

Summer 2004

**The Current Medical Liability Insurance Crisis:
An Overview of the Problem, Its Catalysts, and
Solutions, Third Annual Health Law Colloquium,
Session 1: Federal Efforts and State Approaches to
the Crisis**

Barry Furrow

SESSION 1: FEDERAL EFFORTS AND STATE APPROACHES TO THE CRISIS

DR. HYMAN: It's a real pleasure to be here. Barry Furrow is a giant of the health law field. He is currently the Director of the Health Law Institute and Professor of Law at Widener University School of Law. Barry has been in this business for quite a while. He has written a vast array of articles. He is the lead author on the single best selling textbook of health law. [He] has a whole series of other textbooks. Just to give you a sense of Barry's significance in the field, he received the highest award from the American Society of Law, Medicine and Ethics for a law teacher, the Jay Healey Award, in 1995, and he is still at it. You only get that after a lifetime of achievement.

Barry has a lot of slides and we have a lot of ground to cover. So just to give you a sense of what the framework is for the rest of this morning, Barry is going to talk, I am going to make some brief remarks thereafter, and then we will open it up to questions. So, with no further adieu, Professor Barry Furrow.

PROF. FURROW: Thank you, David. It's a pleasure to be introduced by David. David, since he went into law teaching, has been a fearsome scholar and commentator on other people's work and has offered incredible insights in every area he has written. So, I'm looking forward to seeing his reactions to my talk as well.

You must understand I am an academic, which means, as I said to someone before the session started, academics know a small amount about a whole lot of things, but we don't normally bore down as deep as an insurance actuary does. We don't always understand in the trenches how something feels, but we look at the studies. We have a global perspective that's gleaned from reading a whole lot of stuff all the time. So, that's the best I can offer you, my sense of this crisis.

I started in academia in 1974. In the summer of 1974, I worked at the University of Maryland with Ken Abraham putting together a malpractice conference to follow up on the 1973 Department of Health Education and Welfare (HEW) report on the malpractice crisis of 1972. So, it keeps going around.

In some sense, there is nothing really new here. In some sense, there are some new forces at work. You have to sort out, for purposes of what you

want to do, what these different issues are.

So, let me take you to the graph that says it all: "Net Profit or Loss as a Percentage of Net Worth for Medical Malpractice Insurance Companies."¹ A downward sloping line is a bad thing. Any economist would tell you that. Insurance companies are bleeding money. That's a description of a malpractice insurance crisis. You are not making money on a line of insurance, in this case, a malpractice line. So, that's the way to frame the issues. That's the image to keep in mind, a line dropping precipitously. That's why there is a crisis.

I want to round up the usual suspects for you and these are caricatures, so anybody in one of these groups, feel free to take offense. I will try to smooth it out later.

Possible suspects in the malpractice crisis are the patient-consumer, the trial lawyers, the American Medical Association (AMA), national politics, the physicians, the health systems, and finally, the insurers. These are the seven groups I would look at either as fuel for the crisis, pouring gasoline on the crisis, or as a piece of the crisis that you have to peel apart.

The patient-consumer, Bruce Willis on steroids. The patient from hell. He is even-armed, cranky, hyper-vigilant, demanding, intolerant of error. This is, I think, the AMA's view of the litigious patient. I will talk more about this later, but my response is that in fact, there aren't really very many suits brought out of the universe of possible claims. Consumers are remarkably forgiving of error in the doctor's office, but there are more doctors than there are errors, so the curve still keeps going up.

We know from the 1984 Harvard Medical Practice Study that the tort system undercompensates victims of negligence.² So, for every Bruce Willis, there are a dozen patients who don't do anything. The overlap area [see chart] represents actual victims of negligence who file a claim.³ That means more people sue than have a legitimate claim, as measured by some standard of care test and there are lots of victims who never do anything, for a variety of reasons—some of the claims are too small [or] lawyers won't take them.

The next slide shows the relationship between injuries and claims.⁴ This slide I owe to Michelle Mello, who presented at another conference I saw.

1. U.S. GEN. ACCOUNTING OFFICE (GAO), PUB. NO. GAO-03-702, MEDICAL MALPRACTICE INSURANCE: MULTIPLE FACTORS HAVE CONTRIBUTED TO INCREASED PREMIUM RATES 29 (June 2003), available at <http://www.gao.gov>.

2. Troy A. Brennan et al., *Incidence of Adverse Events and Negligence in Hospitalized Patients: Results of the Harvard Medical Practice Study I*, 324 NEW ENG. J. MED. 6, 370-76 (1991).

3. See App. A, Graph: The Tort System Undercompensates Victims of Negligence.

4. See App. B, Graph: Relationship Between Injuries & Claims.

It's striking. What it tells you is essentially that about one out of fifty potentially valid true negligent claims are ever brought and forty-nine are not [brought]. So, out of all the hospitalizations, three to four percent result in injuries, and one percent might be attributed to substandard care, as measured by physician peer reviewers. Of the valid potential claims, two percent end up in actual claims. And then [the chart indicates] the frivolous versus valid claims. "Frivolous" is a term of art to mean you can't prove it. It doesn't mean "frivolous" [in the true sense of the word]. Lawyers don't bring frivolous claims very often. It's too expensive. You end up with fifty-percent of the claims that are brought being paid.

It's not a pretty picture of the tort system. The tort system is not particularly a hero in this crisis. It doesn't do very well as a compensation system, but it also, in some ways, isn't the fall guy that it's often painted to be.

Are there increases in malpractice litigation? Is that driving the prices? There is little evidence of a rapid and sudden increase in the frequency and severity of judgments over the last few years. But, there has been a steady increase in severity of judgments starting with baseline effects of medical healthcare cost inflation and then adding on other effects.

The data isn't very good and one of the running comments I will have throughout my talk is [that] the data isn't very good. It would be nice to have better data about the insurance industry, about practice patterns, about errors in doctors' offices. There is a lot of research that needs to be done and a lot of data that needs to be disclosed. Some of that has to be disclosed under compulsion. I think where David and I may disagree sometimes is that I am a terrific fan of regulation. I like the market too, but regulation has its place.

The second suspects are the trial lawyers, Dickie Scruggs on the rampage. Dickie Scruggs, of course, brought the tobacco litigation. He led the litigation against Aetna and managed care companies on behalf of both consumers, which got dismissed, and doctors, which is now being settled. So, he should be a hero of doctors, but he, in my mind, is an example of a ferocious plaintiff's attorney. This is a lawyer abusing a failed tort system, penalizing doctors at random, generating frivolous lawsuits, and overcompensating undeserving plaintiffs. It's a vision of tort lawyers gone mad based on hopelessly flawed assumptions painted by political pundits who have a political ax to grind.

My response, and we already saw a little piece of this, is that the tort system under-compensates. Its deterrent effect may be real, but it's very hard to prove it. It does have some effect on limiting access in some markets, but it's not as bad as you think, according to the General

Accounting Office (GAO) report⁵ and in fact, these are tough cases to bring from a lawyer's point of view. I have trained a lot of plaintiff's lawyers. These are not easy cases to file. They are not easy cases to bring. They are very expensive and insurers and doctors fight very, very hard. So, don't worry about Dickie Scruggs.

