



A SHORT GUIDE TO UNDERSTANDING TODAY'S MEDICAL MALPRACTICE INSURANCE “CRISIS” (AND USEFUL QUESTIONS TO ASK)

September 25, 2002

Topics

Introduction	2
Late Breaking News	3
The Problem and The Cause	4
The Insurance Industry: Unregulated Corporate Greed	4
Medical Malpractice Insurance – Problems That Transcend Time and Place	5
The Cause – The Insurance “Cycle” and Mismanagement	7
Exiting Med Mal Insurers – Mismanagement and Fraud to Blame, not Juries	9
How 9/11 Factors In: Exploding Rates/Exploited Policyholders	11
Juries Are Not Causing Insurance Rates to Jump	12
Myths About Litigation, Defensive Medicine and Costs	14
A Chronology of Insurance Industry Leadership on “Tort Reform”	15
The Solutions	
Rejecting the “Tort Reform” Solution – Serious Responses by Serious Policy Makers	17
What Happens to Insurance Rates After Tort Restrictions Are Enacted?	18
The Last Insurance Crisis – “Tort Reform” Had No Impact	20
California – A Failed Model For Restrictions On Patients’ Rights	21
The Cruel Impact of Damages “Caps” on Patients – Three Voices	23
Doctors and Malpractice	
Do Doctors Want Insurance Help or Just Special Treatment in the Courts?	24
Doctors’ And Their Problems	25
How Much Medical Malpractice Is There?	27
Recent Investigative News Stories – Some Examples	29

Introduction

Insurance rates are rising in many states for doctors, trauma centers, hospitals, HMOs, nursing homes and other health care providers.

No question, insurance rates are up. It must be because claims are up. Insurance companies must be paying out more money to patients. Otherwise, why would they raise rates? It makes intuitive sense. The problem is, it's not true. And it's nothing new.

In 1989, Michael Hatch, then Commerce Commissioner of Minnesota, released an investigation of two malpractice insurers including the country's then largest, St. Paul. Hatch found that during the prior six years, at the time of America's last insurance "crisis," these companies had increased doctors' malpractice premiums some 300 percent. Yet the number of claims against doctors had not gone up, the amount paid out by insurance companies had not increased, and the number of frivolous claims had not increased.

In response to a question by ABC's *Nightline* as to how this could happen, Hatch responded, "Because they had the opportunity to do it. There was a limited market. People need coverage. The companies knew they had a corner on it, and they raised their rates accordingly."

Sadly, not much has changed in the world of insurance, except one thing – add insurance companies to the list of corporations whose business and accounting practices, mismanagement and greed have wreaked havoc on the American public.

Some are starting to fight back. Americans for Insurance Reform, a coalition of nearly 100 consumer groups from around the country, is attempting to strengthen state oversight of insurance industry practices with regulatory and legislative proposals that would end the current crisis – interestingly, proposals not endorsed by organized medicine. (For more information on AIR and how you can help, *see* <http://insurance-reform.org> or call 917/438-4608.)

This guide contains the latest information about medical malpractice insurance for doctors, hospitals and other health care providers. It also suggests key questions that should be asked of those who advocate "tort reform" as a solution to an industry-wide insurance problem that recurs, like clockwork, once every decade.

Copyright © 2002 by Center for Justice & Democracy. All rights reserved.

Center for Justice & Democracy is an independent, non-profit, non-partisan, national consumer organization dedicated to raising public awareness about the importance of our civil justice system.

Late-breaking news

- **September 2002:** In Mississippi, where a contentious medical malpractice “tort reform” battle was waged all summer, Medical Assurance Co. of Mississippi notified doctors that it will raise its rates by 45 percent in 2003 “regardless of the special session outcome” since “tort reform” does “not provide a magical ‘silver-bullet’ that will immediately affect medical malpractice insurance rates.”
- **September 2002:** The National Association of Insurance Commissioners (NAIC) agreed to examine the current insurance crisis as a self-inflicted problem created by the insurers.
- **August 2002:** The editor of *Medical Liability Monitor*, which surveys insurance carriers about their rates, told the *Los Angeles Times* that her published data are being misused by medical groups to suggest that California doctors pay far less, on average, than their peers in Florida, Illinois, New York, Texas and Michigan. Carol Golin says her publication doesn’t even calculate average premiums because circumstances and jurisdictions are so different that “we don’t think they exist.”
- **August 2002:** In Nevada, which enacted severe caps on medical malpractice compensation, two major insurance companies proclaimed that they would not reduce insurance rates this year or next. This announcement came less than a month after the bill’s passage.

The Insurance Industry: Unregulated Corporate Greed

It is sometimes presumed that certain actions by insurers, like price-gouging, reduced coverage, arbitrary policy cancellations, and even threats by insurers to abandon a state altogether, are inevitable in our free market economy.

There is no inevitability to this, however. These corporate abuses are allowed to occur largely because U.S. lawmakers have chosen to provide the insurance industry with little regulatory oversight and to afford them protections that no other industry in the United States enjoys.

For example:

- The insurance industry is accountable to no federal agency, no federal regulatory laws, few federal anti-trust prohibitions (allowing them to price-fix, for which other business leaders could serve jail time), and is subject to virtually no oversight by the Federal Trade Commission (unless specifically requested to do so by a majority of the House and Senate Commerce Committees.) 15 U.S.C. 1012-1015.
- In most states, the insurance industry is subject to weak state regulatory authority, and data disclosure requirements for insurers are almost non-existent. Even in states where insurance departments have adequate authority over rates, offices usually lack a sufficient number of actuaries and other staff to exercise proper oversight. As a result, the insurance industry dominates most insurance departments and rates reflect this.
- The insurance industry continues to have massive political influence through enormous financial contributions to key lawmakers. According to the Center for Public Integrity, “the insurance industry boasts the most industry representation in the halls of statehouses across the country with 2,269 businesses and associations registered.”

It does not have to be that way. Americans for Insurance Reform, a coalition of nearly 100 consumer groups from around the country, is attempting to strengthen state oversight over rates with regulatory and legislative proposals that would end the current crisis – interestingly, proposals not endorsed by organized medicine.

QUESTION: If physician lobbies are really concerned about reducing insurance rates for doctors, why are physician lobbies not endorsing broad insurance reform proposals to end the current insurance crisis and to prevent future ones, or even AIR’s request for an immediate freeze on medical malpractice rates?

QUESTION: Medical malpractice insurance companies are starting to threaten state lawmakers with boycotts of states that refuse to enact “tort reform” – restrictions on lawsuits by the sick and injured – are enacted. How can insurers reconcile this kind of threat with the U.S. Supreme Court decision that held that insurance companies may not boycott their insureds by agreeing to deny them coverage? (*St. Paul Fire & Marine Inc. Co. v. Barry*, 438 U.S. 531 (1978).)

Medical Malpractice Insurance – Problems That Transcend Time and Place

Today’s insurance crisis for doctors is only a small part of a much larger insurance problem that is affecting homeowners, motorists and all kinds of policyholders, including consumers in other countries, all at the same time.

