TO: DENNIS KANIN

FROM: JAMES C. HUROWITZ

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RE: MEDICAL MALPRACTICE PROBLEM

Medical malpractice has become a matter of grave national concern today. This is due to the dramatic increases in the cost of medical malpractice insurance for health care professionals in the last fifteen years and also the reduction in the number of insurers willing to offer medical malpractice insurance to health care professionals, particularly physicians. Physicians, as groups and individuals, in many instances are faced with the possibility of being unable to obtain coverage. This in turn, creates a situation where patients injured through the negligence of health care providers might not be able to obtain adequate compensation for such injuries.

HEW Secretary Casper Weinberger, has termed malpractice insurance "a major crisis problem" and declared that "we cannot sit by and watch a significent number of doctors be unable to get very necessary coverage". Approximately one year before Secretary Weinberger made these remarks, HEW published a massive $2 million report on the entire medical malpractice problem, prompting hopes that some action was forthconimg. But now, no action has been taken and a major crisis has developed.

Most primary insurance companies have removed themselves from handling medical malpractice insurance. Now, less than twelve companies are handling 90% of the business. Malpractice insurance is considered risky and uncertain and represents only a small percentage of their business.

The reasons for the sharp increase in malpractice premiums are:

1) the virtually universal use of attorney contingency fees which raise the cost of litigation and encourage high court awards. The total compensation for malpractice claims in 1970 aggregated $80 million. Legal fees cost insurance carriers an additional $10 million.

2) the ease in bringing malpractice suits is growing. Legal grounds for compensating patients have been gradually liberalized. These include:

a) doctrine of res ipsa loquitor which shifts burden of proof from plaintiff to defendent.

b) doctrine of informed consent which says that the physician can be held liable if a patient is able to prove he was not adequately informed of all risks.

c) the oral guarantee of good results in which the patient does not have to prove that the physician was negligent but simply that the physician did not fulfill a claimed oral guarantee of a successful outcome of treatment, even though the physician denies giving such a claim.

d) discovery of a rule which allows for an extension of the statute of limitations in malpractice cases. This permits long delays in the filing of claims and also has an adverse effect on insurance rate settings. The difficulty arises in predicting

the magnitude and severity of losses for a given year.

However, the rise in the number of malpractice suits is no indication of a rise in the number of injuries. In a survey conducted in two hospitals, involving 23,750 discharged patients, 1,780 received medical injuries. (7.5%) Of these, only 31 people brought suit, which is 1.7% of the number who actually received injuries and 0.14% of the total number of discharged patients. It is the 1.7% figure which is [illegible] increasing at 8-10% per annum. The number of malpractice suits is approximately 20,000 per year. Today one out of three physicians faces a malpractice suit in his career. It is important to remember that the increase in malpractice settlements, which results in higher premiums, is the result of more lenient laws and a greater public awareness of the benefits of bringing suit . It is not due to an increase in the number of injuries.

The size of awards in malpractice claims has increased 13-14% per year. In 1970, the average award was approximately $5,000. In 1973, it had increased to $8,000 and, in 1974, multi-million dollar verdicts had been handed down in California at the rate of one per month. One case resulted in an award of $4 million. According to Dr. Malcolm Todd, who is President of the American Medical Association, only 16¢ of every dollar of a settlement goes to the accident victim. Other sources place the figure as high as 38%. Lawyers receive about 50% of the settlement and the remainder goes to expert witnesses and insurance overhead. To put this into perspective, in auto insurance, 44¢ goes to the victim: a situation long thought to be scandalous and has resulted in no-fault insurance in some states. Social Security pays 97¢ to the patient, Blue Cross 93¢, and other health insurance settlements pay an average of 83¢.

Premiums for malpractice coverage are prohibitively expensive and threaten to continue to rise. In the past ten years, the average national cost of malpractice liability insurance has risen 950% for surgeons and 540% for other physicians. In New York, new physicians are paying $10-15,000 per year. Some specialists like anesthesiologists, pay $34,000. Total cost has increased from $61 million in 1960 to $500 million in 1973. There exists a wide disparity among states regarding medical coverage. In California, coverage in 1972 was eight times greater than Wyoming and six times greater than Maryland. Estimates forecast annual rises of 10-25% per year for the rest of the decade if nothing is done. At that rate, new physicians in New York could pay $31,000 per year by 1980. This would compound the problem of a shortage of physicians.

Of course, the ultimate rise in premiums ~~goes to~~ is paid by the patient, medicare, and other programs paying for health care. The patient also receives no relief during the period between the injury and the settlement if he brings his case to court. This is due to the inordinately long time required to settle malpractice claims. The reasons for this are congested courts, the length of time lawyers take to prepare their cases, and the fact that some injuries take a few years to appear in patients.