The third suspect is the AMA. The current president of the AMA is not only an M.D., but [also] a J.D. The AMA has got every medical society whining about caps as being the ultimate solution. [T]hey have evolved from a 1985 proposal of a very sophisticated kind of worker's compensation-style administrative law system, which would have been expensive, but would have compensated many small claims. It would have solved some of the problems the tort system doesn't solve. [Currently, the AMA] has dummed its proposal down to copying MICRA, the California \$250,000 cap, without adjustments for inflation. Shame on them. The AMA knows better, but it's about all they can sell that's easy to explain. That's one of the problems with this crisis. It's hard to explain. It has so many facets to it.

The fourth suspect is national politics. Let's pour some gasoline on the controversy. Karl Rove, the neutralizer, George Bush's mastermind. There is no doubt there is an opportunity to declare a war on the trial lawyers. They fund a lot of the Democratic campaigns. Let's cut back their ability to litigate by whittling back on the tort system. Karl Rove certainly has talked about this. Let us not worry about him too much—this has rarely been a national question.

The fifth suspect is the physician, Dr. Prima Donna. This is a foot-stomping angry physician with no patience, little understanding of the system, and no awareness of the consequences of tort reform. But, it is indeed true that there is reason to weep in some specialties and in some areas for very particular reasons. [For example,] I come from Pennsylvania and there is a lot of gnashing of teeth in Pennsylvania.

The doctors have several complaints. First, they are forced into defensive medical practices that are unproductive as an overreaction to liability. Evidence is equivocal at best. The strongest influence on physicians is clinical information and how it's processed. I might add reimbursement is another important piece of that. [While] the evidence is that they [the doctors] react in terms of tort fears, the studies don't support it as the driving force.

Second, they [complain that they] spend too much on insurance. Well, compared to what? For most doctors, premiums have been too low for over a decade, artificially priced under what the market and an actuary would say

5. GAO, *supra* note 1.

is appropriate. Now, you get an accelerating catch-up phenomenon in premium pricing. You haven't planned for it, but in some sense, it's predictable. Of course, if physicians were great investors, they wouldn't be physicians anymore because they would be rich. But they are not great investors. We know that from reading Medical Economics. They get burned all the time and it's hard to plan for this one.

Third, physicians worry a lot about litigation. Physicians are obsessed with trial lawyers. They worry far beyond their risk of being sued.

The sixth suspect is health systems, "St. Iatrogenesis Hospital." Iatrogenesis is provider-induced patient injury. Are more medical misadventures occurring? Of course they are. The healthcare system is a legitimate culprit. The Institute of Medicine (IOM) report, in effect, fingered the healthcare system, projecting up to approximately 100,000 deaths a year in a hospital setting, based on the 1994 New York studies.⁶ The unhappy part of the picture is the patient safety medical error piece of the malpractice insurance crisis. Medicine is dangerous—much more dangerous than it used to be because it can do a lot more than it used to and it uses high-powered drugs and complicated procedures done to sicker and older patients.

Healthcare is a very chaotic and poorly managed environment, in my judgment, in many institutions. [It is] complex, interactive and hasn't been subjected to the kind of thoughtful system reforms that you would expect for a system that cares for human beings. System failures account for most errors in hospitals. One study traced eighty percent of hospital adverse drug events to system malfunctions such as staffing shortcomings or actual physical design limitations in the surgical suite. These are simple things that a practitioner of feng shui would come in and fix. Where are the drugs? Where are the labels? How easy is it to get confused?

Adverse drug events account for about ten percent of all hospitalizations and the most recent study in the Archives of Surgery from just two weeks ago shows that the office setting has a ten-fold increased risk of adverse events or death compared to the hospital.⁷ [I]f you think the hospital is scary, watch out for the doctor's office. If doctors are going to do any surgical procedure, do they have a properly trained nurse anesthetist? Do they know what they are doing? Do they have infection control? No, no, and no, except in New Jersey, which is highly regulated in terms of the office setting. There is a lot of danger out there for patients and there are

6. INST. OF MED. (IOM), TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 26 (2000).

7. Hector Vila et al., *Comparative Outcomes Analysis of Procedures Performed in Physician Offices and Ambulatory Surgery Centers*, 138 ARCH. SURG. 991 (2003).

too many incompetent doctors in the system and they are not properly disciplined by state medical boards. They don't pay much attention to this.

I did an online survey using the public citizen database of various states and disciplines. I discovered that if you look at a state and you see 3000 disciplinary actions against doctors and then you burrow in a little bit, you discover that a large number of them involve failures to satisfy Continuing Medical Education (CME) requirements. It's trivial regulation at some level. They don't really go after serious quality problems in many of the states because of funding and other limitations.

If there are incompetent doctors, are they reported by hospitals? Are they reported by managed care plans that have the ability to track and see the outliers? No. The last Inspector General reported [that] eighty-four percent of HMOs and sixty percent of hospitals never reported a single adverse event to the national physician database.⁸ Additionally, from 1990 to 1999, HMOs reported 715 adverse actions, which is pathetic for a country with almost 800,000 doctors. [W]e are not doing a very good job.

The seventh suspect, and my last and final player, is Ralph Actuary in heat. A rapacious industry, stocking up on easy premium dollars to invest and luring innocent doctors with seductively low premiums. Insurance is an engine for making money. Malpractice insurance is a subset of an insurance market that is a very competitive market with economic behavior that can lead to what you find in a free marketplace. Insurers are going out of business, fighting like crazy to achieve market share, and it's the

doctors, who are the insureds, and they suffer the consequences of premium swings. So, the insurance industry is in some ways a paradigm of a free market and operation. Rapacious? Not particularly—it's a market.

[L]et's talk about the insurance crisis. It's created by rapid, unexpected premium increases. It's sticker shock. It has an uneven, unexpected effect on revenue in an era when physicians simply can't pass along these added costs to the insurers or the patients. The system is much more constrained than it was in 1985 during the second malpractice crisis or in 1972 or 1973-74 during the first. We have had three crises. [The system is] more constrained by managed care and by federal reimbursement policy. Doctors are really stuck between insurance pressures and rigidities in reimbursement. They can't pass their costs on. They have reasons to scream.

I am going to tell you things you already know better than I do, many of you at the table. How do you set premiums? You have ratemaking, based on actuaries and their attempts to predict, you have market characteristics,

8. Robert Pear, *Incompetent Physicians Are Rarely Listed as Law Requires*, available at <http://www.forensic-psych.com/articles/artcompetentphy.html>.

and you have investment earnings. They [the actuaries] really worry about money.

The first factor [in setting premiums] is ratemaking—the science or the art of predicting future claims and expenses based on past experience. You look at the expected severity of judgments and the expected frequency of claims and you have to decide on the mean [judgment and] the largest judgment. And the largest judgments are what terrifies the actuary because what's the consequence of a \$50 million settlement or jury verdict on a small insurance company? [Also], you have frequency of claims. Is there an increase in filings? Is there an expected increase in filings? Will settlements increase? What are the dynamics of the legal system? That is part of the actuary's job in predicting insurance.

Insurance is based on the law of large numbers. The problem is small numbers. Auto insurance is the paradigm case—hundreds of thousands of policies. You can smooth everything out and write a policy and predict pretty accurately your exposure. However, malpractice is a problem of a small pool with some states having a lot of the losses. There is a lot of variation regionally within states. There simply aren't large numbers, and the awards vary tremendously, with fifty percent of the dollars paid out on three percent of the claims. [Therefore], a single claim has a catastrophic effect on a small area.

[Further], there is a lack of independence in claims against the doctor. A few doctors are typically responsible for a bulk of the claims for one reason or another, which is not always clear. Because of that lack of independence, unlike with auto accidents, lawyers can learn from experience. They can learn from looking at providers. There are providers in Philadelphia that are probably named right now in fifty ongoing cases. They do a lot of surgery. Lawyers talk to each other. They learn.