We are hearing more about doctors’ and hospitals’ insurance problems today for several reasons.

- When insurance companies impose arbitrary rate hikes on certain doctors and hospitals that are so high, or in some cases make insurance unavailable at any price, these doctors and hospitals cannot function, a situation that can reduce access to health care.
- Unlike homeowners or motorists, the well-organized and well-funded American Medical Association (AMA) has moved quickly to take political advantage of the insurance situation, devoting \$15 million to it this year. The AMA and associated medical lobbies are not pushing for insurance reform, however. They are primarily lobbying for organized medicine’s longstanding priority – lawsuit restrictions – even though such limits will not solve the current insurance crisis.

Doctors’ current insurance problems are no different from those affecting:

- **Other lines of insurance.** Skyrocketing premiums and cancellations of homeowners’ policies are at crisis proportions in many states. In Texas, where insurance rates are going up 500 percent for some, Governor Rick Perry called the top three writers in his state (Allstate, Farmers and State Farm) “an insurance cartel” taking action “to bring the state to its knees.” He has sued Farmers Insurance for deceptive trade practices leading to these astronomical rate hikes. Auto insurance, liability policies for small businesses and commercial properties and even health insurance policies are starting to experience steep increases as well.
- **Other countries.** Over the past year, industry publications like *Best Wire* and *Best’s Insurance News* have reported repeatedly on a similar insurance crises that exists in Australia, and on price hikes that Canadian policyholders are starting to experience. In fact, CJ&D and AIR representatives have been in demand by Australian programs like *60 Minutes Australia* as well as the Australian Broadcasting Network to discuss parallels between the U.S. and Australia’s current insurance problems. See., e.g., <http://www.abc.net.au/worldtoday/s591441.htm>.
- **Other times.** Volcanic eruptions in insurance premiums have occurred three times in the last 30 years – in the mid 1970s, again in the mid-1980s, and now today. In the mid-1980s, news reports reminiscent of today included: “Doctors are threatening to quit practicing some specialties or move out of the state while South Florida hospitals and trauma centers have threatened to shut down or have curtailed services,” (*St. Petersburg Times*), May 7, 1987;

“Doctors and hospitals in [West Virginia] have been saying for weeks that they would have to close their doors at the end of this month when three major insurance companies planned to cancel malpractice insurance coverage” (*Washington Post*, May 24, 1986) In the 1980s, lawmakers in some 46 states passed “tort reforms” after being told by insurance companies and others that this was the only way to reduce high insurance rates. Evidently, it didn’t work.

QUESTION: How can restrictions on U.S. jury awards in medical malpractice cases solve an insurance crisis that affects many other lines of insurance, including homeowners’, auto and health policies, and even insurance in other countries?

QUESTION: In the mid-1970s and mid-1980s, lawmakers around the country enacted extensive “tort reforms” after being told by insurance companies and others that this was the only way to reduce skyrocketing insurance rates. If this were the solution, why are we faced with an identical insurance crisis today?

The Cause – The Insurance “Cycle” and Mismanagement

The Insurance Cycle. Two facts are critical to understanding why policyholders are being price-gouged across the board. First, insurers make their money from investment income. Second, because of the nature of how they make money, insurance is a cyclical business.

- **Here’s how it works in general:** During years of high interest rates and/or excellent insurer profits, insurance companies engage in fierce competition for premium dollars to invest for maximum return. They may engage in severe underpricing and insure very poor risks just to get premium dollars to invest. When investment income decreases because interest rates drop, the stock market plummets and/or cumulative price cuts make profits become unbearably low, the industry responds by sharply increasing premiums and reducing coverage.
- **Here’s how it is working today:** During the 1990s, as the Fed focused on inflation, interest rates stayed relatively high and insurers’ cut rates. No matter how much they cut, insurers wound up with great profits investing the float on the premium in stocks and bonds (the “float” occurs during the time between when premiums are paid into the insurer and losses paid out). Over the last two years, however, the market turned with a vengeance and the Fed cut interest rates again and again, well before September 11th. Insurers responded by raising rates.

Insurer Mismanagement Compounds Problems. Compounding the impact of the cycle have been misleading business and accounting practices. As the *Wall Street Journal* found in a front page investigative story on June 24, 2002, “[A] price war that began in the early 1990s led insurers to sell malpractice coverage to obstetrician-gynecologists at rates that proved inadequate to cover claims.... Some of these carriers had rushed into malpractice coverage because an accounting practice widely used in the industry made the area seem more profitable in the early 1990s than it really was. A decade of short-sighted price slashing led to industry losses of nearly \$3 billion last year.” Moreover, “[i]n at least one case, aggressive pricing allegedly crossed the line into fraud.”

The Result Has Been No Surprise to Industry Observers.

- “The [medical malpractice insurance] market is in chaos....Throughout the 1990s ... insurers were ... driven by a desire to accumulate large amounts of capital with which to turn into investment income. Regardless of the level of ... tort reform, the fact remains that if insurance policies are consistently underpriced, the insurer will lose money.” Charles Kolodkin, Gallagher Healthcare Insurance Services, “Medical Malpractice Insurance Trends? Chaos!” (September 2001), found at <http://www.irmi.com/expert/articles/kolodkin001.asp>.
- “I don’t like to hear insurance-company executives say it’s the tort [injury-law] system – it’s self-inflicted,” says Donald J. Zuk, chief executive of Scpie Holdings Inc., a leading malpractice insurer in California. Christopher Oster and Rachel Zimmerman, “Insurers’ Missteps Helped Provoke Malpractice ‘Crisis,’” *Wall Street Journal*, June 24, 2002.

- **QUESTION:** To what extent are today's rate increases an attempt to recoup money that insurers lost in the stock market, bonds or in other poorly-performing assets, and to what extent are insurers adversely affected by today's low interest rates?

Exiting Med Mal Insurers – Mismanagement and Fraud to Blame, not Juries

Why have St. Paul Co. and smaller companies exited the medical malpractice insurance market? In 2001, one of the country's largest medical malpractice insurance companies, St. Paul, pulled out of the medical malpractice insurance market, creating significant supply and demand problems in states like Nevada.

According to a June 24, 2002, *Wall Street Journal* front page investigative article, St. Paul, with 20% share of the national market, pulled out after mismanaging their underwriting and reserves. In the 1980s, the company set aside too much money for malpractice claims. So, using a tricky accounting method, in the 1990s the company "released" \$1.1 billion in reserves, which flowed through its income statements and appeared like big profits. Seeing these profits, many new, smaller carriers came into the market. Everyone started slashing prices to attract customers. From 1995 to 2000, rates fell so low that they became inadequate to cover malpractice claims. Many companies collapsed as a result. St. Paul eventually pulled out, creating huge supply and demand problems for doctors in many states. Christopher Oster and Rachel Zimmerman, "Insurers' Missteps Helped Provoke Malpractice 'Crisis,'" *Wall Street Journal*, June 24, 2002.

St. Paul – Years of Mismanagement and Other Problems.

