MALPRACTICE
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"The positions of both sides of the Medical Malpractice debate are well known and virtually calcified." Health Affairs, July/August 2003, editor's prologue to malpractice articles.

None of the problems with our health care system is more contentious than medical malpractice. For the last twenty-five years I have been listening to the doctors and the insurance companies saying the problem is the lawyers and the lawyers saying it is the doctors and the insurance companies. I have become convinced that each side is right about the other. We need to go beyond that sterile debate, look at what the problems really are, and find some new solutions.

Rising malpractice insurance rates are typically the problem that touches off the political battle. These are a source of rising health care costs although they are far from the most important source. Direct malpractice costs are generally thought to be between one and two percent of total health care costs. They have been going up faster than many other costs recently; the PricewaterhouseCoopers (PWC analysis shows that for 2001-2002 they accounted for 7% of the total health care cost increase (1). Traditionally when doctors or hospitals get a malpractice insurance increase they grumble, then they preserve their own income by raising their prices to the rest of us. The trouble comes because now they often can't raise their prices. Approximately half of provider revenues come from government programs, including Medicare

and Medicaid, where the government sets the fees. Governments can be quite insensitive to provider requests to raise fees to offset higher malpractice insurance costs. Cutting health care provider reimbursement is a common tactic for dealing with budget problems at both the federal and state level. In the proper competitive environment managed care and even large insurers can squeeze provider reimbursement as well. When the doctors start threatening to leave an area over malpractice problems there are usually two interacting problems--increasing malpractice insurance costs and an inability to recover those costs through fee increases

We in Wyoming are having that problem in one of our communities right now. The doctors in Newcastle have just quit delivering babies. The community is small and the doctors were each delivering between 20 and 25 babies a year. At that rate their malpractice insurance costs had risen to over $1,000 per delivery ($38,945 with obstetrics, $12,593 family practice without obstetrics, = $1,317 per baby @20 babies per year (2). Roughly half their deliveries are paid for through the state Medicaid program which pays $866.25 per delivery for a normal vaginal delivery; the payment increases to $1,401,87 if normal pre-natal and post partum care is provided. The Medicaid program was not even paying the doctor's out of pocket costs. They couldn't raise their private rates because in that community most young couples starting a family could not afford a higher rate and too many were not covered by insurance. The economics were clear--the doctors were losing money with each delivery. They dropped the obstetric

part of their practice and now a woman in Newcastle has to be driven 73 miles to Gillette, Wyoming or 80 miles to Rapid City, South Dakota to have her baby delivered by a medical doctor. With the distances involved I strongly suspect many are not getting as much prenatal care as they should. This same scenario has occurred in many communities across the country and it doesn't just affect the small towns. In many cities family practitioners and even obstetricians with smaller volumes have had to drop obstetrics and the deliveries are be done by a few doctors with a high enough volume to afford the premiums.

The malpractice crises tend to be cyclical. Investment income has a big influence on them. In malpractice insurance there is a long time between when the premium is paid and when the benefits are paid so the insurance company has a long time to invest the premiums. A good return on investments can offset increases in costs. That's what happened in the mid to late 1990's. During that period rates were relatively stable--one of the major malpractice insurers in Wyoming even had a slight cut in rates When interest rates fell drastically, the insurance companies had to have major increases in premiums. The related stock market decline had some impact, but most malpractice insurer investments are in interest bearing securities, not common stocks.

attorneys frequently blame the insurance companies for reduced investment earnings and say therefore the insurance companies are the ones to blame for rising malpractice insurance rates. Mary Alexander, President, Association of Trial Lawyers of

America, told the NCSL (National Conference of State Legislatures) 2002 Annual Health Policy Conference "Here's the truth: insurance industry is responsible for today's medical liability crisis. Insurance companies saw their profits go down with stock market two years ago. They raised rates to make up for their investment losses. The insurance industry pulled the same trick in the mid-1970's and the mid 1980's." (3)

This is a misunderstanding of the way insurance works. Insurance companies get money from premiums and from investment income. The revenues from the combination of these two sources have to cover their costs for them to stay in business long term. If they can't get as much from investment income because investment returns are down, then they have to get more from premiums. If a single company had a problem because it made bad investments, answer might be too bad; they've got to improve their investment performance and keep their rates down to match their competition, but that doesn't apply when all or most of the companies have same problem with declining investment returns.

The behavior of the commercial insurance companies is instructive. They are voting with their feet and leaving the market to the physician mutuals and other carriers owned by health care providers. St. Paul Companies, variously described as the largest (HHS) and the second largest (West Virginia Insurance Department medical malpractice insurer left the market in December 2001. PHICO, the eighth largest was declared insolvent in February 2002 (4). MIXX pulled out of all its states to reorganize and sell

only in New Jersey and Frontier Insurance Group left the medical malpractice market (5).

An objective comment on the commercial situation of malpractice insurers can be found in the Value Line Investment Survey relative to the St. Paul Companies. In describing the things management had done to strengthen St. Paul, Value Line "The company exited the highly unprofitable medical malpractice segment,..." (6).