Also, there are changing circumstances. Medical cost inflation is normally much higher than the growth in the gross domestic product in the normal inflation rate. Payouts have risen, in part, in sync with medical inflation. There is debate about this. We have a data issue here. The consumer group, Americans for Insurance Reform (AIR), says [that] medical cost inflation explains everything about the malpractice crisis.⁹ That's not true in Pennsylvania, that's not true in Florida, that's not true in the problem states. It may be true in South Dakota, which is a great place to be a doctor if you don't want to worry about your premiums, but it's not true in the big urbanized states.

There has been an expansion in legal doctrine and I think probably Nina

9. AMS. FOR INS. REFORM (AIR), MEDICAL MALPRACTICE INSURANCE: STABLE LOSSES/UNSTABLE RATES 4 (2002).

[Appel, Dean of Loyola University Chicago School of Law], David [Hyman], and I will take some responsibility for this. We are professors and we push the envelope. The casebooks are full of the cutting edge cases. A case has one decision that develops a new doctrine and we spread it, and the courts also pay attention, and our students try to use it. Loss of a chance is a good example of this. Can you sue a doctor for a misdiagnosis that increases the patient's risk of dying from thirteen to twenty-five percent? The chance is lost, an opportunity was missed to diagnose. Some states have adopted the loss of a chance doctrine. That's an exposure that didn't exist twenty years ago because that doctrine didn't exist. More cases can be brought and more is being done—more diagnosis and treatment of diseases we couldn't treat before. You miss a diagnosis and the patient loses that opportunity, even if he was going to die anyway. That's compensable.

Also, we have sharpened the rules of evidence. The standard of care is more accessible. Thousands of new studies are pouring out every day and the standard of care starts to crystallize in some disciplines. The medical society is crystallizing it. They develop evidence-based medicine and the result is [that] the lawyers notice. They use specialty standards and they read the research. They do their homework and it makes the settlement value of these cases go up. That, of course, has an insurance consequence.

Finally, social attitudes are changing. Not every patient is becoming Bruce Willis. They are more informed. They are more aware of medical errors and system failures. There is no doubt that they are more sensitive to risk than they used to be and that they do pay attention.

The second factor driving premium rates is insurance market characteristics. How many doctors are there? What's the distribution among specialties? What kind of competition is there from other insurers? Is there a cap fund or some kind of state fund that allows physicians protection from excess losses because that helps to smooth out the market a little bit?

The third factor is investment earnings. We have a lumpy underwriting cycle here. There is a problem because what insurers do is collect premium dollars and invest them in the bond market, primarily, and also in the stock market. Some smaller carriers invest it more in the stock market; it depends on state regulation and what the restrictions are on their investment. It looks like they [the insurance carriers] are no smarter than the rest of us—they didn't get out in time and their reserves took a hit. You can lose money selling insurance as long as you are collecting the money and investing it. It doesn't matter, as long as your aggregate income is held up by your investment earnings.

Past malpractice crises were driven by precipitous drops in the rate of return. We knew that. It's [the rate of return] gone down even more today.

The average return on investment in 1997 was 5.6%, [in] 2002, [it was] 4.0%.¹⁰ Today I am not sure what it would be—2%, 2.3%? The bad news is the drop in your return on an investment of 1% leads to a 4% increase in premiums and a 2% drop leads to an 8% increase in premiums. You can do the math. This is where it starts.

Thus, premiums have to be raised to recapture the loss on investment rate of return. What happens? Some carriers can't keep it up and they drop out of the market. Those who remain can be predatory and can raise premiums quickly. The GAO study suggests that, for the most part, the increases are quite predictable, and legitimate increases mask the losses.¹¹ However, the result is sticker shock.

Here you have a graph that's income as a percentage of premiums collected.¹² In 1975, there is a low point; in 1983-85, there are low points. There is a dip in 1992 and then the graph just keeps going. The graph doesn't extend with data, but if you kept going it would be below zero and dropping in 2003. That tells you that you are not doing very well. Why do we have this insurance cycle? The stock and bond markets dropped and this particular graph tracks that very nicely and explains some of the insurance premium pricing problems.

We have cash flow underwriting and once the premiums reach actuarially sound levels, profits start to rise. This is a market in general where it doesn't take much to enter it. I had a meeting with the Delaware Commissioner of Insurance and a new company that came into Delaware. They [the company] saw this as an opportunity because everybody else had dropped out [of the market], either because they went bankrupt or in St. Paul's case, because they quit. They were coming in to offer lower rates; they were competitive. And so, the cycle begins again. It doesn't have a lot to do with frequency or severity of claims. You get low-ball pricing with low-barrier entry. Doctors are notoriously promiscuous in shopping for insurance. They don't have any loyalty. The next company comes along with a lower premium and they jump. That's a problem for insurers that are trying to offer an office management/risk management package, offering stability in pricing.

In Pennsylvania, one law firm has been working to develop an insurance exchange product—a new entry in the malpractice insurance market in Pennsylvania, now Florida, and I gather they are thinking about Illinois. The risk management piece of the product, auditing doctors' offices, is a major part of what they do and they think doctors will remain loyal because

10. GAO, *supra* note 1, at 25.

11. *Id.*

12. AIR, *supra* note 9, at 3.

the promise is that their premiums won't have these jumps. They may be a little higher to start, but they will be stable and predictable. Well, it remains to be seen.

As a response to the market, insurers raise premiums. They also drop lines of insurance that are hard to predict and malpractice is one of the worst. They [also] drop out of the market altogether. St. Paul's has dropped out and it was at one point the biggest carrier nationally. [The result of all this] is medical distress. It hurts. You get doctors who are now over-anxious as a result and they indeed have an issue.

My summary of the insurance universe is that the current malpractice crisis, like the previous two, is fueled by this investment insurance cycle; by healthcare cost inflation, which is ramping up as more and more is done—healthcare is becoming a big driver of our economy; and there are increased levels of medical errors. There is no doubt about it. We have a problem for some providers, in some parts of the country in particular.

I will give you a few data bytes. The data is not always totally trustworthy and some of these are extracted from older studies of the previous crisis, but they are interesting. They are worthy of further confirmation.

Premiums are higher when a population's exposure to iatrogenic injuries increases. More surgery leads to higher premiums because there is more risk. It's a "risk" business that insurers are in. Also, when there are more doctors, premiums drops. Higher real income increases premiums. That's no surprise. If you make your money, your wages are higher, your losses are higher, you are a better plaintiff and more attractive for plaintiff's lawyers to bring the lawsuit.

Additionally, the percentage of population over sixty-five is correlated to premiums. If you want to be a doctor, you are probably better off in Iowa, the state with the highest percentage of over sixty-five population. They are Midwestern, they are sweet, they are not litigious, and they are old. They are not worth as much. They don't work anymore. Now, everybody works all the time. Iowa, Nebraska, South Dakota, Minnesota—those are the good news states.

[Furthermore], more lawyers doesn't mean higher premiums or higher claim severity because these cases are hard to bring. There is no evidence that pumping more graduates out of law schools makes a big difference.

Finally, premium regulation based on prior approval by the state insurance regulators is associated with lower premiums. That's the problem with the California MICRA caps model—it's a paradigm for malpractice reform. California has fairly intense regulation of insurers. Many states do not. Most states, Minnesota and Missouri, for example, let the market work its way out, which is fine in most lines of insurance. [However], in

malpractice, it has a premium sticker shock problem for the insurers. So, great regulation isn't a bad thing if you want to solve a crisis.