Even after getting out of the medical malpractice business, St. Paul's problems continued to demonstrate that poor business practices, not medical malpractice insurance, have really been at the heart of the company's downfall. In May 2002, the company was placed on credit watch with negative implications and in July 2002, St. Paul had its ratings lowered again by Standard and Poor's due to its handling of asbestos and other environmental claims.

- **Nevada.** In May 2002, the Nevada Attorney General's office filed an administrative complaint against St. Paul in connection with its decision pull out of the medical malpractice market. The complaint cites St. Paul for alleged unlawful business practices, unauthorized policy modifications, payment of commissions to unlicensed agents, unlawful policy cancellations and nonrenewals and failure to return unearned premium payments.
- **West Virginia.** A group of Charleston surgeons have sued St. Paul for "grossly poor management" that led St. Paul to drop malpractice coverage.

Other Fraud.

Reliance. In June 2002, the Pennsylvania Insurance Commissioner filed suit against directors of the defunct Reliance Insurance Co., alleging breach of fiduciary duty and negligence. From 1998 through the first half of 2000, the company's directors allowed more than half a billion dollars in dividend and other payments to be paid to holding companies of which Reliance directors were major shareholders.

Phico. In 2001, Pennsylvania regulators filed a civil fraud suit against the Pennsylvania Hospital Insurance Co., or Phico, which filed for bankruptcy in December. The company's board was allegedly misled on the adequacy of Phico's premium rates and funds set aside to pay claims. "On the way to becoming the nation's seventh-largest malpractice insurer, the company had suffered mounting losses on policies for medical offices and nursing homes as far away as Miami." Christopher Oster and Rachel Zimmerman, "Insurers' Missteps Helped Provoke Malpractice 'Crisis,'" *Wall Street Journal*, June 24, 2002.

QUESTION: How can insurers continue to blame lawsuits and juries for the lack of affordable medical malpractice insurance in some states, when the evidence suggests that mismanagement and fraud are to blame for so many medical malpractice insurers leaving the market?

How 9/11 Factors In: Exploding Rates/Exploited Policyholders

While the bulk of recent rate increases are not related to the insurance industry's economic cycle and not pricing for terrorism, *per se*, price increases in general were sped up by the 9/11 attacks, collapsing two years of anticipated increases into a few months.

Rates going up, up, up

- In an August 29, 2002, *Reuters* story, reporter Bill Rigby wrote, "Sept. 11, 2001, was a bad day for insurers; but every day since has been cause for celebration. As the one-year anniversary of the destruction of the World Trade Center approaches, insurers are looking back on 12 months of solid price increases in nearly every line of business — and they can expect more. 'Happy days are here again,' Dean O'Hare, the chief executive of Chubb Corp. crowed in February, welcoming back big price rises for the first time in more than 10 years."
- Within days of the attacks on the World Trade Center, Marsh & McLennan Cos., the world's largest insurance broker, "began planning to form a subsidiary to sell insurance to corporate customers at sharply higher rates than were common before Sept. 11. Marsh also accelerated plans to launch a new consulting unit to capitalize on heightened fears of terrorism." Christopher Oster, "Insurance Companies Benefit From Sept. 11, Still Seek Federal Aid," *Wall Street Journal*, November 15, 2001.
- Lloyd's of London told its members in a newsletter that the September 11th terrorist attacks were a "historic opportunity" to make money, adding that premiums "had shot up to a level where very large profits are possible." "Lloyd's slammed for 'national disgrace,'" October 29, 2001, found at http://news.bbc.co.uk/1/hi/english/business/newsid_1626000/1626414.stm.
- Commenting on predictions that premiums would probably rise over 200 percent in 2002, Chubb Corp. CEO Dean R. O'Hare said, "This business is back and is headed straight up." Pallavi Gogoi, "Insurance: The Coverage Crunch," *Business Week*, November 19, 2001, found at http://www.businessweek.com/magazine/content/01_47/b3758098.htm

But are they justified?

- Chris Mandel, president of the Risk and Insurance Management Society, said, "It was a massive overreaction. ... There's no real basis for the prices being charged in the marketplace." *Bests*, May 20, 2002.
- A consulting actuary with Tillinghast-Towers Perrin said, "[T]here is clearly an opportunity now for companies to price gouge — and it's happening... I think companies are overreacting, because they see a window in which they can do it." "Avoid Price Gouging, Consultant Warns," *National Underwriter*, January 14, 2002.

QUESTION: Have insurers seized upon September 11 as an opportunity to price-gouge customers and boost profits, as anecdotal evidence indicates?

Juries Are Not Causing Insurance Rates to Jump

Each time the market turns hard and insurance rates begin to rise, insurers blame jury awards for the price jumps, as if juries miraculously engineer big awards to occur precisely as the cycle turns hard. To buy this position, one would have to accept the notion that jury awards were high in the mid 1970s, then low for a decade, then high in the mid-1980s, low for 17 years and are now high again. This is ludicrous

Jury scholar Valerie P. Hans, sociology and criminal justice professor at the University of Delaware, recently wrote in the *Wilmington News Journal*, "Juries aren't perfect, but they make a convenient target even when other factors are at the root of the problem. In Delaware and elsewhere, [juries] most frequently find for the doctor. ... The medical malpractice win rate is likely low because of the jury's trust in doctors the jury's tendency to doubt plaintiff claims and settlement patterns. When plaintiffs do prevail, jury awards are positively related to the severity of injury. The more serious the injury, the higher the award, which is what we'd expect if jurors were basing their awards on appropriate factors such as the cost of medical care and lost income. ... Pain and suffering awards also parallel the severity of the injury."

Despite the hype, juries are extremely conservative. The average claims payout by medical malpractice insurance companies is about \$30,000 per claim and has been virtually unchanged for the last decade, according to a 2001 study by the Consumer Federation of America of actual claims paid. In fact, total insurance payouts to all claimants have hovered between \$2.5 billion and \$4 billion per year. By comparison, Americans spend twice that much – about \$8 billion – on dog food each year. Memo from Joanne Doroshow to Interested Persons with attached spreadsheet prepared by J. Robert Hunter, Director of Insurance, Consumer Federation of America, November 14, 2001.

In most cases, juries award nothing at all to medical malpractice patients. Injured victims win before juries in only 23 percent of cases. In 1992, the rate of medical malpractice plaintiff victories in front of juries was 7.5 percent higher at 30.5 percent. *Examining the Work of State Courts, 2001; A National Perspective from the Court Statistics Project* (2001), p. 94; "Tort Trials and Verdicts in Large Counties, 1996," U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, NCJ-179769 (August 2000), p. 9.

The jury verdict statistics that most insurers trumpet were discredited by the *Wall Street Journal* in a June 24, 2002, front-page cover story. The paper found that, "The statistics come from Jury Verdict Research, a Horsham, Pa., information service.... But Jury Verdict Research says its 2,951-case malpractice database has large gaps. It collects award information unsystematically, and it can't say how many cases it misses. It says it can't calculate the percentage change in the median for childbirth-negligence cases. More important, the database excludes trial victories by doctors and hospitals — verdicts that are worth zero dollars. That's a lot to ignore. Doctors and hospitals win about 62% of the time, Jury Verdict Research says. A separate database on settlements is less comprehensive. A spokesman for Jury Verdict Research, Gary Bagin, confirms these and other holes in its statistics."

