suits as having arisen from circumstances beyond their control. Many seemed to believe that the threat of the tort system was too broad and lacked specificity.

Although physicians believed they practiced medicine defensively, they did not report long-term changes in their practice patterns as the result of a specific suit. Thus, it was not clear whether defensive medicine resulted from the malpractice environment or from other factors such as advances in the science and technology of medicine, changes in societal expectations as to what constitutes an appropriate level of care, or changes in Peer Review Organization (PRO), state and hospital requirements, or a combination of factors.

Another important finding concerned physician attitudes about iatrogenic injury and negligence. Physicians tended to equate a finding of negligence with a judgment of incompetence. Thus, although willing to admit that all doctors make mistakes, physicians were often unwilling to label substandard care as negligent and were opposed to compensation for iatrogenic injury.

events (conditional upon an adverse event) as those in the lowest quartile.

Moreover, there may be a bias in our results toward showing no deterrent effect. Our goal was to determine whether there is a negative relationship between claims rates and injuries, but hospitals and physicians that have higher injury rates may have more claims filed against them. This possible positive relationship between injuries and claims would tend to mask any true deterrent effect. We have tested for this bias and do not find any evidence of it, but our test could simply be failing to detect it.

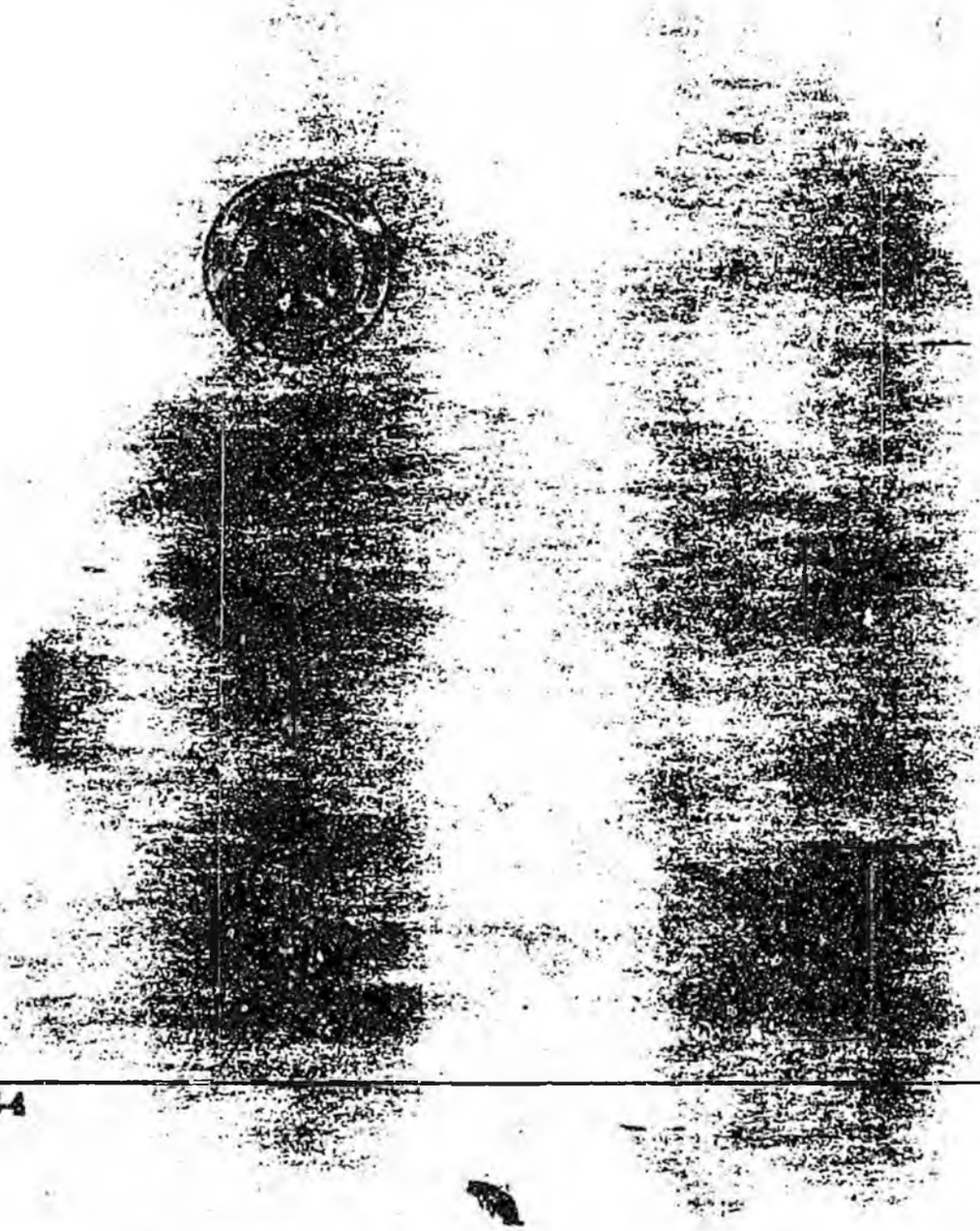
Finally, even if we had been able to conclude that our data ruled out all but a negligible deterrent effect, we could not conclude that abolishing the tort system would have no effect on injury rates. All the hospitals in our sample faced some threat of a claim if an injury occurred, and the most we could hope to learn was the effect on injury rates of variation in that threat. Abolishing the tort system could reduce that threat to zero (depending on what, if anything replaced it), and we cannot learn from our data what the effect of that might be.