David [Hyman] is going to talk about some of the fixes that I am not spending much time on. I will just run through a number of ideas that have been discussed. Some are happening, some are hypothetical.

The government is funding demonstration projects now, in terms of some malpractice reform items. The Healthcare Offer and Recovery Model, which was something that Jeff O'Connell developed in the 1970s, and was subsequently proposed in 1985 in legislation. It never [went] anywhere, but it's resurfaced now in the latest Institute of Medicine report.

Further, we can enforce quality more effectively. I can tell you that in the Eastern District of Pennsylvania, the U.S. Attorney is using the False Claims Act savagely to go after providers for poor quality, not for cost issues. He is looking at long-term care [facilities], academic medical centers, and hospitals. He is going to federalize healthcare quality using the False Claims Act. Secondly, there is a new rule from the Center for Medicare and Medicaid Services (CMS) on medical error, which tells hospitals they have to develop error disclosure and an error management system.¹³ It piggybacks on the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) rule.¹⁴ It's a wimpy regulatory prep. CMS is a very wimpy regulator, in my opinion. They don't like to do it. They are piggybacking, but it has potential if you can lose your Medicare status if you don't put into place a good program.

A third potential solution is tort reform. I would say [to] leave it to the states. It is a state problem and it's a very particular state problem in parts of the state only. In Pennsylvania, it's Pittsburgh and Philadelphia. It's a very localized issue best dealt with by the states.

Fourth, pay for performance. Medicare is experimenting with this concept—the idea of reducing error by ratcheting up quality. It's not a bad one. The Blues, Aetna, and U.S. Healthcare have worked on this for years. I just talked to somebody at Blue Cross in New Jersey; they are beginning to develop a tiered bonus system for their physicians. They try to actively promote quality by paying higher rates for doctors who meet certain benchmarks. Clearly, that's going to keep developing.

As for state reforms, if you are going to reform the tort system, I would suggest the Missouri model. Pain and suffering, non-economic loss, is a variable for an actuary. They lose sleep over it because it's hard to predict.

13. Quality Assessment and Performance Improvement, 68 Fed. Reg. 3435 (Jan. 24, 2003) (codified as 42 C.F.R. 482).

14. See Joint Comm'n on Accreditation of Healthcare Orgs., *Reporting of Medical/Health Care Errors*, at <http://www.jcaho.org/accredited+organizations/patient+safety/medical+errors+disclosure/index.htm>.

Lawyers know it's not that hard to predict. Over a lot of cases you can roughly benchmark what it's going to be. I would say if you are going to have caps, adjust them for inflation. Start at \$500,000, which is about what Missouri is at, and let them ride along with inflation. That's fair to plaintiffs, at least.

The problem is that the Indiana studies suggest that you have to be careful what you wish for because Indiana put caps into place and it appeared to change litigation and settlement practices and judgments went up.¹⁵ It may have a perverse effect on lawyer-provider settlement practices and lawyer incentives.

Also, I suggest mediation to help price the value of a claim. Some states have mediation where, in effect, a panel prices the case. You can settle. If you don't settle, you go to trial and if you don't get ten percent more than the mediation price, you have to pay the other side's attorney's fees. Some counties in Michigan have this and it really hurts. It makes you pay attention and price the case properly.

I am not going to go into arbitration. I think arbitration is a mistake for a number of reasons I don't have time to talk about.

There are other models—stabilize the insurance market. Joint underwriting associations, which some states have and some don't, [can be used] to cover the distressed specialties that really have problems just to ride out the cycle. It's a taxpayer or a specific tax-generated fund to help deal with sticker shock, get the specialties out of danger, and make sure there is coverage available. [Another possibility is] intensified regulation of insurers [including] a mandated risk data provision, rate regulation, and notice of renewals [that allow] enough time for the doctors to react and seek another policy.

An additional state reform is mandated error disclosures. This is something Pennsylvania started in the last two years. Pennsylvania has the new Patient Safety Authority which requires hospitals to disclose near misses and medical errors.¹⁶ It has whistleblower protection. It ties into the Department of Insurance's regulations and there are substantial penalties for noncompliance. We will see if they mean business. But, it's a particular kind of regulatory model that isn't the JCAHO kind of mild accreditation approach, although that can hurt too. Here, there are penalties and they are actively soliciting whistleblowers to turn in their institutions. We'll see how this plays out. It was based on the Surgeon General of Pennsylvania's

15. William P. Gronfein & Eleanor D. Kinney, *Controlling Large Malpractice Claims: The Unexpected Impact of Damage Caps*, 16 J. HEALTH POL. POL'Y & L. 441 (1991).

16. See Pa. Patient Safety Auth., *Reporting Medical Errors*, available at <http://www.psa.state.pa.us>.

experience with the Veteran's Administration (VA) system; he was very impressed by the new VA, with all of its error management strategies.

The fourth state reform strategy is to refocus medical discipline and regulatory efforts. Pay more attention to the office, where it turns out lots of bad things are happening. Think about regulation of office practice [and] office surgery as a piece of improving the medical discipline.

[Regarding] private efforts, there are provider strategies. Some hospitals here may be doing it. It turns out [that] the Hickson study found that at Vanderbilt University Medical Center, the doctors who were getting sued had bad personalities.¹⁷ They were litigation prone. A good psychologist could pick it right out. Vanderbilt launched a program to retrain their litigation-prone doctors. They may not be error-generating doctors, but patients hate them and if something goes wrong, they want to sue them. It's a personality question of sorts. It manages some risks and eliminates them.

Secondly, do hospitals have governing board policies that allow summary suspension of problem doctors? Medical staffs normally dominate hospitals. This empowers the board, under the bylaws, to deal with bad actors swiftly. I have an Illinois case for you, which some of you probably litigated and know more about, but I thought the court's language was hard and interesting in the case.¹⁸ Lastly, better integrated patient safety is [another] provider strategy, which I think David will talk to you about.

[There are patient strategies as well, such as] better search[es] for quality. I asked my healthcare regulation class about this (they are nurses, doctors, lawyers)—how many of them have searched systematically online for quality. Many of them had when they needed something done because Pennsylvania has the Health Care Cost Containment Council (PHC4), which generates mortality/morbidity figures on all of Pennsylvania's hospitals. You can shop until you drop and you can pick what you want for what procedure you need. The data is often problematic and limited, but it's still helpful. Patients can also demand proof of efficacy.

Another [patient] strategy is more tort litigation. It's ironic [because] doctors want more tort litigation, [but] only against managed care. The system works great if you are suing managed care. It doesn't work at all if you are suing the doctors. That's a tension that one has to sort out. I would tend to move tort litigation, as I would payment systems, toward systems, integrating systems, insuring systems, suing systems, trying to get the doctors a little bit off the hook, and worry about error reduction through

17. See Gerald B. Hickson et al., *Patient Complaints and Malpractice Risk*, 287 JAMA 2951 (2002).

18. *Lo v. Provena Covenant Med. Ctr.*, 796 N.E.2d 607, 614 (2003).

other strategies.

Buyers [also have strategies]. I mentioned New Jersey Blue Cross' strategies of tiered payment systems paying for quality. Can you do risk rating? Can you, as a part of your premium pricing, actively try to manage groups and have rates reflect risk? With small numbers, that is more difficult to do, admittedly.