Malpractice crises do tend to be triggered by economic factors, but economic factors alone do not account for the depth of the doctors's feelings. Being sued is never a pleasant experience--the doctor's professional competence is being challenged in a strange and public environment where the doctors have difficulty knowing how to defend themselves, particularly with the larger community. They may well even be advised by their lawyer to say nothing--something said in public defending themselves might be used against them in court. The doctors feel, and academic studies bear them out, that many of the suits are unjustified and they are being sued for bad outcomes they were powerless to prevent. They feel that the legal system is not doing them justice. And there is always the fear, even if it rarely happens, that a runaway jury will go beyond their insurance and destroy their finances and with it their kids's college education or their retirement.

The doctors's fear of being sued explains another problem that is very expensive for all of us--defensive medicine. Fear is the only motivator for defensive medicine--malpractice insurers

encourage it for their own financial protection, but fear is the primary motivator

A practicing obstetrician once explained one part of defensive medicine to me. "Every woman," he said, "who needs a hysterectomy gets a bladder function study. She doesn't need it--the surgery has nothing to do with bladder function. But a percentage of the women who need hysterectomies also have bladder problems. In a few cases where these were not documented ahead of time lawyers were able to convince juries the surgery caused the problem. Therefore all women facing hysterectomies get bladder function studies." Unnecessary and expensive from the woman's point of view, absolutely necessary from the doctor's.

It is hard to document how much defensive medicine costs us I have seen estimates as high as 20% of total health care costs The problem is that it can be hard to separate defensive medicine from reasonable but cautious practice. Is the extra test just to be on the safe side really justified? Was the MRI really needed when the doctor very likely would have done exactly the same job setting the fracture based on the X-ray? No doctor wants to imagine himself or herself on the stand in a courtroom answering the question "Now doctor, explain why you didn't take that MRI that would have shown what my client's problem really was?"

I do not know whether the real cost of defensive medicine is 10% of total costs or 20%. I suspect it is somewhere in that range although I can't even prove that. I also suspect that defensive medicine has become so ingrained in the way medicine is practiced

if we were to remove the legal system motivations we'd still have it for a long time. I tell medical audiences that if we were to have the most effective tort reform possible it would still take a generation to get rid of all the defensive medicine.

Another factor driving defensive medicine is that someone is making money providing all those tests. A surgeon I know has told me of seminars where the makers of the newest technological devices ply the doctors with horror stories of patients whose problems were missed because their new device wasn't used. Mix the doctors's natural desire to do the best possible job for their patients with the fear of being sued if they leave any stone unturned and add whatever additional personal earnings they may get from reading the

and you have quite a recipe for selling new medical technology.

Defensive medicine is more than just an economic problem Some of it is risky for the patient. An extra blood test is just expensive. An invasive procedure always carries some risk of something going wrong. Any test using ionizing radiation carries some risk of causing future problems. The risks of ionizing radiation causing cancer are well documented. Now the risk of a single X-ray is quite small and modern technology continues to reduce it further. But some of the new techniques use a lot of ionizing radiation. Professor William Orrison, MD, Professor of Radiology at the University of Utah Medical School told the 2002 Health Policy Conference of the National Conference of State Legislatures (NCSL) that a single full CT scan carried a one in two

thousand risk of causing a fatal cancer 7). That's a reasonable risk if the doctors really need the CT scan to diagnose a serious medical problem so they can treat it effectively. It's a totally unreasonable risk if the doctor merely needs to protect himself against legal risk. Dr. Orrison fears that in ten to twenty years we may suffer an epidemic of cancer from our excessive use of CT scans.

I do have to report there is some controversy about the level of risk from the CT scan. Dr. Orrison was using the figures from the Conference of Radiation Control Program Directors published May 8, 2002. Another expert, Dr. Michael Brant-Zawadzki, used the risk figure of 1 death per 2,500 CT scans and then cast some doubt on the risk estimates because they are extrapolations from the epidemiologic data on what happen to the Japanese atomic bomb survivors (8).

From the public policy point of view I don't think it makes much difference unless the real risk is radically lower than either of these two estimates; its unreasonable for the patient to run the risk if the primary purpose is to protect the doctor from personal liability. It is also important to understand that giving the patient this kind of risk runs no extra legal risk for the doctor. If the patient gets a brain cancer ten or twenty years later it would be impossible to prove in court it was a particular CT scan that caused it and not one of the natural causes or some other radiation exposure.

Even though the real extent of defensive medicine is hard to

quantify it is clearly a major cause of our excessive health care costs and a cause of the differences in both cost and quality between our system and that of the other developed countries serious tort reform ought to remove the need for at least the worst of the excesses.