GAO

December 1986

MEDICAL MALPRACTICE

Case Study on Indiana



GAO/HRD-87-21S-4

Preface

December 31, 1986

Representative John Edward Porter and Senator John Heinz, Chairman, Senate Special Committee on Aging, asked GAO to identify the actions taken by the states to address medical malpractice insurance problems and to determine changes in insurance costs, the number of claims filed, and the average amount paid per claim. These case studies discuss the situation in each state.

This study on Indiana focuses on the views of various interest groups on perceived problems, actions taken by the state to deal with the problems, the results of these actions, and the need for federal involvement. A summary of the findings for all six case studies can be found in our overall report, Medical Malpractice: Six State Case Studies Show Claims and Insurance Costs Still Rise Despite Reforms (GAO/HRD-87-21, December 31, 1986).

Richard L. Fogel
Assistant Comptroller General
for Human Resources Programs

Overview

Indiana officials generally believed that Indiana's Medical Malpractice Act of 1975 and subsequent amendments have greatly stabilized the state's malpractice insurance situation over the past 11 years by holding down premium costs and attracting additional companies into the market. They support these views by pointing out that the cost of insurance for Indiana physicians and hospitals is among the lowest in the nation,[1] compared to the mid-1970's, when it was higher than most neighboring states. In addition, they pointed out that the Rockwood Insurance Company, the Pennsylvania Hospital Insurance Company, and the Physicians Insurance Company of Indiana entered the Indiana medical malpractice market in 1978, 1981, and 1982, respectively, which helped ensure the continued availability of insurance at competitive prices.

Indiana officials also commented that the leading physician medical malpractice insurer had no rate increases from January 1, 1975, until July 1985, when the rate increased by 12 percent. However, most physician insurers increased their premiums in 1985. For example, the Department of Insurance reported rate increases in 1985 ranging from 12 to 76 percent.

A key provision of the act was the establishment of a Patient's Compensation Fund to pay malpractice awards or settlements in excess of $100,000 up to a $500,000 cap. To participate, physicians and hospitals pay a surcharge based on the premiums paid to their insurance companies for the basic coverage.