[What are the] prospects for crisis relief? I call it waiting on Greenspan. We are waiting for him to see what happens with interest rates. Has the bond market improved? If it does, the insurance market will inevitably rebound. Profitability will increase. Investment income will become good news instead of bad news and premiums, well, they will never drop back to basis. Every cycle moves the basis up, but they will drop back and it will appear [that] the crisis is over. Better insurance regulation and better products may smooth out some of this. Pressures from buyers in the government will move us toward lower levels of errors, one hopes. Then you can manage litigation and look at high-risk providers.

I left patient education. It will have good effects if it's properly done. It seems to me worker's compensation systems have learned to manage premiums to some extent by much more intrusive and intensive workplace safety programs. As a result, some worker's compensation systems have stabilized their premiums.

Healthcare is much more complicated, admittedly, in some ways. Nonetheless, it seems to me [that] a real patient safety movement, an institutional safety movement, as the prospect, with these other reforms may be holding us back from yet another malpractice crisis in thirteen to fifteen years. I'm sure I will still be writing and lawyering then and we will be talking about it again if it happens. Thank you very much.

DR. HYMAN: Thank you, Barry. A couple of preliminary remarks. I'm actually spending half of my time at the Federal Trade Commission, and so I am required to say that nothing I will say should be imputed to any member of the Federal Trade Commission or the Commission itself. That's not because the Federal Trade Commission has done anything in particular on medical malpractice for complex statutory and jurisdictional reasons, that's primarily the ambit of the States and the Department of Justice, but I'm just required to make that disclosure.

I am going to talk briefly really where Barry left off, which is the patient safety side of this. The focus, I think earlier, was certainly significantly more on the insurance side of this and I think it's important not to lose site of the fact that we have medical malpractice litigation in response to medical malpractice, i.e., problems with quality.

There is [a] lot of debate about how effectively medical malpractice

litigation deals with the problem of medical malpractice. The data issue is certainly an important one to keep in mind, but the title really is there is [a] lot of blame to go around, so let me just go directly to it.

The empirical literature on quality is pretty scary. They are not tabloid headlines. The Institute of Medicine report identified that medical error is the eighth leading cause of death in the United States, ranking ahead of breast cancer, motor vehicle accidents, and AIDS.¹⁹ That's just in the hospital. That's not deaths out of the hospital. That's not injuries in the hospital or out of the hospital that don't result in death. This is a very significant issue economically and most of the costs are borne by patients and their families.

There is a lot of literature on quality. I am going to focus on a recent article in the Journal of the American Medical Association (JAMA), which looked at all of the states using twenty-two process base measures in Medicare fee-for-service for six different medical conditions. The benchmark quality goal for all twenty-two of the measures was 100%. Everybody should have gotten all the things they identified. The median performance was 73%. That's a C. It's a C in areas where patients lives are at stake. There are a lot of variants within states and within measures. The actual performance at its lowest was about 11%. For some measures, though, they actually clocked in at 100%.

If you look at this data, you could have two hypotheses. One hypothesis is the worse your quality, the more medical discipline you should have in response to it. If you had that, the line would start at the origin and go upward and to the right. An alternative hypothesis is if you really aggressively go after problems and you have a high medical discipline rate, you should have better quality in response to that. Then it would start in the upper left-hand corner and go down. If you look at the results, you don't see anything like that. There doesn't seem to be any relationship whatsoever between medical discipline and measures of quality that were used in this study.

Just to summarize, quality problems were too common in healthcare. The dominant finding is that there are large gaps between the care people should receive and the care they do receive. That [the gap] doesn't always lead to death, [but] it can lead to less than optimal outcomes. It doesn't matter whether you look at preventive, acute or chronic [care]. It doesn't matter whether you look at overuse or underuse. It doesn't matter whether you look at the type of health facility that's providing it. It doesn't matter what your age range is and it doesn't matter where you look in the country.

This is a pretty chilling picture. Now, "why" is the next question. This

19. IOM, *supra* note 6, at 1.

is another element of the “through the looking glass” nature of this problem. Each of these groups—lawyers, physicians, academics and patient safety advocates—have different explanations for these problems. The lawyers say it’s because there is too much medical malpractice. The physicians say it’s because there is too much malpractice liability. The academics, as Barry, I think, has very ably pointed out, say there is a lot of negligence and injuries out there, but the liability system isn’t doing a very good job in response. The patient safety advocates, which have become an increasingly great significance in the public’s fear, have argued that it’s really the systems that are the problem and liability is not part of the solution because it stifles error reporting and inhibits cooperation. Not surprisingly, there are competing solutions, some of which we heard about this morning.

Lawyers argue for more aggressive tort litigation, elimination of peer review privileges and public access to the National Practitioner Data Bank (although it turns out nobody is reporting, so why bother?). Some [p]hysicians have argued aggressively, and with some success in various states, to cap damages and attorney’s fees, have expert screening panels, and some alternative dispute resolution.

In academics, the Harvard Medical Practice Team has been in love with no fault enterprise liability and has argued for it over the last fifteen years.²⁰ Originally they argued for it on the grounds that there was inadequate compensation in the existing system. They have now repackaged it and argue for it on the grounds [that] it will help deter medical error. It’s a response to the patient safety problem. Academics are also very keen on voluntary error reporting.

The patient safety movement is interested in broadening the debate to include not just errors that result in death, but near misses, focusing on processes and encouraging voluntary reporting of problems by cutting back on liability. Why isn’t liability contributing much [to the crisis]? Well, there is too much bad litigation. Bad in the sense of cases brought in where there isn’t negligence. That is, there is not enough litigation for where there was actual negligence.

[T]here are seven times as many patients that are injured due to negligence as file claims; the more severe the injury, the smaller that number [that file claims] becomes. The number drops down to about one in three with very severe injuries. It’s important to recognize that the Harvard Medical Practice Study treated as adverse errors everything from one

20. HARVARD MEDICAL MALPRACTICE STUDY, PATIENTS, DOCTORS, AND LAWYERS: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION IN NEW YORK (1990).

additional night in the hospital to death.²¹ That was the range they were looking at. So, 7.6 includes a lot of things that aren't severe enough to justify, in the patient's mind or their lawyer, bringing the claim. To the extent it's an elderly or poor person that's injured and was sick already, the incentives for private litigation go down because there isn't the prospect of economic damages recovery.

Now, liability hasn't done a very good job [of stemming the medical malpractice crisis]. In a paper that I have been working on with a co-author, I argue that liability isn't going to do a very good job no matter how you tweak it because the real problem is that the system of compensating healthcare providers isn't tied to quality or outcome. A good doctor gets paid the same as a bad doctor. There is no other sector in the economy where compensation has no relationship to whether you are doing a good or a bad job. In fact, in healthcare you can get paid more for doing a rotten job under some circumstances, which is a very peculiar thought. There is no system of compensation that makes agents better off for making principals worse off that hangs around for very long.

The other problem is the cost and benefits of quality improved are separated. A healthcare provider that aggressively pursues quality improvement incurs upfront costs for doing so, sometimes very substantial costs, staggering costs for some of these measures. All of the benefits of that accrue to the patients, but the provider's compensation is exactly the same as somebody down the street who doesn't make those investments in quality. There is no business case, or at least not a compelling business case, for providers to invest in quality. If your patients had money-back guarantees, that would change the dynamics. Nobody is calling for that, but it's important to appreciate [that] compensating people in a way that's completely unconnected to the quality of the services [provided] can lead to perverse results.