A number of lawyers have told me that the real problem with malpractice is malpractice. They're on to something. We have a major problem with medical error in this country. The 1999 Institute of Medicine report To Err is Human should be a wake up call to all of us. It reported we have between 44,000 and 98,000 deaths per year in the United States from medical error. This would make medical error at least the 9th leading cause of death and maybe as bad as the 5th leading cause

The next chapter will explore medical error in more detail For now it is sufficient to understand the experts believe most of the medical error is system error. The National Institute of Medicine in their summary of To Err is Human puts it well:

"One of the report's main conclusions is that the majority of medical errors do not result from individual recklessness or actions of a particular group--this is not a "bad apple" problem. More commonly, errors are caused by faulty systems, processes, conditions that lead people to make mistakes or fail to prevent them." (9)

This is not surprising. Our health care providers have a very human motivation to do the best they can for their patients. licensing systems do, with rare exception, enforce a minimum level

of competence. As we have learned more about our own complex biology, the systems to treat the things that can go wrong have become correspondingly more complex. And we all know systems involving people are subject to human error. Well meaning people make mistakes for all kinds of reasons--they don't understand instructions, they don't know what someone else did to the same patient or don't understand how it effects their work--there are hundreds of reasons. The system they are working in needs to be engineered to prevent these mistakes or catch them before they do any harm. To be effective any system run by people needs a good quality control mechanism to find and fix the sources of errors.

From the error rate we see, our health care systems do not have an effective quality control mechanism. The tort liability system has been one of our principal quality control mechanisms and the error rate shows it is an ineffective quality control mechanism.

Worse than being ineffective as a quality control mechanism the tort liability system is an obstacle to effective quality control. To find and fix system errors, the people in the system have to identify the errors and be open and honest about the circumstances leading to them. In a situation where personal legal liability attaches to errors it is not safe for people to be open and honest about what happened. Their lawyers will be the first to tell them "don't admit to anything." Hatlie and Sheridan writing in Health Affairs put it well "Far from encouraging transparency in health care, our adversarial legal system has normalized hiding

information about risk."(10)

To give one example, the doctors here in Wyoming tell me that the rate of autopsies outside of the coroner's criminal cases has dropped to almost zero, and this is true nationally as well (11). Autopsies were a traditional means for the doctors to learn what went wrong in hopes they could prevent it in similar cases in the future. Some of the decline is caused by better diagnostic ability before death, particularly the new imaging techniques, and some may be due to excessive self confidence by the doctors in their diagnostic ability. For the most part, however, an autopsy isn't safe. It might show an error and cause a lawsuit. If an error is suspected, it could provide the evidence that could prove the error in court. It's safer to bury the mistakes than learn about them. A by product of that is that the mistakes get repeated.

Given the size of our problems with medical error, obstacles the tort liability system places in the way of effective quality control are very important. Any serious tort reform must address them.

A related problem is the way the legal system can obstruct efforts to remedy errors. Not all errors are system errors. Problems can still be caused by individual incompetence, arrogance, or substance abuse. The estimates I hear are that these are 10% to 15% of all medical errors. The legal system makes it difficult for other doctors to police their own and deal with these problems. We had a case in our community that made the public press where a hospital staff committee tried to discipline a fellow

doctor. He hired an attorney, sued, and won a judgement in part on due process grounds. This was not covered by insurance and the doctors involved had to pay out of their own pockets. After that a number of our local physicians told me they would never ever, no matter what the circumstances, vote to discipline a fellow physician. I know of another case that was never reported publicly where a hospital committee tried to restrict the privileges of a doctor who was doing surgery beyond his training and professional competence. The doctor hired an attorney and threatened to
The hospital committee backed down. The doctor in question continued his practices, botched a surgery, and killed a woman. Then peer pressure ran him out of town, but as far as I know nothing formal was ever done to stop him from doing the same thing elsewhere. I believe the doctor is now out of practice due to age.

A problem related to its failure as a quality control mechanism is that the tort liability system is not good at identifying and compensating medical errors. The evidence from the Harvard Medical Practice study is that the tort liability system misses most of the valid claims. It showed that only about 2% of the injuries due to substandard medical care resulted in malpractice claims (12).

The Harvard Medical Practice study itself did not analyze how the claims that were brought fared through the legal system,
the researchers involved followed these and published the results in 1996 (13). At the time of publication, eleven years after the events occurred, five of the cases remained open and unresolved.

researchers got access to the confidential insurance company files. In two cases where the initial analysis showed no negligence the insurance company files had evidence that malpractice did occur. With adjustment for this additional information made, the results show that in 40% of the cases where there was a payment made, there was either no evidence of negligence or no evidence of an adverse outcome both of which are required to show malpractice. Of the cases in which there was evidence of negligence and adverse outcome, 36% resulted in no payment. Of the total claims filed, only 21% were valid.

These results are appalling. The system misses most of the real cases and 36% of the real cases that did get filed resulted in no payout. In forty percent of the cases were there is a payout, there was no malpractice. Of all the cases except the unresolved cases, the correct result was achieved 56% of the time; the system has a 44% error rate. No wonder the system is ineffective as a quality control mechanism and the doctors feel it is not doing justice.

The comments of the researchers on what they found are instructive although couched in the restrained language of the academic researcher. "In some cases there were substantial settlements only because the physicians in question would have made witnesses; in others, there was a tenacious defense even though negligence was privately acknowledged; and in still others, the cases were prolonged as part of a legal strategy. Such maneuvers are accepted as part of the art of litigation.