QUESTION: What are insurers actually paying out in verdicts and settlements, in actual numbers and adjusted for inflation?

QUESTION: If jurors can be trusted to decide the death penalty in capital murder crimes, why can't they be trusted to compensate injured medical malpractice patients? What is the basis for such a lack of confidence in jurors and judges, and the reviewing courts, to make fair decisions?

Myths About Litigation, Defensive Medicine and Costs

Medical malpractice litigation in this country is far from frivolous. In a major study released in 1999, the National Academy of Sciences Institute of Medicine found that up to 98,000 people are killed each year by medical errors in hospitals —far more than die from car accidents, breast cancer or AIDS. (These figures vastly underestimate the magnitude of the problem since hospital patients represent only a small percentage of the total population at risk). Yet eight times as many patients are injured by medical malpractice as ever file a claim; 16 times as many suffer injuries as receive any compensation. Moreover, according to the National Center for State Courts, there has been no change in the volume of medical malpractice cases in the last five years.

Medical malpractice costs make up only a tiny fraction of total health care costs. According to a study by the Consumer Federation of America, medical malpractice costs, as a percentage of health care costs, are at an all time low, 0.55 percent. Report author J. Robert Hunter, former Texas Insurance Commissioner and Federal Insurance Administrator, said, “Medical malpractice insurance is amazing value, considering that it covers all medical injuries for about one-half of one percent of health system costs!” Memo from Joanne Doroshow to Interested Persons with attached spreadsheet prepared by J. Robert Hunter, Director of Insurance, Consumer Federation of America, November 14, 2001.

Far more costly than malpractice lawsuits are the costs of medical errors. Total national costs (lost income, lost household production, disability and health care costs) of negligence in hospitals are already estimated to be between \$17 billion and \$29 billion each year, of which health care costs represent over one-half. Moreover, these figures vastly underestimate the magnitude of the problem since hospital patients represent only a small percentage of the total population at risk, and direct hospital costs are only a fraction of the total costs. Kohn, Corrigan, Donaldson, Eds., *To Err is Human; Building a Safer Health System*, Institute of Medicine, National Academy Press: Washington, DC (1999).

Defensive Medicine. At most, a very small portion of health care costs result from” defensive medicine.” In 1994, the Office of Technology Assessment (OTA) was asked initially by proponents of sweeping malpractice tort restrictions to study the issue. OTA found, among other things, that only “a relatively small proportion of all diagnostic procedures – certainly less than 8 percent – is likely to be caused primarily by conscious concern about malpractice liability risk.” OTA found that “Most physicians who order “aggressive diagnostic procedures ... do so primarily because they believe such procedures are medically indicated, not primarily because of concerns about liability.” The effects of traditional tort reforms – particularly caps on damages and amendments to the collateral source rule – on defensive medicine “are likely to be small.”

In 1995, Dr. Wayne Cohen, who was then medical director of Bronx Municipal Hospital, said, “The city was spending so much money defending obstetrics suits, they just made a decision that it would be cheaper to hire people who knew what they were doing.” Dean Baquet and Jane Fritsch, “New York’s Public Hospitals Fail, and Babies Are the Victims,” *New York Times*, March 5, 1995.

QUESTION: If the cost of medical errors is far greater than the costs of medical malpractice lawsuits brought by the small number of injured patients who actually file cases, how can reducing the number of lawsuits — lessening the financial incentives for hospitals and HMOs to operate safely — lower the system’s costs?

A Chronology of Insurance Industry Leadership on “Tort Reform”

1975 -1976: Insurance industry manufactures first liability insurance “crisis” - *i.e.*, unaffordable or unavailable insurance. States, including California, enact “tort reform” —restrictions on the rights of injured consumers to sue and obtain compensation from corporate lawbreakers and other wrongdoers —after insurance companies tell them this is the only way insurance rates will fall.

1975 –1976: Insurance industry spends \$5.5 million on ads published in 18 national publications, claiming that large jury verdicts effect jurors’ pocketbooks. Ads describe fictitious cases, like Crum and Foster's “lawnmower as a hedgeclipper” advertisement where an individual supposedly was awarded millions by a jury for injuries sustained when he improperly used a power lawnmower to trim his hedges. Both *Business Insurance* and a congressional committee confirmed that the case was a total fabrication.

1978: New York Supreme Court finds two Aetna ads misleading enough as to convince some jurors to reduce arbitrarily awards to injured people. The court held that these ads “violate[d] the state public policy against jury tampering, unduly burden[ed] plaintiffs’ right to an impartial jury, and distort[ed] the trial process by providing otherwise inadmissible insurance evidence...”

1985-1986: Insurance industry manufactures second liability insurance “crisis ” *i.e.*, unaffordable or unavailable insurance. States, including California, enact more “tort reform” after insurance companies tell them this is the only way insurance rates will fall.

1986: Insurance companies like Aetna, Geico, Nationwide and Transamerica, and insurance trade associations join with other corporations to form the American Tort Reform Association (ATRA). Nearly 40 ATRA members are insurance companies or insurance-related organizations and six ATRA directors work for insurance companies or law firms that frequently represent insurers. According to the *Legal Times*, “most of [ATRA’s] funding comes from large corporate donors. Insurance firms ... are each good for \$50,000 or \$75,000, one unnamed lobbyist familiar with the Association told the publication.”

1986: The Insurance Information Institute (III) purchases \$6.5 million worth of print and television ads, designed to reach 90 percent of all U.S. adults, in order “to change the widely held perception that there is an ‘insurance crisis’ to a perception of a ‘lawsuit crisis.’”

1987: Insurance industry begins a \$7 million image advertising blitz and announces plans for an even bigger three- to five-year \$90 million nationwide public relations campaign to improve its public image.

1988: A dozen state attorneys general file antitrust class action against insurance industry after finding that a number of insurance companies, including Aetna, Cigna, Hartford and Lloyd’s of London conspired to create the insurance crisis of the mid-1980s. They restricted coverage to commercial customers, thus raised prices, creating an atmosphere intended to coax states into enacting “tort reform.” The case settled in 1995 for \$36 million.

1988: Insurance industry begins to pull back from public leadership of the “tort reform” movement.

1994: ATRA advisor Neil Cohen tells Public Affairs Council audience to hide insurance industry involvement in “tort reform.” Cohen said, “[K]eep high-profile corporate clients carefully hidden from public view, since this would detract from the illusion that ‘tort reform’ exploded spontaneously among outraged citizens and small businesses.” Specifically, Cohen said, “In a tort reform battle, if State Farm —I think they’re here, and Nationwide —is the leader of the coalition, you’re not going to pass the bill. It is not credible. O.K., because it’s so self-serving.” Jane Fritsch, “Sometimes, Lobbyists Strive to Keep Public In the Dark,” *New York Times*, March 19, 1996.