Malpractice insurance costs are between 2 and 4% of a physicians' overhead. Hospitals spend approximately $4 daily per bed for malpractice protection. Studies have found that 74% of medical injuries occur in hospitals. Of this, 39% occur in the operating room and 34%

happen in the patient's room.

One result of high insurance premiums is that some physicians are practicing 'defensive medicine'. Physicians view each patient as a potential malpractice claimant and order possibly unnecessary procedures or refuse to perform risky but helpful ones. This results in poorer quality care and higher overall cost. Another result of this increase in insurance premiums is that shortages, particularly spot shortages, of physicians could result. Many physicians and hospitals in some localities face the prospect of being unable to obtain insurance at any price or unable to obtain it at prices they can afford. Without reasonable malpractice premiums, young physicians will not be able to afford to start private practices. Many might then want to relocate to other states that have more reasonable availability of insurance. The early retirement of older physicians is also a definite result.

Some physicians also blame the higher premiums on the use of physicians' assistants (PAs). These people theoretically free a physician from duties which trained assistants can perform. This allows the physician to focus his skills where they are most needed and also to serve more people. However, it is argued that this increases the possibility of malpractice suits because the physician is treating more potential mal-practice suiters and the use of PAs increases the possibility of suit. In 1971, the Comprehensive Health Manpower Training Act (PL 92-157) and the Nurse Training Act (PL 92-158) were enacted. These laws provided funds to support PA programs with the intention that physician shortages would be partially allayed. The only significent legal impediment to the effective use of PAs is the absence of legislation. There are twenty-five states which do not legally recognize PAs. Studies have shown that, in these states, there is no greater malpractice liability imposed on either the physician or assistant. Therefore, it appears that alleged concerns that PAs are not effectively integrated into health care systems is without foundation. According to Eli Bernzweig, the problem could be due to:

1) the attitudes of physicians themselves towards PAs.
2) matters pertaining to training and credentialling of PAs.
3) economic concerns of medical and nursing conditions
4) other non-medical legal issues.*

Various bills and proposals gave been offered to solve the malpractice insurance problem:

1) the "National Medical Injury Compensation Insurance Act of 1975". This act, introduced by Senators Inouye and Kennedy on January 17th, provides no-fault insurance for those institutions and physicians who want to participate. The concept is that compensation would be based on actual loss so that court costs could be eliminated. (S215)

2) the "National Medical Malpractice Insurance and Arbitration Act". This act, also introduced by Senators Inouye and Kennedy on January 29th, requires both the claimant and health care provider to arbitrate malpractice disputes. (S482)

3) Contingency Insurance- if sizeable blocs of physicians are deprived of insurance, the government could step in as it did in the case of flood insurance. A federal stand-by program could offer coverage to affected physicians at reasonable rates set up by a commission.

4) Providing reinsurance- the government could establish

* "Malpractice Problem & the Use of Physicians' Assistants" Appendix- Commission report on Medical Malpractice, p. 168

a plan to back up private insurers with reinsurance for settlements over a certain amount, say $25,000.

5) Mandatory directive- states could decree that if a company withdraws from malpractice insurance it will be prohibited from writing any other business in the state.

6) Encouraging out-of-court settlements by providing screening panels which are composed of physicians and lawyers who will jointly decide on the merits of a case.

Criticisms of the two most feasible solutions are:

1) No-fault Insurance
   a) there is no idea of the cost of such a system.
   b) schedule of payments frequently discriminates against payment because it seldom keeps pace with rising costs and is often unreasonable at the outset.
   c) it does not hold anyone accountable for negligence and therefore does not solve the initial problem

2) Arbitration
   a) it is a lengthy and expensive process
   b) tends to treat patient more favorably than courts
   c) undue coercion might be used to persuade patients to accept a settlement.

RECOMMENDATION: It seems that all of the above solutions to the high costs of medical malpractice insurance do not focus on the primary cause. The astronomical increase in premiums only underlies and brings to light the archaic problem of poor quality health care. If health care were subjected to controls, regulations, and review by specified commissions; if the shortage of physicians was lessened by allowing qualified assistants to participate, then the quality of health care would improve, the number of malpractice suits would decline and similarly, the price of insurance would decline.

I propose the following three-step solution:

1) Initially, establish a joint underwriting association (JUA) in each state where market conditions are critical. This association would only be a temporary emergency measure which would stay in effect until more permanent steps could be implemented. In each state where necessary, a medical injury insurance reparations commission would be created. It would be composed of the insurance commissioner, commissioner of health, and nine members to be appointed by the governor, two of whom would be representantives of the JUA, two from the medical profession, two members of the bar, one agent and two representatives of the public.. This commission would be charged with developing an insurance reparations system which can be operated at a reasonable cost, equitable to all the parties involved.