Nonetheless, they raise questions about whether tort law is the most effective system of compensating injured patient and creating rational mechanisms of preventing injuries." (14)

The reader needs to understand that although the Harvard Medical Practice Study and its followup are the best available on this topic these studies are subject to a great deal of controversy. They have been used (and misused) by the advocates on each side of the tort reform debate to bolster their case. The studies have major limitations. The Harvard study was done using the hospital medical records of a sample of nonpsychiatric patients discharged from nonfederal acute care hospitals in New York in 1984. It was first published in the New England Journal of Medicine in 1991. The first thing we have to say is that it is out of date; things may have gotten either better or worse since 1984. The existence of adverse events or negligence in individual cases was based on an elaborate system ultimately relying on the judgement of at least two physician reviewers. This system has been criticized as producing results that are not fully reproducible. Finally, although the number of cases reviewed was large (31,429) the number of resulting malpractice claims was small (51 so caution should be used with the resulting percentages. For example, take the figure that 40% of the malpractice claims where there was an indemnity payment were cases where there was no negligence and hence no malpractice. This is a sample and not a study of all malpractice cases in New York. It is subject to sampling error. Clearly the correct figure could be 30% or 50%.

Statistically it could even be 20% or 60%. My conclusion is whichever of these percentages is correct, from a public policy point of view, the error rate in the malpractice system is high.

All that being said, these studies were carefully done by reputable researchers and published in a well respected peer reviewed journal. They are the best we have on the subject. It shows a major problem that an effective reform must address.

A further problem with the tort liability system is that it is inefficient at compensating those who do get hurt by medical negligence. The best data we have indicates that of the money spent on medical malpractice insurance about three quarters goes to the people who run the system and only one quarter gets to injured victims. What happens to the money? First the insurance companies take a cut--selling costs, administrative costs, and, they hope, a profit. Then the defense attorneys and their expert witnesses get a share and these costs include amounts spent on cases that have no merit and get no payment but still must be defended. plaintiff's attorneys and their expert witness get a share. finally there is something left over for the people who are hurt.

Again a word of caution about the quality of the data. best information I have comes from a report published in 2002 by the U.S. Department of Health and Human Services (HHS). reports "However, only 28% of what they (hospitals and doctors) pay for insurance coverage actually goes to patients; 72% is spent on legal, administrative, and related costs." (15) When I

investigated this issue in 1987, I had to combine a report from Rand Corporation (16) with information from A. M. Best (a Company which collects and publishes insurance statistics) and came up with 26% going to the injured victim which I then broadened to a range of between 20% and 30%. More recently I analyzed information submitted through the Wyoming Insurance Commissioner to Wyoming's Health Care Commission by the Doctor's Company, one of our two major malpractice insurers. It provided information on all Wyoming cases closed by the Doctor's Company between Dec. 31, 1997 and Dec. 31, 2000 (17). This information gave a good picture on insurance company costs, defense costs, and payouts, but it provided no information on how the payouts are divided between the costs the injured victim must pay from the settlement (expert witness fees, court costs, etc. the lawyer's contingency fee, and what's left for the victim. I had to use a range of between 30% and 60% for the combined contingency fees and costs. The result was that range of what the victim got on average was between 23% and 40%.

The insurance company side of this equation is available with some careful analysis of the filings that the companies make with the State Insurance Commissioners. The division of the awards between costs, lawyers, and victims, however is protected by a veil of secrecy due to award confidentiality agreements lawyer/client privilege. Until we lift this veil, we can only estimate how bad the system really is.

Even if we take the high side estimate for what the victim gets, we can see we have a major problem. The results of a civil

justice system are measured in dollars and cents--that's what injured victims get. Any civil justice system where the people who run the system get the majority of the take, and that is clearly true here, is a scandal and a disgrace. The price of justice has gotten so high, at least in the medical liability area, that the system does justice for neither side.

A further complication is the evidence from the Harvard Medical Practice Study that 40% of the malpractice awards go to people who had bad outcomes but were not injured by malpractice If the 40% figure also applies to the amount of the dollar awards, when that is applied to the estimate that only 25% goes to the plaintiffs, then only 15% of the total spent on the whole system goes to people actually hurt by malpractice

Time is also a problem; the litigation process is slow. HHS reports "Even successful claimants do not recover anything on average until five years after the injury, longer if the case goes to trial." This would be an even more important problem if victims depended more on the legal system to meet the expenses errors cause them. However, HHS reports "More than half the amount the plaintiff receives duplicates other sources of compensation the patient may have (such as health insurance)." (18)

My policy conclusions from all this are that we need a different system to help those injured by malpractice and that as we experiment with reforms we can't do the victims much harm because they aren't getting much help from the current system.

Much of the discussion around tort reform has centered on the

jury system. Lawyers defend it as one of our key freedoms and a cornerstone of our democracy. Insurance companies and doctors denounce run away jury awards and warn that jurors sometimes don't understand the complexities of health care and sometimes make decisions based on sympathy for a plaintiff with a bad outcome rather than the existence of negligence. The positions on both sides of this argument are largely irrelevant. When it comes to medical malpractice, we don't use the jury system much in this country. Most cases get settled before going to a jury. For example of the 213 cases the Doctor's Company closed in Wyoming from 1997 to 2002, none involved a jury verdict; all awards came from settlements. The threat of a jury trial verdict does influence settlements, but another major influence is the way each side can increase the other's costs through depositions and other legal maneuvers in the run up to a possible trial. The report from the Doctor's Company was instructive because the company reported the defense costs for each settlement (technically called Allocated Loss Adjustment Expense). There were three cases settled for nearly $1 million each. In two of these costs were low, $1,700 in one case, $28,700 in another, but for one the costs were high, $146,000. The four half million dollar settlements showed even more variation-- $13,200, 13,900, 60,900, and 282,600. These figures show that some cases the outcome of a trial is clear and one side or the other gives up quickly, but in other cases the costs can get large enough to be a major factor in settlement negotiations. Thirty-nine of the 87 cases with settlements were