2002: Insurance companies once again decide to take public credit for leading “tort reform” movement. For example, *Best Wire* reported on September 9, 2002, “[A]t least one industry advocate feels the insurance lobby is gaining strength in its battles with the likes of the American Bar Association and the Association of Trial Lawyers of America. ‘After years of lobbing grenades and fending off single attack, after single attack, the insurance industry has coalesced and coordinated its effort to be as effective or more effective than the ABA has been the past 10 years,’ said Maria Berthoud, senior vice president of federal affairs with the Independent Insurance Agents and Brokers of America.”

QUESTION: How does the “tort reform” movement feel about the insurance industry, one of the most disliked industry’s in America, taking a public leadership role again in pushing tort restrictions after years of hiding behind corporate front groups?

Rejecting the “Tort Reform” Solution – Serious Responses by Serious Policy Makers

Listen to anyone other than the insurance and medical lobbies, or politicians beholden to them, and the fallacy of enacting “tort reform” to solve a self-inflicted insurance problem becomes clear.

- **National Association of Insurance Commissioners.** In September 2002, the National Association of Insurance Commissioners (NAIC) agreed to examine the current insurance crisis as a self-inflicted problem created by the insurers. The NAIC appointed a Market Conditions Working Group “to coordinate the evaluation of AIR [American for Insurance Reform]’s recommendations and to monitor the most distressed lines of business, formulate solutions, and propose regulatory responses.” AIR has requested insurance departments to undertake 14 different audits, investigations and reforms to control excessive insurance prices including an immediate freeze on malpractice and homeowners’ rates and regulation of excessive rates.
- **National Academy of State Health Policy.** A July 2002 study by the National Academy of State Health Policy (funded by the Robert Wood Johnson Foundation) found that “[t]he move toward more restrictive tort reform does not address the complexity of the problem. Previous rounds of tort reform that followed the malpractice insurance crises of the 1970s and 1980s have not succeeded in preventing periodic and dramatic rises in insurance premiums. *The Medical Malpractice Insurance Crisis: Opportunity for State Action*, National Academy of State Health Policy (July 2002).
- **U.S. General Accounting Office.** In July 2002, ten members of the U.S. House of Representatives requested a U.S. General Accounting Office (GAO) investigation of the insurance industry’s responsibility for creating nationwide medical malpractice insurance problems for doctors, including how the insurers’ declining investment income and “insurance industry practices” have contributed to skyrocketing insurance rates for doctors over the last few months. This study is ongoing.

Alternatives. There has been a burgeoning interest in the formation of captive insurance companies and risk retention groups for doctors, hospitals, nursing homes and other medical groups in states that have lost carriers. In Pennsylvania, a new medical malpractice “reciprocal exchange” insurer has applied to do businesses in the state. This is similar to Miix Group Advantage Insurance Co., a new physician sponsored company proposed in New Jersey.

Rates Freezes. Some state officials have moved to freeze rates. In July, New York state’s insurance department rejected a requested 8% rate increase for that state’s largest medical malpractice insurer, saying the company did not need it. In Pennsylvania in August 2002, Pennsylvania’s Attorney General urged the state insurance commissioner to suspend the up to 48% medical malpractice insurance rate increase for Pennsylvania’s joint underwriting authority.

QUESTION: If legislative and regulatory bodies recognize that doctors’ insurance problems are caused by insurance industry practices, why are some lawmakers focusing only on lawsuits and “tort reform” as a solution?

What Happens to Insurance Rates After Tort Restrictions Are Enacted?

Nothing.

In Mississippi, where a contentious medical malpractice “tort reform” battle has been waged during the summer of 2002, Medical Assurance Co. of Mississippi notified doctors that it will raise its rates by 45 percent in 2003 “regardless of the special session outcome” since “tort reform” does “not provide a magical ‘silver-bullet’ that will immediately affect medical malpractice insurance rates.”

In New Jersey, at a June 3, 2002, meeting of the New Jersey Assembly Joint Committees of Banking & Insurance and Health & Human Services on Medical Malpractice, Assemblyman Paul D’Amato asked Patricia Costanta, chairman and CEO of the MIIX Group of Insurance Companies, whether if the state passes caps on damages, you promise not to raise premiums and will reduce them. Her response: “No, we’re not telling them [insureds] that.”

In Nevada, lawmakers were subjected to a nasty campaign by insurers and organized medicine during the summer of 2002, including the deliberate closing of trauma centers, in order to strong-arm the legislature into enacting severe caps on medical malpractice compensation. Insurance groups fought any attempt to add a provision to guarantee lower rates should the legislation pass. Within weeks of the law’s enactment, two major insurance companies proclaimed that they would not reduce insurance rates.

Insurers now say that they are “waiting to see” if the cap will be upheld constitutionally, as many state constitutions prohibit caps since they directly interfering with the right to jury trial, the right to a remedy, equal protection and/or separation of powers.

Such excuses are nothing more than a convenient cover for one undeniable fact: Insurers have never lowered rates as a consequence of “tort reform” because such measures are based on an untrue premise: that the legal system, rather than the underwriting practices of the insurance industry, is responsible for gyrations in the cost and availability of insurance.

- In 1986, the state of Washington enacted what was considered at the time “one of the most comprehensive [tort] reform bills yet.” However, after the law passed, Washington State Physicians Insurance Association, which had testified that the law would reduce premiums by 25% to 30%, asked for a rate hike. “State hires outside firm to look at liability rate request,” *UPI*, December 4, 1986. *See also*, “Tort reform legislation: Did state get ‘suckered,’” *Seattle Times*, July 1, 1986.
- Following enactment of extensive “tort reforms” in Florida in 1986, Aetna and St. Paul Marine Insurance Company said they would not reduce rates. In fact, filings by 104 insurers in Florida showed that out of 277 filings, 175, or 63 percent, showed no savings from “tort reform” while none showed savings of more than 10 percent. “‘Tort Reform’ a Fraud, Insurers Admit,” and “Tort Reform Will Not Reduce Insurance Rates, Say 100+ Florida Insurers,” National Insurance Consumer Organization (1986).

- In 1986, Connecticut enacted major “tort reforms.” But by 1987, one state lawmaker was noting, “The insurance industry now says those measures will have no effect on insurance rates. We have been disappointed by the response of the insurance industry. The reforms we passed should have led to rate reductions because we made it more difficult to recover, or set limits on recovery. But this hasn’t happened.” “Insurers Warn,” *UPI*, March 9, 1987.

QUESTION: Why have insurers routinely asked for premium hikes after they have been successful getting “tort reforms” passed, and why has there not been a backlash by legislators, medical lobbies and other policy holders?

The Last Insurance Crisis —“Tort Reform” Had No Impact

As with every insurance cycle, eventually rates will stabilize and availability will improve around the country, irrespective of tort law restrictions enacted in particular states.

This is precisely what happened after the last insurance “crisis” of the mid-1980s. By the late 1980s, rates stabilized and stayed flat for 17 years in every state. In 1991, for example, Washington state’s insurance commissioner Dick Marquardt concluded in a report that it was “impossible to attribute stable insurance rates to tort-law changes or the damages cap,” since rates also improved in states that did not pass tort reform. “Health care Reform – Bush’s insurance cap plan a proven failure,” *The Seattle Times*, May 16, 1991.