The temporary JUA would be composed of all insurers writing personal injury liability insurance. It would be implemented in those states either where no malpractice insurance is available at all, or malpractice insurance rates are increasing at a rate equal to the rise in the cost-of-living in that year. These guidelines would be retroactive and apply to the established rates of 1975. In those states where the rise in rates exceeded the rise in the cost-of-living, there would still be the possibility of a new rate which is still higher than the rise in the cost-of-living. The difference is that the new rate

then all states, right?

would be decided by the commission of the JUA which is composed of representatives from all involved parties. The two members on the commission who represent the medical profession are dependent upon the type of insurance being discussed. If it is hospital insurance, then they would be representatives from hospital; if physician malpractice insurance, then the representatives would be doctors, etc.

If this type of plan is unsuccessful, then an emergency, federal solution may be necessary; perhaps along the lines of the existing flood insurance program.

2) Shortly after the implementation of a JUA, a House or Senate Committee could be set up to investigate the actual problems existing in health care which often results in malpractice suits. Since 74% of alleged malpractice occurs in hospitals, injury prevention should mostly focus on them. Investigation and analysis of the frequency and causes of general categories and specific types of adverse incidents causing injuries to patients should be carried out. In addition, attention should be given to licensure, relicensure, certification, and credentialling of health personnel to assure their competence. Also, special attention can be given to monitoring drug prescribing, and increasing the number of nurses and assistants. This can be accomplished either through more efficient use of PL 92-157 and PL 92-158 or through new legislation which would expand clinical training. At the conclusion of its investigation, this committee would draft a bill based on its findings. Included in the bill would be a provision requiring physicians, nurses, and other people in health-related fields to participate in medical seminars and to take periodic examinations to insure their competence. The purpose of this committee would be to reduce as much as is humanly possible injuries which result from negligence and carelessness. The quality of health care would then be upgraded because, theoretically, unqualified personnel would be removed. There would be more assistants to lessen the burden on physicians, contributing to better health care.

3) This final step places malpractice insurance into a national health insurance plan when one is made law. There are a number of ways to do this:

a) A national insurance plan could be written so that a physician became a government employee. If this were the case, he could not be personally held liable. If he were sued for malpractice, the government, in effect, would be sued. Physicians, however, would have mixed views relating to this. On one hand, they would favor being government employees because they would not have to pay malpractice premiums. For example, an anesthesiologist would receive approximately $30,000 more per year. On the other hand, physicians cherish their independence. They would most likely choose independence over greater income if given the choice.

b) this recommendation involves a compromise between the two above choices. It seems that, because physicians treasure their independence, the best method would be to allow them to stay privately employed and also to have the opportunity to take advantage of some government employee benefits. If malpractice in-

surance became nationalized, its rates would be much lower for the following reasons. For a physician to receive national malpractice insurance, which would be the only kind available to him, he would have to meet rigid regulations, similar to those outlined in part 2, above. If he met these requirements, he could buy insurance at rates set and controlled by the government. Hopefully, if he does meet the requirements, his quality of health care would be excellent, which would lead to fewer malpractice suits and lower insurance premiums. He would also be more apt to undertake more preventative measures in national health medicine because the factor of additional cost to the patient would no longer be relevant. This would also lead to better health care and lower insurance rates. If a physician had national malpractice insurance and had successful suits brought against him, a certain number of times, he would be subject to review and possible loss of license. There will always be some cases where malpractice suits will be brought and in these circumstances physicians would not be held liable. It will also be required that, if a physician feels an operation is risky, he can secure the patient's signature which will remove any responsibility to him if something goes wrong. The rates will be uniform for the same types of physicians in an area where the cost-of living is the same. For example, all internists in New York City would pay the same rate. Likewise, for the pediatricians. But those rates would be different from the internists in, say, Lowell, Massachusetts. If many suits were brought against the internists in NYC, the price of insurance would not go up any faster, but some of them would lose their licenses.

If malpractice insurance were nationalized, government employed lawyers would defend a physician against a suit. A government malpractice insurance office would be established. It would be staffed by salaried lawyers. Their job would consist of arguing all malpractice suits and the running of the office. Since they are paid by salary, they would not collect the 40-50% of the settlement which lawyers are now collecting and accounts for the high costs of existing malpractice insurance.

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In summary, this model presents physicians who are privately employed, but who receive insurance from the government. His rates would be lower, and the quality of health care he imparts would be better. He is subject to rigid government regulations, which contribute to lower rates for there would be less negligence suits. He is aware of the omnipresent threat of loss of license if too many suits are brought against him. Lawyers receive government salaries so their rates would not be dependent on the number of cases they argue. Also, they do not draw the 40-50% of the settlement which is the major factor in high insurance rates.

The cost of such a plan would not be great. Physicians would still pay the insurance rates and this, for the most part, would pay for the operation of a malpractice office and the employment of lawyers. The commission supervising the implementation and coordination of the regulations and periodic education of health personnel would be, in part, paid for with this income. The rest would be appropriated through the health insurance budget.