settled for less than $100,000. The defense costs on these ranged from tiny ($9 for a $1,900 settlement, $10 for a $25,000) to major ($112,000 for a $71,600 settlement, $52,800 for a $12,500 settlement). The tiny amounts reported are so small there must be some general review and legal costs that never get allocated to specific cases. In how many of these 39 cases did one side or the other settle for less than they should have because of the threat of additional litigation expenses? The data shows it is a factor both sides must consider, but does not show how much it happens.

So the tort liability system has multiple problems. What can we do to reform the system?

The most common reforms are the package that goes by the initials of MICRA which California passed in 1975. The principal reforms here are caps on non-economic damages, abolition of the collateral source rule (deduct compensation from other sources like health insurance from the malpractice verdict), periodic payment of damages (pay over time instead of a lump sum), and limits on lawyer's contingency fees. The big ticket items on this list are the caps and the abolition of the collateral source rule. Writing in Health Affairs William Sage reported, "Indeed, research has shown that the favorable effect of the Medical Injury Compensation Reform Act (MICRA) on malpractice premiums in California is primarily attributable to two provisions: a $250,000 cap on noneconomic damages, and the admission into evidence of collateral sources of payment for the plaintiff's economic losses."(19)

The collateral source rule is important because if it is

abolished then the victim's other sources of funds like health insurance or, in case of accidents, auto insurance are used to reduce the malpractice judgement. In a malpractice case these other sources can be half or more of the possible judgement.

Some states like Colorado have put a cap on total damages, but in most it's limited to non-economic damages. The argument is that the economic damages are real injuries that can be objectively measured and its only fair they should be compensated. The non-economic damages like pain and suffering are also real, but they cannot be objectively measured and are the source of much of the uncertainty over a malpractice claim and the principal source of excessive jury verdicts. A problem with this is that at least in Wyoming state some factors one would think would be economic damages can be classified as non-economic because they can't be proved. Who can prove what the damage to the potential lifetime earnings was from an injury that permanently crippled a baby at birth? Beyond health care expenses, how do you measure the economic damages done to someone who has no wages but is retired or stays at home to raise children or care for a disabled family member?

The doctors and insurance companies say the MICRA reforms work and are the proven prescription for the malpractice problem. They point to an impressive array of statistics that show MICRA reforms have dramatically slowed the growth in malpractice premiums. For example Rick Nauman from Louisiana Medical Mutual Insurance Company told an NCSL Health Policy Conference in November 2002 that data

from the NAIC (National Association of Insurance Commissioners) showed that between 1976 and 2000 California malpractice premiums rose on average 167% while those for the rest of the U.S rose on average 505% 20). HHS reached similar conclusions using data different source to compare California rates to major states without MICRA reforms (21). Our Wyoming Medical Association bombarded us legislators with a version of these statistics and I suspect this is true in other states where the enactment of caps is an issue.

The lawyers deny the claim MICRA is effective. They claim the improvement in California came from the passage of insurance reforms by a 1988 initiative. I can't buy this claim for three reasons: First, the data showing a slower rate of premium increase in California and other states with the MICRA reforms comes from reputable sources. Second, The Wyoming Health Care Commission a survey of malpractice rates in Wyoming and its neighboring states in the fall of 2003. They included all the states that border on Wyoming plus North Dakota which does not. All these states have a cap on damages, most have other reforms as well. They used Doctor's Company which does business in all the states, so there should be similar rate setting methodology. They surveyed eleven classes of medical malpractice risk. Wyoming, which has none of the MICRA reforms, had the highest rates in all but two categories, Emergency Medicine and General Surgery where Wyoming ranked third. Utah, where the reforms are recent, was highest in these categories. Third, look at what the MICRA reforms do.

systematically reduce the payout from insurance companies malpractice cases. I can see how people can argue that the result is unjust, but I can't see how anyone can argue that the MICRA reforms don't reduce what the malpractice insurers would otherwise have to pay out. By reducing the payouts, the reforms ought to reduce the premium growth.

Another argument frequently heard against the MICRA reforms is that the malpractice insurers won't promise to reduce their rates as a result. This claim is accurate. Almost universally malpractice insurers have said that while reforms should slow the rate of premium growth they will not result in rate cuts and the reforms will have no immediate effect. I heard Wyoming's largest malpractice insurers testify this way before my committee in December 2002. What the opponents of reform don't tell you is the rest of the story which is why reforms don't produce immediate rate cuts. When they testified before my committee, malpractice insurers were very clear. They are skeptics. They base their rates on their claims experience. They don't believe the reforms will be effective until they see the results in their claims experience. A major reason for this is the courts sometimes throw the reforms out or attenuate their effect. A table published by the National Academy for State Health Policy in July 2002 is instructive. It shows that 24 states currently have caps damages but in 7 states caps were enacted but later held unconstitutional. Thirty states have abolished the collateral source rule but in three others this reform passed but was later

held unconstitutional (22). An insurance company doesn't know if a reform will be effective until it has been tested in court and that takes time.