Premium Deceit – the Failure of “Tort Reform ” to Cut Insurance Prices found no correlation between “tort reform” and insurance rates. In 1999, the Center for Justice & Democracy released *Premium Deceit – the Failure of “Tort Reform ” to Cut Insurance Prices*. This study was the first-ever, and remains the only, comprehensive look at property/casualty insurance price rates in every state in the nation since the mid-1980s. Its actuarial analysis was conducted by J. Robert Hunter, who discovered that “[d]espite years of claims by insurance companies that rates would go down following enactment of tort reform, we found that tort law limits enacted since the mid-1980s have not lowered insurance rates in the ensuing years.”

States with little or no tort law restrictions have experienced approximately the same changes in insurance rates as those states that have enacted severe restrictions on victims ’ rights.” In other words, laws that restrict the rights of injured consumers to go to court do not produce lower insurance costs or rates and insurance companies that claim they do are severely misleading this country ’s lawmakers.

The American Tort Reform Association and the American Insurance Association have supported *Premium Deceit*’s conclusions. When commenting on *Premium Deceit*, spokespeople for national “tort reform” organizations, agreed with *Premium Deceit*’s conclusions in the following published statements:

- “We wouldn’t tell you or anyone that the reason to pass tort reform would be to reduce insurance rates.” Sherman Joyce, president of the American Tort Reform Association, *Liability Week*, July 19, 1999.
- [M]any tort reform advocates do not contend that restricting litigation will lower insurance rates, and ‘I’ve never said that in 30 years.’” Victor Schwartz, *Liability Week*, July 19, 1999.
- “Insurers never promised that tort reform would achieve specific premium savings.” Debra Ballen, AIA executive vice president, March 13, 2002 news release and report.

QUESTION: How do the American Tort Reform Association and the American Insurance Association reconcile the above statements with the contradictory positions both groups are now taking?

California —A Failed Model For Restrictions On Patients' Rights

In the mid-1970s, California enacted severe tort restrictions for patients who have been injured by malpractice (MICRA). Among other things, this law allows patients to recover no more than \$250,000 in non-economic compensation no matter how egregious the malpractice or serious the injury. The medical and insurance lobbies are campaigning to spread this law, one of the most draconian in the nation, to other states, arguing falsely that this cap has kept premiums down.

Deceptive Statistics Provide the Basis for “Low Average Premium” Assertion. According to the *Los Angeles Times*, the editor of *Medical Liability Monitor*, which surveys insurance carriers about their rates, says her published data are being misused by Californians’ for Patient Protection to suggest that California doctors pay far less, on average, than their peers in Florida, Illinois, New York, Texas and Michigan. Carol Golin says her publication doesn’t even calculate average premiums because circumstances and jurisdictions are so different that “we don’t think they exist.” Charles Ornstein, “Verdict Not In on Malpractice Caps,” *Los Angeles Times*, August 3, 2002.

California Rates Are Actually About the Same as the Nation’s. The 2000 average premium per doctor in California was only 8.2 percent below that of the nation (\$7,200.61 vs. \$7,843.75). But more significantly, the average malpractice premium in California between 1991 and 2000 actually grew more quickly (3.5 percent), than it did in the nation overall (1.9 percent.) According to actuary J. Robert Hunter of the Consumer Federation of America, “there is not much difference in the rates or the rate of change between California and the nation based on the latest decade of experience.” <http://consumerwatchdog.org/healthcare/pr/pr002549.php3>.

Premium Deceit. In 1999, the Center for Justice & Democracy released *Premium Deceit – the Failure of “Tort Reform ” to Cut Insurance Prices*. This study was the first-ever, and remains the only comprehensive look, at the impact of tort restrictions on property/casualty insurance rates in every state in the nation, including California, since the mid-1980s. *Premium Deceit* found no correlation between “tort reform” and insurance rates.

Who Has Profited from California’s Law? Insurance Companies. According to a report by California’s Foundation for Taxpayer and Consumer Rights, only California insurers have profited greatly from California “tort reform” law. Since the mid-1980s, California malpractice insurers have paid out in claims less than fifty cents of every dollar they have taken in through premiums. By contrast, malpractice insurers nationally have typically paid out in claims more than two-thirds of every premium dollar. <http://consumerwatchdog.org/healthcare/pr/pr002549.php3>

Who Has Been Hurt by California’s Law? Patients. The impact of California \$250,000 damages cap on patients has been, quite simply, unfathomable. Twelve year old Steven Olsen is blind and brain-damaged because at age two, a hospital refused to give him an \$800 CAT scan that would have detected a growing brain mass. In 2001 Steven had 74 doctor visits, 164 physical and speech therapy appointments, and three trips to the emergency room. Steven’s mother Kathy had to leave her job because caring for Steven is a full time job. He must be watched constantly. A jury awarded Steven \$7.1 million in non-economic compensation for his doomed life of darkness, loneliness, pain, physical retardation, and around-the-clock supervision. However, the judge was forced to reduce the amount to \$250,000, outraging the jurors.

Has the Cap on Damages Kept Doctors in California? No. California is touted by “tort reform” groups as a highly attractive state for doctors to practice because of the state’s \$250,000 cap on liability for noneconomic damages. Yet the U.S. Census Bureau reports that California is falling in the number of doctors, per capita, compared to the population. The California Medical Association blames the physician exodus on low reimbursements. In other words, low Medicare/Medicaid reimbursement has had far more impact on a doctor’s willingness to practice in a state than tort restrictions.

QUESTION: If California’s tort law has made the state so attractive to doctors, why are they leaving the state? If California’s tort law has kept insurance rates down, why have average California medical malpractice insurance rates risen to almost twice the national average over the last decade?

The Cruel Impact of Damages “Caps” on Patients – Three Voices

Steven Olsen and California’s Cap on Damages. The impact on patients of California’s \$250,000 cap on non-economic damages has been, quite simply, unfathomable. Twelve-years-old Steven Olsen is blind and brain-damaged because at age two, a hospital refused to give him an \$800 CAT scan that would have detected a growing brain mass. In 2001 Steven had 74 doctor visits, 164 physical and speech therapy appointments, and three trips to the emergency room. Steven’s mother Kathy had to leave her job because caring for Steven is a full-time job. He must be watched constantly. A jury awarded Steven \$7.1 million in non-economic compensation for his doomed life of darkness, loneliness, pain, physical retardation, and around-the-clock supervision. However, the judge was forced to reduce the amount to \$250,000, outraging the jurors.

Former Reagan administration official Richard Levine. Richard Levine served eight years as the youngest member of Ronald Reagan’s National Security Council staff and the youngest Deputy Assistant Secretary of the Navy. He wrote an op-ed in the December 25, 1995, *Washington Times* strongly opposing “tort reform” and a proposed \$250,000 cap on noneconomic damages. Levine said, “Nearly two years ago I incurred catastrophic damage to my face due to malpractice. This has left me in a state of near-constant agony....I would beg Congress to limit my suffering. I would beg them to limit the suffering of those who have been blinded, paralyzed or disfigured by incompetence. This they cannot do, but this Congress still sees fit to limit people’s ability to recover that which can never be adequately be recovered and to set the limit at \$250,000.”