The road forward, which again Barry has talked about very effectively, is [that] everybody has their own pet solution which neatly dovetails with how they diagnose the problem, and typically their self interest. The media focuses on the malpractice insurance affordability crisis, and there is a real crisis. There is a dramatic spike in the premiums that providers in certain specialties and certain states are facing. It's important to recognize that and to think about ways of dealing with it, but it's also important to recognize this is a manifestation of a series of underlying causes. Consequently, unless you want to be in the soup again in five to ten years, I think reframing the debate to try and align the economic incentives more effectively and to try and incorporate both malpractice and patient safety

21. *Id.*

strategies to address this is going to work better.

We are now seeing the first malpractice crisis of the twenty-first century. It would be useful if we rethought how we went about it. One way of doing it is to think about what we can learn from other industries. With regard to worker's compensation, there is a cartoon with a county hospital and it has a sign of the sort that any of you that have ever been in a factory will be very familiar with. It says up at the top "172 days without an accident." I submit to you if there was a billboard outside healthcare providers that announced that [the number of days without an accident], you would start making the business case for quality a lot different than the current environment does. We are going to need to come up with other strategies.

Now [with] that said, we have [time] for questions.

DR. PARSI: I'm Kayhan Parsi with the Neiswanger Institute for Bioethics and Health Policy at Loyola. I enjoyed both of your talks, but I wanted to pick up on this issue that Professor Hyman mentioned about academic solutions, and what you finished off, Professor Furrow, with workman's compensation. There is a recent article in the *Annals of Internal Medicine* by Troyen Brennan and Michelle Mello where they talked about all the deficiencies of the current tort system and argued once again for a no-fault system.²² I am just wondering why is that such [a good option]? I understand all [of] the political reasons, but with all the deficiencies, we are looking at a broken system. Why are we still trying to tweak the system with all of these different things [instead of] trying to do something completely different? I am curious what your thoughts are.

PROF. FURROW: Your question is why don't we move to some kind of a no fault or enterprise liability system. I think David and I have both written about the problems with these systems. It's a very nice idea to have an integrated system that's responsible for paying for patient injury and they can then police within the institution the error of generation points, the doctors, nurses, or whatever it is.

The problem is, first of all, we have never really achieved integration in our healthcare system. We still have a fragmented, scattered system. [Neither] horizontal nor vertical integration has really happened. You saw what happened in Clinton's Health Security Act—it died. It was an attempt at some modest degree of integration. The second problem with these no-fault systems is where a patient has an injury, even a small one, the hospital says "we made a mistake, we are going to cover your care, bring your

22. Troyen A. Brennan & Michelle M. Mello, *Patient Safety and Medical Malpractice: A Case Study*, 139 ANNALS INTERNAL MED. 267, 271 (2003).

lawyer in, and let's sit down and we will talk about giving you money." This is the VA model. You don't ever have to go to court. You never have to file suit. The system makes a tender. It works in the VA, for a variety of reasons unique to the VA.

Well, what's the problem from a hospital or insurance company's point of view? The universe of claims, now screened out by the tort system because they are too small, is huge. I think hospitals always were afraid of the consequences of opening up a system and paying everybody, even for little things. Exposure is great, and I think insurers would have the same problem. I don't know how you insure against a universe of claims that's now vastly larger than the current system. The current system is great because it filters out a lot of claims from an insurance point of view, even though it has other problems.

The data [shows] two reasons why enterprise liability has never taken off. There has been no lobby pushing it because insurers and hospitals are anxious about it and we have never had the integration that would allow it to happen. I mean, doctors are still on staff. They have these curious arrangements where doctors run a hospital through the staff and the hospital administration and the board have to fight to gain power over them in contrast to more national systems like the British or the Italian, where clearly they are integrated national health services. The British are still struggling now with how to compensate for increased errors. It's a hard fix.

DR. HYMAN: Just very briefly. You can get there [an integrated system] either voluntarily or by statute. Voluntarily is hard for the reasons that Barry has outlined and I went through [the reasons] in an article in the *Texas Law Review* a few years ago.²³ The truth of the matter is you need a pre-existing structure that maps well onto the sorts of things enterprise liability is trying to accomplish. With the very limited exception of some academic medical centers, there aren't really many institutions that have that kind of arrangement where you need exclusive arrangements with a controllable number of physicians to control the risk and capture the benefits of doing it.

The related reason is that most people think it's a lot more expensive to run an enterprise liability system. So, you are encouraging individuals to voluntarily move to a system where they pay more. That's a very hard sell. As Yogi Berra once said, "if people want to go to the ballpark, nobody is going to stop them."

By statute it's very hard. The states that have attempted this have gotten

23. David A. Hyman, *Medical Malpractice and the Tort System: What Do We Know and What (If Anything) Should We Do About It?*, 80 TEX. L. REV. 1639, 1647-54 (2002).

absolutely nowhere. The reason for that is reform of a particular type is everybody's first preference and doing nothing is everybody's second preference. The result is you get a legislative stalemate. You don't see it being adopted by statute in individual states either, for all of these reasons. Other questions?

MR. BRYANT: Ed Bryant, Gardner, Carton & Douglas, former adjunct professor at the Institute for Health Law at Loyola. One of the solutions raised by you, Professor Hyman, dealt with the issue of paying physicians more for better results. I suspect that most people in the room who have tried to see something like that work would conclude that what would really happen is that the good ones would stay where they are right now and the bad ones would get less. But the more important part of my question is whether you have seen it? Both of you can comment on Professor Dranoff's article about a year ago on the Maryland and New York experiments in paying physicians more for better results, where he concluded that what physicians did when they were paid more for better results is they selected their patients more carefully and didn't give access to the ones who needed it the most.

DR. HYMAN: I have seen the paper and it's actually a very interesting paper. The system that was at stake didn't pay for performance. What it did was disclose results for cardiac surgery. After a lot of econometrics, the conclusion was that the result of making information available was a sorting effect by healthcare providers. They shifted who they provided the services to and they seemingly denied care to the sickest patients.

[I]t was a very interesting result. I have some questions about it. Let me put it this way: any system of creating incentives [actually] creates the incentive to sort. We think that's a good thing in many areas of the economy. We think giving tort lawyers a share of their recovery encourages them to select cases where there is the prospect of a recovery and not to bring frivolous cases. We think that it makes sense for them to spend their time on things where there will be beneficial feedback from their effort rather than negative feedback.

The embedded assumption in the analysis of your question is that everybody should get everything and somebody should pay for it. Again, in healthcare most people view that with the utmost equanimity, except for economists, who are shocked and appalled. As a recovering economist I am still sort of shocked and appalled that thinking about whether the benefits are not greater than the costs is not worth asking.

PROF. FURROW: I have two responses to that study. One is you [the

provider] can try to adjust for your patient so that when you do your data disclosure you can take into account the harder cases, when you pay for harder cases [and this] prevent[s] the sorting or screening out patients who you [the payor or patient or researcher] don't want screened out.

The second observation is that in New York, which has been disclosing cardiac mortality rates for a long time, the effect on the institutions has been interesting because they have scrambled when they ranked poorly to look at why, to sort it out, to get rid of providers, to improve their procedures so that they could rise up in the institution wide rankings. So it clearly has had a positive effect on cardiac care in New York on an institution-by-institution basis, according to the studies I have read. It's certainly not a bad thing to have public data available as to how you do, [but] understanding it does have these problems you described.

UNIDENTIFIED SPEAKER: I would like to ask about a parallel crisis—the shortage in nursing—which I think might have an impact on the angry patient who is no longer getting the kind of individualized care he or she expected. I [also] think it might increase the number of errors that occur during the patient's care. I'm wondering if you see that as an important aspect of the malpractice crisis?