Indiana officials were concerned that the increasing number and size of payments from the Fund might adversely affect its solvency. For example, claims paid by the Fund increased from 11 in 1980 to 36 in 1985, while amounts paid increased from $3.9 million to $11.7 million. The surcharge rate increased from 50 percent in April 1984 to 100 percent in April 1986. According to the consulting actuary for the Indiana Department of Insurance, the Fund had accrued $90 million in unfunded liabilities as of December 31, 1985. If this trend continues, further increases in the surcharge may be needed.

Our consulting actuary noted that because of the normal development pattern of payouts, increases in the number of claims paid and the total amount paid out by the Fund during this period would have been

[1]See Medical Malpractice: Insurance Costs Increased but Varied Among Physicians and Hospitals (GAO/HRD-86-112), September 15, 1986, pp.31-34, 60-69.

expected. He added that since the fund was established on a pay-as-you-go basis, increases in the surcharge rate would have been expected as the number of claims and total amount paid out increased.

According to the Department of Insurance, the state Patient's Compensation Fund was kept solvent in 1984 only by a transfer of $7.2 million from the reserves of the state's medical malpractice joint underwriting association.

Several actions have been taken in recent years to strengthen the Fund's ability to remain solvent. These actions include (1) increasing surcharges, (2) allowing the Department of Insurance to hire private-sector lawyers and other personnel to help defend claims against the Fund, and (3) permitting periodic payments in lieu of lump-sum payments.

While many state officials believed that Indiana's legislation has benefitted the state's malpractice situation, the state's trial lawyers have expressed the view that injured parties have lost certain rights. They are principally concerned that the $500,000 cap on total awards may be insufficient to compensate some individuals who sustain major injuries from malpractice incidents. The Trial Lawyers Association believes that Indiana's cap should be raised to at least $1 million per claim and that insurance companies should be required to accept liability for the first $200,000 of each claim and the Patient's Compensation Fund the remainder.

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Figures

Indiana: Low Rates but Solvency of State Patient's Compensation Fund a Concern

Background

Population, Physician, and Hospital Characteristics

Almost two-thirds of Indiana's 5.5 million people live in urban areas.[2] Indiana is the 14th most populous state. Indiana had 8,542 physicians as of December 31, 1985,[3] and 116 nonfederal community hospitals with 24,696 available beds in 1984.[4] A total of 7,270 physicians were providing patient care—5,904 were office-based and 1,366 were hospital-based. Table 1 shows the distribution of patient care physicians among 13 selected specialties:

Table 1: Number of Nonfederal Patient Care Physicians in Indiana in Selected Specialties as of December 31, 1985

		Hospital-based practice		
	Office-based practice	Residents	Full-time physician staff	Total
General practice	1,562	206	51	1,819
Internal medicine	661	192	30	883
Pediatrics	299	65	28	392
Psychiatry	188	34	56	278
Pathology	149	31	40	220
Radiology	159	0	16	175
Ophthalmology	204	25	1	230
General surgery	453	88	14	555
Anesthesiology	334	82	21	437
Plastic surgery	38	3	0	41
Orthopedic surgery	234	30	5	269
Obstetrics/gynecology	352	57	6	415
Neurosurgery	45	7	4	56

Of Indiana's community hospitals, 60 were nongovernment, not-for-profit; 52 were state and local government institutions; and the remaining four were investor-owned. Sixty-nine percent of the state's hospital beds were located in nongovernment, not-for-profit hospitals; 28 percent in state and local government hospitals; and 3 percent in investor-owned hospitals. The most prevalent hospital size was 50 to 99

[2]Population and ranking are as of July 1, 1984 (preliminary), and the urban/rural mix is as of April 1, 1980, from the Statistical Abstract of the United States 1986, 106th Edition, pp. 10, 12.

[3]Physician Characteristics and Distribution in the U.S., 1986 Edition, Department of Data Release Services, Division of Survey and Data Resources, American Medical Association (forthcoming).

[4]Hospital Statistics, 1985 Edition, American Hospital Association, p. 70.