I personally have two problems with the MICRA reforms. First, I am convinced that some victims of actual malpractice will be hurt by not getting all their damages covered. Second, reforms don't solve most of the problems with the system. They will not help the poor percentage of the money in the system that goes to the injured victim. By limiting what the victim gets the caps may make this problem worse. MICRA does nothing to reduce the failure of the tort system as a quality control mechanism little to remove the obstacles it places in the way of effective error reduction. The MICRA reforms don't reduce the legal system error rate (compensation where there was no malpractice and lack of compensation were there was malpractice and a claim was made). MICRA does nothing to improve the low percentage of those hurt by errors who even ask for compensation.

MICRA will moderate the growth in malpractice premiums. There is some evidence that it will reduce the amount of defensive medicine. There is a widely reported study, known as the Stanford study, by David Kessler, an economist and Mark McCllean, MD which showed a decrease of 6.9% in the spending on heart attacks and 10.1% on coronary artery disease in states with MICRA style tort reform as opposed to states with little or no reform. To quote the Wall Street Journal "The reduced spending had little effect on readmission or mortality rates. The money spent on defensive

medicine was wasted." (23)

There is also now a suggestion that MICRA may not always be adequate to solve the premium rate problem; its effect can be overwhelmed by other factors in the insurance and litigation systems. The Center for Studying Health Systems Change (HSC) every two years studies 12 nationally representative metropolitan communities to track changes in local health care markets reports its findings in a series of very useful Issue Briefs Orange County, California is one of the communities. HSC reports "However, HSC findings indicate malpractice insurance pressures in Orange County are similar to those in many of the other communities studied." (24)

On balance I view the MICRA reforms as unsatisfactory, but I have voted for them in the past and will do so again if they are my only choice. With Wyoming's low physician reimbursement and our status of the only state in our region without meaningful reforms I am afraid that as our existing physicians retire we will unable to recruit adequate replacements and MICRA will help fix this problem.

Limiting attorney contingency fees is one part of MICRA that appears to help with the problem of the low percentage going to the injured party. I suppose it does, although it doesn't directly reach the half of the money that goes for insurance company administrative costs or defense costs. I think, but cannot prove, its real effect is to reduce payouts and defense costs by making some of the complicated cases too expensive for the plaintiff's

lawyers to risk given the limits on their fees.

The National Academy for State Health Policy chart shows that 16 states including Wyoming have this reform. They are wrong about Wyoming. In this area we have a sham reform without any real effect. The history is this: In 1987 I introduced a bill limiting attorney's contingent fees. I introduced the bill late in session and I didn't want it to go to the Judiciary Committee because too many of its members might have a conflict of interest on the subject. I asked Senate President John Turner to use it to balance the committee workload. Balancing the workload is a real problem the Senate President has. In any given session there will usually be one or two committees that for one reason or another have a light work load. President Turner sent the bill to Mines Committee. The Mines Committee wasn't very busy. I introduced the bill on a Wednesday and they scheduled the hearing on it for the next Tuesday. At the hearing I gave the pitch for the bill. I was followed by Perry Dray representing the Wyoming State Bar Association. He said that the bill was unnecessary because the Wyoming Supreme Court had just adopted a rule that had the same formula for limitations that the bill did, and waved a copy of the rule. That was easy for the committee--we don't need to waste time passing unnecessary legislation so they killed the bill. Later when the new rule became generally available we looked up what it said. Sure enough, it had the same limitation formula the bill would have provided, but it also had an exception. The exception provided that the attorney and his client could contract

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verdict was large enough, they could be liable not only for their share, but also for the share of the other parties above the settlement amounts. One radiologist who did everything right except maybe being extra aggressive about seeing the attending physician got the word about the X-ray results was reported to have had to pay $300,000 to avoid this risk. In that case joint and several liability amounted to legal extortion and denied the minor defendants any meaningful right to a day in court or justice.

Repealing joint and several liability ends an abuse of the system, saves some money, but doesn't address the major problems with the tort liability system

Many states have created a review panel that must review all potential malpractice cases before a suit can be filed. These can either have teeth in them (sanctions like making the results of the review admissible in court) or no teeth. The thought behind this proposal is that a review panel will get rid of potential suits that don't have merit. These are of two kinds. In some cases the plaintiffs think they have been injured and want an objective outside party to look into it. If the review panel says "No, the doctors did everything they should have and did it right," the potential plaintiff goes away satisfied. In other cases, the suspicion is that the case is filed without proper investigation, maybe even for the purpose of obtaining a settlement that is less than the cost of defending the case. A panel can weed out these cases. We tried a toothless panel here in Wyoming and it seemed to be working until our Supreme Court decided it was unconstitutional.

This reform, while useful, does not address many of the problems with the current system.