PROF. FURROW: I think there has been some evidence recently that nursing staffing levels directly correlate to increased levels of patient injury. The question is how does the system respond to it. I can tell you that in Pennsylvania, Delaware, and New Jersey nurses are now being paid at the level of, for a registered nurse, \$80,000 to \$90,000 a year. Hospitals are scrambling to recruit. Of course the consequence is it shortens the budget in other areas and it's an issue for all institutions that have a budget to balance. Clearly the market has responded here and more nurses are in place, staffing levels have improved, at least in my part of the country. Clearly nurses are very important. They are a major part.

There is a series of studies by a Harvard sociologist about teams within hospitals. Hospitals are a box. Within it you have teams that operate more or less effectively. There are also studies that look at the operation of a surgeon, for example, at cross hospitals where he or she has privileges. You find that the mortality rate and efficacy of the surgeon varies across teams, even within the same hospital, which tells you something about the system, the nursing system, the integration in the delivery of healthcare, something that hasn't been studied enough, but is really part of the puzzle in error reduction.

DR. HYMAN: Other questions?

MR. SCHNEIDER: I'm Mark Schneider. I am with Loyola University's Stritch School of Medicine. I have a basic problem with the interplay of quality and malpractice. I think there are two separate systems going on here. The funding, the decision-making, the analysis that goes into mega millions of dollars that affects malpractice is almost divorced from quality. It's an accident that there are quality issues related to that. So, I think there are really two separate strings and to tie them together and think we are going to fix the malpractice problem by fixing quality is a misnomer. I would appreciate your view on that.

PROF. FURROW: I don't disagree with you. I think hospital risk management has very little to do historically with quality management. It has to do with managing risks from slip and falls to surgical mishaps to drug errors. I think you are right.

It seems to me that the patient safety movement has been pushing to better integrate two parallel universes, [which] is not easy to do. I don't have an easy answer to that. I think you have to wait for the next articles David and I write to see the answer.

DR. HYMAN: Again, I agree. I think they [quality and malpractice insurance rates] have been divorced. The question that's been on the table, particularly by the patient safety advocates, is if you remove the threat of liability with all of the problems that there are with liability, do you somehow miraculously expect the quality to be free from the threat of liability, to emerge and trample over all the existing institutional problems that have prevented the systematic delivery of high quality care? I think on that question, the available evidence really isn't there and liability, at least my bottom line is, it's not perfect, but getting rid of it probably makes things worse rather than making things better. Even if you don't believe that, the politics of getting rid of it are going to make it very hard to do. There was another question?

PROF. FURROW: Let me make a comment on the last question. It seems to me David is right. Patricia Danson, now at the University of Pennsylvania, long ago wrote in a book on medical malpractice that she thought the system was worth keeping, if you could look at, say, a ten percent reduction in the error rate that the malpractice system is responsible for.²⁴ It's very hard to point your finger at that and say it works.

24. PATRICIA DANZON, *MEDICAL MALPRACTICE: THEORY, PRACTICE, AND PUBLIC POLICY* 225-27 (1985).

On the other hand, I certainly know that providers pay attention to the risk that their exposure to malpractice brings. I was talking to the general counsel at Cooper Health System in Camden, New Jersey. They just hired the Harvard Risk Management Group to come in and remake their whole risk management operation with a real quality focus. I think that's probably as good a group as there is to try to integrate and improve their insurance payouts, at the same time reducing their patient risk. It's hard to integrate, but I think doing away with the system is no panacea.

MR. GOLDSTEIN: My name is Neal Goldstein. I'm a partner with Much, Shelist in Chicago and I represent a fair amount of physicians. I don't have the benefit of the statistical analysis that you in the academic world have, so I have to go on the anecdotal, but I see a lot of anecdotes. I think that in dealing with physicians and their personalities, they don't really need to be incentivized to provide quality care [because] it's almost their nature [to do so.]. If you look at their backgrounds and where they were in school, and the fact that they went into medical school, residency and fellowship, these are people who are very much incentivized and motivated to provide the greatest quality.

I think from my experience, and I would like your comment on it, the real problem isn't the self-policing. [The real problem is] that physicians, at the same time they are quality-oriented, also walk around with the attitude of "there are but for the grace of God go I," so therefore if I am going to point out a problem with Dr. X, my colleague, he therefore could do the same with me. I would like to hear your comments on whether there is validity to really pursuing the self-policing more aggressively.

PROF. FURROW: That's part of what I referred to in improving medical discipline. I think it depends on what you are talking about—what kind of physician group and what kind of practice. Are errors detected? Are they disclosed? Is the hospital trying to manage them? What happens?

There are some wonderful cases, or horrible cases, of doctors who operate on patients who are clearly not candidates for surgery and they die. Why didn't the hospital have some kind of pre-approval process for surgery in certain situations? Hospitals are very poor controllers and that is part of the problem. I would start with that rather than this kind of soft policing approach, it seems to me.

I have great sympathy for the ethic, the professional ethic, the drive for excellence. I think it's a question of over time—how institutions detect the tiring doctor, the depressed doctor, and the problem doctor whose quality is slipping? Is that detectible? Is data available? Is it being monitored? Is anything being done?

Clearly we all, as we age, lose things and we need to stay sharp and somebody needs to be paying attention to us. Professional ethics doesn't do it. Internal motivation doesn't do it all by itself.

DR. HYMAN: [O]ne last question.

MR. BROWN: Max Brown, general counsel at Rush University Medical Center. I appreciated both of your comments, but I would like to have you address the issue of high attachment points. Many of the academic medical centers in Chicago have attachment points that are at \$15 million. Rush currently has a \$15 million attachment point for each and every occurrence that takes place.

Barry, when you talk about the insurance premiums and the difficulty, if we could find the insurance companies first, that would be great, but as you know St. Paul has left the market. What has been your experience in terms of a venue like Cook County where major medical centers have such high attachment points? Actuarially, how long can that system continue?

PROF. FURROW: I don't know the answer to that. The studies haven't looked at, or intend to look at, lines of insurance sold to individual doctors since academic medical centers are more self-insured than by surplus lines. This is a problem in Pennsylvania, quite clearly. I think in the Cooper [Health System, Camden, New Jersey] situation they are much higher than that for their attachment point. That's why they brought in the Harvard group. They don't want to make any more mistakes. They can't afford it. They are setting aside too much in reserves. It [attachment points] hasn't been studied very well. The situation you are talking about is a problem that the investment cycle may not cure from your point of view. I don't have a solution for you.

MS. KURTZ: I'm state representative Rosemary Kurtz. I am on the Healthcare Availability & Access Committee. There are three other representatives here, Julie Hamos, Eileen Lyons, and Patricia Bellock, that are on this committee. However, my question is federal. The Senate is trying to put together a federal law and it seems that tort reform is the problem.²⁵ The authors or the sponsors are Senator Frisk, the majority leader, and Senator Dianne Feinstein, so it's truly bipartisan. I would like you to comment on what you think of the bill that they are trying to put

25. Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act, H.R. 5, 108th Cong. (2003), *available at* <http://thomas.loc.gov>. The legislation was placed on the Senate Legislative Calendar on Mar. 21, 2003.

together because I understand they have reached a stymie on the tort reform.

DR. HYMAN: The bill reflects a fairly traditional cap driven approach to the problem, which if your sole focus is to decrease the amount of payouts and make insurance more affordable, the evidence, if from California and not from Indiana, suggests that will work. The evidence from Indiana suggests that this provides a baseline target for negotiation and you could see some creep. If you don't index it, it erodes in value over time.