Insurance Lobbyist Frank Cornelius. In 1975, Indiana lobbyist Frank Cornelius, whose clients included the Insurance Institute of Indiana, helped secure passage of a \$500,000 cap on medical malpractice awards and elimination of all damages for pain and suffering in Indiana. As he wrote in the *New York Times* on October 7, 1994, he now “rue[s] that accomplishment.” Beginning in 1989, Frank Cornelius experienced a series of medical negligence catastrophes that resulted in his wheelchair confinement, respirator-assisted breathing and constant physical pain. When he turned to the Indiana courts to provide a remedy for his massive injuries and hold the negligent health care providers accountable, the law was no longer there for him. Though his medical expenses and lost wages amounted to over \$5 million, his claims against both the hospital and physical therapist at fault settled for a mere \$500,000—the limit on damages for a single incident of malpractice.

QUESTION: Caps on damages can be catastrophic for children and their families, causing untold suffering, economic devastation, and for some, the destruction of family life. In many cases, caps will shift the cost of compensating sick and injured children from wrongdoers to taxpayer-funded health and disability programs. Reconcile these facts with conservative principles like family values, the protection of children, lower taxes and less government spending?

QUESTION: Chief executives of insurance companies who favor capping noneconomic compensation to patients at \$250,000 are themselves making \$250,000 a *week*—without any pain and suffering at all. How is this fair?

Do Doctors Want Insurance Help Or Just Special Treatment in the Courts?

Doctors have staged walkouts or demonstrations around the country ostensibly “to demonstrate to the media that they’re fed up with the way they’re treated.” “Momentum Builds for Medical Malpractice Captives. *National Underwriter*, September 9, 2002.

Yet in September 2002, Mississippi doctors “showed no support at all for the Legislature creating a state-backed insurance program [to help ease the crisis] ... ‘I smell a rat,’ said Rep. Willie Perkins, D-Greenwood. ‘If doctors don’t want the risk pool, then are we here just to provide them special treatment in court? I don’t think it’s about insurance being available or affordable, I think it’s about people wanting special treatment.’” Joey Bunch, “Tort reform fading on fears of election-year retribution,” *Sun-Herald*, September 13, 2002.

The medical and insurance lobbies have a longstanding political agenda to limit lawsuits, frivolous or not. This is an overwhelming political priority for these groups. In fact, their dislike for trial lawyers and the civil actions they bring, or for those who second-guess their ability or decisions, seems so overpowering that it takes precedence over their desire to resolve insurance problems for doctors.

The obsessive nature of these groups’ dislike for those who oppose “tort reform” can seem comical at times. In a July 31, 2002, published statement, the Physicians Insurance Association of America (PIAA) called consumer groups like Public Citizen, who challenge statistics used by the physicians lobbies, as “fighting to the death for the right to chase ambulances and hover over the sick and dead, this group of wolves in sheep’s clothing has turned nothing less than rabid. Their ranting have gone beyond the bounds of rationality and descended into the maelstrom of sheer lunacy.” PIAA also called them “paranoid.”

A History of Special Treatment. Doctors and hospitals already have more legal protections from lawsuits than any other profession, industry or business in the nation. Many of these laws were passed in response to the last two insurance “crises” – in the mid-1970s and mid-1980s -- after lawmakers were told by medical and insurance lobbyists that such laws were needed to reduce medical malpractice insurance rates, just as they are telling legislators today.

For a list of medical malpractice immunity laws enacted by legislators or voters before this latest insurance “crisis” hit, see <http://centerjd.org/free/Medmallist.pdf>.

QUESTION: Why do doctors and hospitals deserve more legal protection for their negligence or recklessness than any other profession or business?

QUESTION: Why shouldn't incompetent doctors and hospitals be held fully responsible for causing injury to innocent people?

Doctors And Their Problems

Doctors are a wealthy profession. The median annual income for obstetricians, gynecologists and surgeons, is more than \$145,600; for family and general practitioners, it's about \$115,000. (By comparison, the median annual income of lawyers is about \$88,000.) Bureau of Labor Statistics, Bureau of Labor Statistics, U.S. Department of Labor, *2000 National Occupational Employment*.

For the most part, the allegation that doctors are “fleeing” states is nothing more than hype. For example:

- **Mississippi.** The *Biloxi Sun Herald* reported in August 2002: “Medical groups have claimed doctors are fleeing Mississippi, relocating to states with more stable legal climates. So far, the numbers don't bear that out. In fact, the state has gained 564 doctors over the past five years. The state Medical Association has said the growth in doctors lags behind the state's population growth. But while Mississippi still ranks last in the nation in the number of doctors per capita, it has made dramatic gains since 1995. Only four states have grown faster in physician population: Alabama, Alaska, Arkansas and South Dakota.

- **New York.** Although the Medical Society of New York State claims doctors are fleeing New York, the state is ranked third in the nation in its number of obstetricians and gynecologists per capita, well ahead of California (ranked 27th). When compared to the region, only Connecticut (ranked 2nd) is ahead of New York State in the number of ob gyns per capita. Moreover, the number of physicians practicing in New York State has skyrocketed and is increasing at a rate faster than the national average. *First Do No Harm; A Consumer Response to the Medical Lobby's Campaign to Limit The Legal Rights of Injured Patients*, NYPIRG et al., (September 2002)

- **West Virginia.** The *Charleston Gazette* reported in February 25, 2001, “Despite claims from the West Virginia Medical Association that the lack of “tort reform” had caused a mass exodus of doctors from the state, the number of doctors in West Virginia had increased yearly, with the state seeing a 14.3 percent increase in its number of doctors between 1990 and 2000. This increase is at a rate about 20 times greater than the population.” Martha Leonard, “State has seen sharp increase in number of doctors,” *Sunday Gazette Mail*, February 25, 2001.

To the extent doctors are leaving any states, it is not because of lawsuits or tort law. The number one health care issue facing doctors today is Medicare/Medicaid reimbursement. Reimbursement disparity is driving doctors out of states and has led to staffing shortages, according to participants in a recent National Conference of State Legislatures meeting. Doctors in Washington State, for example, say their counterparts in Texas, Alabama, Florida and Mississippi make more money than they do as a result of reimbursement disparity. Doctors say they are turning away new Medicare and Medicaid patients in many states this year. “2002 Doctor shortage has arrived,” *Bellingham Herald*, July 16, 2002.

Low reimbursement has far more impact on a doctors' willingness to practice in a state than tort restrictions. California is touted by “tort reform” groups as a highly attractive state for doctors to practice because of the state's \$250,000 cap on liability for noneconomic damages. Yet the U.S.

Census Bureau reports that California is falling in the number of per capita ratio of doctors to population. The California Medical Association blames the physician exodus on low reimbursements, according to the American Medical News' August 14 headline news story, "Doctors Fleeing California."