Another possible reform is an English rule, copied after the system used in England. It means that the loser, in addition to the judgement, pays the winning side's attorney fees. The effect of this is to make it unsafe to bring lawsuits that are not well founded. The plaintiff runs the risk of having his injuries compounded by defense attorney fees. It also encourages prompt settlement of cases that are well founded. The defense runs the risk of having the plaintiff's attorney fees added to the ultimate judgement. It makes it unsafe for both sides to indulge in the strategy of running the other side's legal expenses up as a tool to force unjustified settlements.

The English rule has potential beyond medical malpractice; it ought to have a positive effect on all civil litigation. It will be hard to enact. I can tell you from practical experience it will be opposed by plaintiff's attorneys and also by defense attorneys who will support other tort reforms. The lawyers understand it will reduce the business for both kinds of attorneys.

Three cautions about the English rule. First, it is only one of the differences between the English legal system and ours. We cannot expect it alone to bring the more moderate tort liability system that England has. Second, it would be dangerous to do it without a constitutional amendment and even with an amendment a sanction for a court ignoring it or throwing it out might be in order. It will hurt lawyers's incomes and the courts do have a

tendency to protect their fellow lawyers's incomes. Third, it should apply equally to all sides. We have a special one sided version of the English rule in our federal civil rights laws. Under section 1983 if a person has his civil rights violated by a state or local government, the fees of the attorney successfully bringing suit against the violation are paid by the offending government. This applies even if the sued government wins on most of the items. If the plaintiff prevails in any part, the government pays the full attorney fees. Some law firms and civil liberties organizations have turned section 1983 into gold mines for their lawyers. Jail condition cases, employment cases, legislative redistricting cases, and establishment of religion cases are favorites.

The remedy I prefer for malpractice system reform would be to replace the current system with one which focuses on patient safety. The new system would apply only to health care malpractice, it would not touch other areas of tort liability. I would create a Health Care Errors Commission whose primary task would be to find and fix the causes of health care errors--in other words to re-engineer the system so errors are prevented in the first place or are caught before they do any harm. In the process the Commission would identify people hurt by avoidable error and compensate them. Compensation would be calculated as Wyoming now does in Worker's Compensation--we would pay for all the medical expenses caused by the error and pay for other losses on a formula. People who think they have been hurt by an error could petition the

commission for an investigation and a hearing, but commission activity would not be confined to cases people choose to bring. As in workers compensation, compensation from the commission would be an exclusive remedy, meaning people could not sue the health care providers. The commission would be funded by premiums from health care providers much as worker's compensation is now funded by premiums from employers.

Commission decisions could be appealed to the courts, but the judicial review would be on the record of the final commission hearing and confined to seeing if the commission had abused its discretion or misinterpreted the law. These limitations on the appeal system are normal ones for an appeal system and are designed to prevent re-creation of the tort liability system at the appeal level. I recommend that the state pay for the attorneys, when needed by an injured patient on a fee schedule the way Wyoming does in worker's compensation so that none of any award has to go to pay for attorneys. I also recommend that if the patient wants to protect his or her own privacy, he or she could cause any hearing, except a court appeal, to be private with the results disseminated in aggregate and in specific only to the extent necessary to prevent future errors and with identities concealed

The Commission should be made up of professionals, both health care providers and others. It would be a mistake to limit it to just health care providers and an especially big mistake to limit it to just doctors. Medicine is increasingly a team effort and the insights of professionals like nurses and allied health providers

will be essential. In redesigning systems to prevent errors, points of view of engineers, systems analysts, accountants, and teachers will all be useful. Additional public representation may be useful.

This kind of a system should remove the fear of individual liability that is a major obstacle to patient safety in the current system. Instead of having to worry about blame and personal liability, the health care providers involved could afford to be open about what happened and participate in developing recommendations to prevent the error from happening again.

The efficiency of the system should be similar to worker's compensation. The most recent figures I have for Wyoming is that 83% of the money spent goes for benefits for injured parties and 17% to administrative costs. I expect the Health Care Errors Commission administrative costs to be a little higher than this due to the efforts to redesign to prevent future errors

This system ought to reduce defensive medicine costs. providers will lose their motivation for defensive medicine and the Commission could investigate the more common practices and see if they really add anything to patient safety

For most patients hurt by medical error this revised system should be a better deal than the current system. For starters, they could get justice without having to pay attorney fees--if a lawyer were needed, the state would pay him.

Reducing the cost to use the system would result in compensation in many cases with real, but relatively small,

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benefit design vs. cost to the society at large. It is safe to say that the big jackpot awards that a few people now get will no longer be available.

This new proposed system is opposed by many trial lawyers. It would cut them out of what has been an important and profitable line of business. It also implies that the legal system, the foundation of their profession, doesn't work in this important area. The result is that professional pride will be added to their economic motivation--a powerful combination. So far I have not had opposition from malpractice insurance companies, but I expect that also. If adopted, this new system abolishes their role and puts them out of business.