The other problem with caps is that they are heavily regressive; that is the people who are most heavily injured are the ones who are paying the price of the caps. If you are not severely injured and your recovery is going to be under the cap anyway, it makes no difference.

I don't think much of it [caps] for the same reason I don't think much of price controls. I don't view it as addressing the root of the problem. It addresses a symptom, and probably the wrong symptom, and if I took nothing else away from medical school, it was direct diagnosis is necessary before you prescribe treatment. I don't view it as the correct diagnosis.

The final point is [that] there is a huge divide between physicians and plaintiffs on causes of malpractice and the nature of the problem, but that's not nearly as big as the divide between academics and the rest of the world on the malpractice problem.

I think Barry and I have given you a fairly standard picture of what the empirical evidence is on the tort system and it simply doesn't match up with a response that says caps will solve everything and a new day will dawn.

PROF. FURROW: There is an excellent report by the Missouri Commissioner of Insurance that looks at their system.²⁶ They have caps adjusted for inflation. His proposal is that they should do a much better job of regulating insureds in Missouri if they want to smooth out malpractice prices.

I think federalizing this with something as simple-minded as caps is a poor idea and it's simply not going to happen. We have been through this. I have bills in my filing cabinet that go back to 1974 and they all look alike. They were more sophisticated in 1974, actually, because they had more academic origins. Now it's just caps and whittling back on the plaintiff's right to sue through mechanisms that affect the tort system and filings and so on.

These are reforms that are too little too late and miss the real point. If

26. Mo. Dep't of Ins., *Medical Malpractice Insurance in Missouri: The Current Difficulties in Perspective* (Feb. 2003), at <http://www.citizen.org>.

anything, I would strengthen the federal initiatives in promoting medical error disclosure, attaching penalties, and driving institutions in particular toward real patient safety.

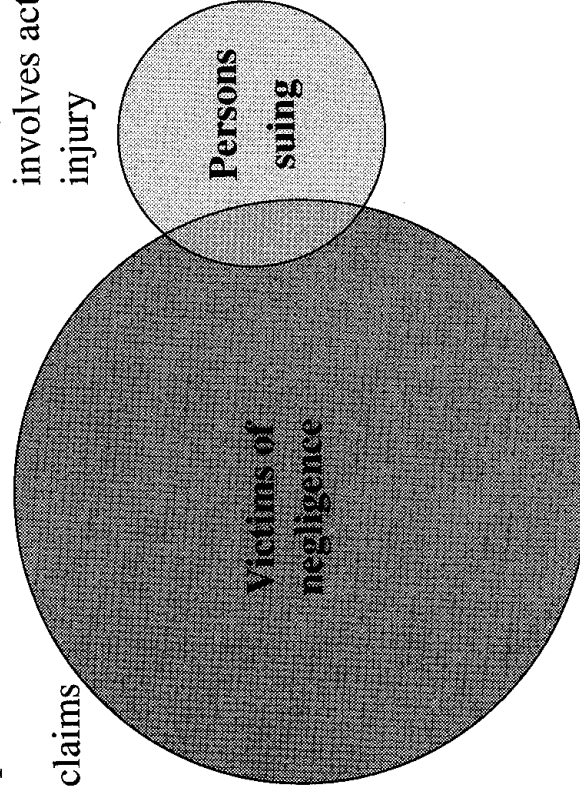
DR. HYMAN: I think that's all the time we have. Thank you.

Appendix A

The Tort System Undercompensates Victims of Negligence

7.6 times as many patients are injured due to negligence as file claims

Only 1 claim in 6 involves actual negligent injury

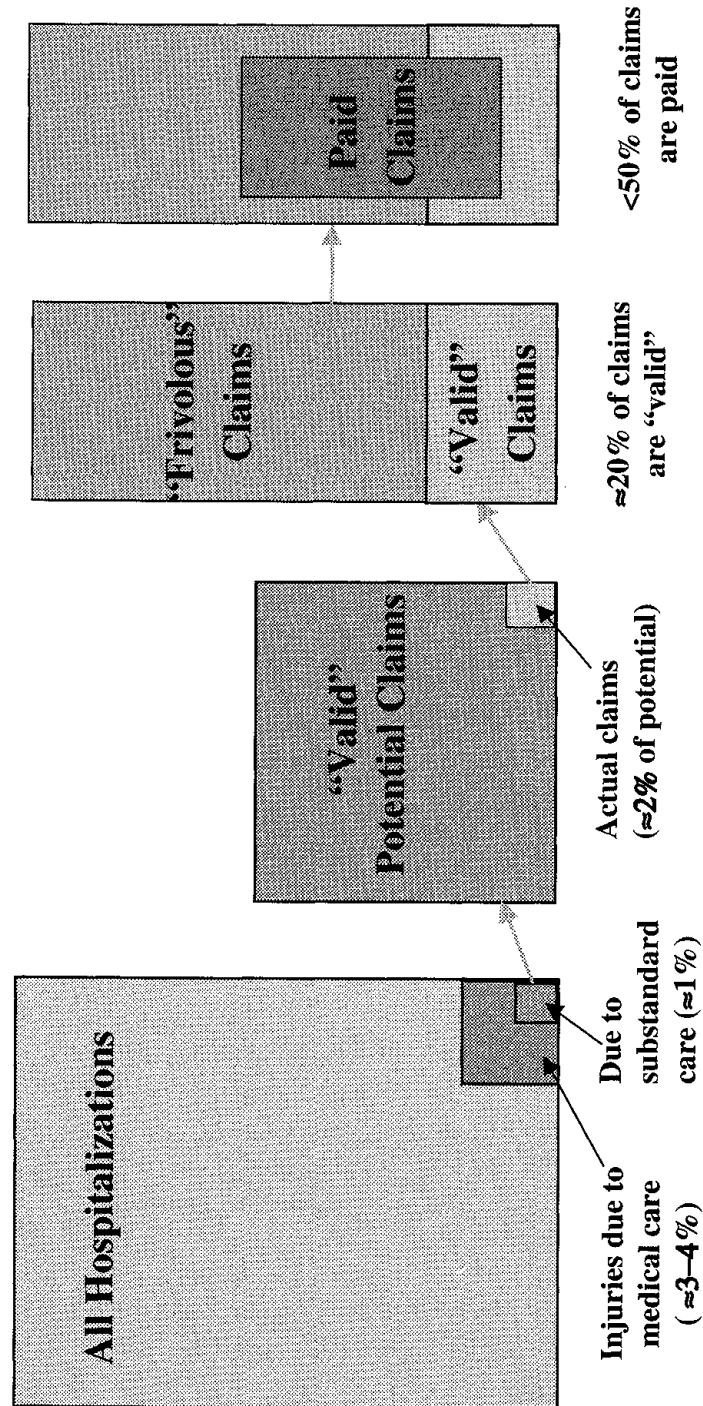


*Data Source: A. Russell Localio, The Nature of Adverse Events in Hospitalized Patients: Results of the Harvard Medical Practice Study, 324 New Eng. J. Med. 6, 377-384 (1991). Diagram Scale is only approximate. Conceptual design from Don Harper Mills and Randall Bovbjerg.

Appendix B

Relationship Between Injuries & Claims*

1:50



*Data sources: David M. Studdert et al., *Negligent Care and Malpractice Claiming Behavior in Utah and Colorado*, 38 Med. Care 250, 251-260 (2000).

Diagram scale is only approximate. Conceptual design derived from Don Harper Mills and Randall Bovbjerg.