To the best of my knowledge this new system has never been tried anywhere in the United States, although some academics and health care experts have made somewhat similar proposals. George Huber writing in Health Affairs proposed injury compensation tables and specialty courts (25). Former United States Senators George McGovern and Alan Simpson have written, "Distrust by doctors is so great that medicine now may need a separate system of justice that can more reliably distinguish between good care and bad care." (26). Michelle Mello of the Harvard School of Public Health has advocated limited administrative (no-fault) systems that would "compensate events that meet the Swedish definition of avoidability" (27). Dr. Mello did question the political feasibility of what I am advocating--a governmental system of administrative compensation as an exclusive remedy.

In the 2003 Wyoming legislative session I and Senator Boggs (D-Rock Springs) first proposed this new system. proposed constitutional amendment got out of committee but defeated by the full Senate on a 15 to 15 tie vote in committee of the whole. I view this result as a reasonable showing for the first attempt at a new system. The committee I co-chair, the Joint Interim Labor, Health and Social Services committee, will present a revised and streamlined version of this proposal to the 2004 session of the Wyoming Legislature.

Footnotes

Chapter 4

1. PricewaterhouseCoopers,"The Factors Fueling Rising Healthcare Costs," April 2002, page 10. This document is a report prepared for the American Association of Health Plans.

2. The rates are for the Doctors Company--obtained by the author from the Wyoming Health Care Commission.

3. Comments of Mary Alexander, President, Association of Trial Lawyers of America, at the National Conference of State Legislatures 6th Annual Health Policy Conference, Session: Medical Errors and Jury Awards; Facing Down a Crisis in Medical Malpractice, November 17, 2002, quoted from the printed comments handed out by Ms. Alexander at the session.

4. West Virginia Insurance Department, presentation to National Conference of State Legislatures

5. U.S. Department of Health and Human Services (HHS), Office of the Assistant Secretary for Planning and Evaluation, "Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs by Fixing Our Medical Liability System," July 24, 2002, page 14.

6. "The Value Line Investment Survey," September 26, 2003, page 607

7. Dr. William Orrison, MD, Professor of Radiology, University of Utah, statement contained in a presentation and the handed out copies of the slides he used, presentation given to the Annual Health Policy Conference, National Conference of State Legislatures, November 2002.

8. Michael Brant-Zawadzki MD and Jeffrey M. Silverman, MD, "CT Screening: Why I Do It," American Journal of Radiology, July 2002; 179: 319--326, quoted by Orrison in presentation cited above.

9. page 2 of a brochure entitled "To Err is Human: Building a Safer Health System, dated November 1999 and distributed by the Institute of Medicine to summarize their publication of the same title.

10. Martin J. Hatlie and Susan E. Sheridan, "The Medical Liability Crisis of 2003: Must We Squander the Chance to Put Patients First?" Health Affairs, July/August 2003, Vol. 22 #4, page 38.

11. Atul Gawande, Complications, A Surgeon's Notes on an Imperfect Science, Picador, New York, 2002, page 191. For an excellent discussion of the other reasons for the decline in autopsies and

26. Geroge McGovern and Alan K. Simpson, "We're Reaping What We Sue," Wall Street Journal, editorial page, April 17, 2002

27. Michelle Mello, presentations to NCSL Annual Health Policy Conference, Nov. 2002 and NCSL annual meeting, quote is taken from her presentation slides passed out at the session.

the continuing need for them read Gawande's full chapter on this subject, pages 187--201.

12. A. Russell Localio, et al, Relation between Malpractice Claims and Adverse Events Due to Negligence: Results of the Harvard Medical Practice Study III, New England Journal of Medicine, 1991; 325: 245--251.

13. Troyen A. Brennan, MD, JD, et al, "Relation between Negligent Adverse Events and the Outcomes of Medical-Malpractice Litigation," New England Journal of Medicine, 1996, 335: 1963--1967

Ibid, page 1967

HHS, Ibid, page 11.

16. James S. Kakalik and Nicholas M. Pace, "Cost and Compensation Paid in Tort Litigation, Institute for Civil Justice, Rand Corporation.

17. Michael O'Donohue, Assistant Vice President, Regulatory Compliance, The Doctors Company, letter to Ken Vines, Wyoming Insurance Commissioner, Oct. 7, 2003

HHS, Ibid, page 11

19. William M. Sage, "Medical Liability and Patient Safety," Health Affairs, July/August 2003, Vol. 22 No.4, page 32.

20. Rick Nauman, Vice President, Louisiana Medical Mutual Insurance Company, presentation at the Annual Health Policy Conference, National Conference of State Legislatures, November, 2002, reported source, NAIC Profitability By Line By State.

21. HHS, Ibid, page 13 citing Medical Liability Monitor's "Trends in 2001 Rates for Physicians' Medical Professional Liability Insurance," Vol. 25, No. 10, October 2001.

22. Mimi Marchev, "The Medical Malpractice Insurance Crisis: Opportunity for State Action," National Academy for State Health Policy, July 2002, page 10.

23. The Wall Street Journal, January 16, 1997, page A 18.

24. Robert Berenson, Sylvia Kuo, and Jessica May, "Medical Malpractice Liability Crisis Meets Markets: Stress in Unexpected Places," Issue Brief No. 68, September 2003, Center for Studying Health System Change (HSC), page 2.

25. George A. Huber, "Creating a Safe Environment," Health Affairs, July/August 2003, Vol. 22, No. 4, page 43.