Managed care reimbursements are also a problem. Reports from states like Nevada say that steadily decreasing reimbursement rates from managed care companies and health maintenance organizations are causing financial problems for the doctors, particularly obstetricians and specialty surgeons.

As one reporter recently put it, "Doctors facing soaring malpractice premiums are susceptible to economic fears these days because they're being squeezed on the income side by private and public health insurers. Big premium hikes have them out front doing the insurers' political dirty work for them, wittingly or not. Leigh Allan, "Cries for Tort Reform All Wet The Numbers Say," *Dayton Daily News*, September 17, 2002.

QUESTION: Most evidence points to the fact that doctors are not "fleeing" states. What statistical evidence exists to indicate that they are?

QUESTION: Assuming doctors are leaving some states, like California, why are tort laws or the "lawsuit climate" being blamed, when reimbursement disparity is the cause?

How Much Medical Malpractice Is There?

In 1985, the director of Maternal/Fetal Medicine at Pasadena's Huntington Memorial Hospital told the American College of Obstetrics and Gynecology, "The greatest cause of malpractice is malpractice. You must understand that some of the malpractice out there is so grievous, offensive and implausible as to beggar the imagination." Letter from Ralph Nader to Florida Speaker Mills and Senate President Vogt (1988).

Sadly, not much has changed. In fact, things seem to be getting worse.

- **Deaths in hospitals due to medical errors.** In *To Err is Human; Building a Safer Health System*, the National Academy of Sciences Institute of Medicine researchers evaluated deaths in hospitals due to medical errors. The report's findings are based on two large studies, one recent study conducted in Colorado and Utah, and an earlier study in New York. When the findings of these studies are "extrapolated to the over 33.6 million admissions to U.S. hospitals in 1997, the results of the study in Colorado and Utah indicate that at least 44,000 Americans die each year as a result of medical errors. The results of the New York study suggest the number may be as high as 98,000. Even when using the lower estimate, deaths due to medical errors exceed the number attributable to the 8th leading cause of death. More die in a given year as a result of medical errors than from motor vehicle accidents (43,458), breast cancer (42,297) or AIDS (16,516)." *To Err is Human; Building a Safer Health System*, Kohn, Corrigan, Donaldson, Ed.; Institute of Medicine, National Academy Press, Washington, DC, (1999).
- **Underestimation of figures.** "These figures offer only a very modest estimate of the magnitude of the problem since hospital patients represent only a small percentage of the total population at risk, and direct hospital costs are only a fraction of the total costs." (More is known about errors that occur in hospitals than in other health care delivery systems.) Not included in these studies are medical errors resulting from care provided in ambulatory settings, outpatient surgical centers, physician offices and clinics, home care, retail pharmacies and nursing homes." *To Err is Human; Building a Safer Health System*, Kohn, Corrigan, Donaldson, Ed.; Institute of Medicine, National Academy Press, Washington, DC, (1999).
- **Medication errors.** "Medication errors alone (accidental poisoning by drugs, medicaments and biologicals, occurring either in or out of the hospital), are estimated to account for over 7,000 deaths annually, compared with less than 3,000 people in 1983, almost a 3-fold increase." Moreover, these estimates are low because "many errors go undocumented and unreported." *To Err is Human; Building a Safer Health System*, Kohn, Corrigan, Donaldson, Ed.; Institute of Medicine, National Academy Press, Washington, DC, (1999). In addition, according to a recent Auburn University study, an average of more than 40 potentially harmful drug errors per day occur in hospitals. The report, which examined 36 hospitals and nursing homes in Colorado and Georgia, found that the most common errors were giving hospitalized patients medication at the wrong time or not at all. Researchers also discovered that mistakes occurred in nearly one of five doses in a typical, 300-bed hospital, meaning about two errors per patient daily. Lindsey Tanner, "Study finds over 40 drug errors daily at hospitals," *Associated Press*, September 9, 2002.

Given the number of medical errors, too few bad doctors are disciplined. In its book *20,125 Questionable Doctors*, Public Citizen’s Health Research Group found that out of 770,320 licensed medical doctors, the care or conduct of only 2.6% of them was considered substandard enough to be cited by a state medical disciplinary board, Medicare or the federal Drug Enforcement Administration, or have their eligibility to participate in Food and Drug Administration (FDA) experiments rescinded. And fewer than one-half of 1% face any serious state sanctions each year.

“Too little discipline is still being done,” the report said. “2,696 total serious disciplinary actions a year, the number state medical boards took in 1999, is a pittance compared to the volume of injury and death of patients caused by negligence of doctors... Though it has improved during the past 15 years, the nation’s system for protecting the public from medical incompetence and malfeasance is still far from adequate.” See, <http://www.questionabledoctors.org/>

Dr. Richard G. Roberts, chairman of the American Academy of Family Physicians and professor of Family Medicine at the University of Wisconsin Medical School, has issued his “Top 10 Myths of Medical Malpractice” in which he lists 10 “Truths” about the civil justice system, including: “About one in 50 hospitalized patients is injured due to negligence, and yet only one in 10 of those files a lawsuit and, among those filing suits, only one in 20 receives money; there is more malpractice committed than is recognized, litigated or compensated; plaintiffs in most cases are not ‘gold-digging;’ and the vast majority [of plaintiffs] have (medical) outcomes none of us would want for ourselves or our loved ones.”

http://www.aafp.org/servlet/mntPress?press_id=1266&prhtml=afp_article_browse&actioncode=select.

QUESTION: Given the epidemic of medical malpractice that exists today, how can policymakers seek to reduce physician and hospital accountability through the courts, policies that will only increase, not reduce, medical mistakes?

Recent Investigative News Stories

Charleston Gazette, September 18, 2002: “The more information that comes in the harder it seems to diagnose the cause of West Virginia’s medical malpractice crisis. For one thing, there does not appear to be a malpractice crisis, but rather an insurance crisis.” “Malpractice state payouts are low,” *Charleston Gazette*, September 18, 2002.

Charleston Daily Mail, September 13, 2002: West Virginia’s settlements and verdicts averaged about \$ 183,000 each, placing the state among the bottom half of the 50 states and the District of Columbia. State doctors also made smaller malpractice payouts than their counterparts in three of eight states the American Medical Association considers “good” states, or those not experiencing a medical malpractice insurance crisis.

Dayton Daily News, September 17, 2002: “Only the figures from insurance companies themselves came close to justifying the big increases in medical malpractice insurance that obstetricians, among others, say could force them out of business. There was no evidence that ‘grasping attorneys and scheming patients,’ as one doctor put it, were having much success. Instead, the numbers indicate that limit on non-economic damages sought by the doctors – and by businesses in general – would have little impact.”

Sun Herald (Biloxi, Miss.) August 11, 2002: “Claims that doctors are leaving the state en masse aren’t supported by data from the state Board of Medical Licensure, or even information provided reluctantly by the state Medical Association”; “Mississippi’s insurance rates are no higher than many other states, including some with caps on damages”; “Mississippi remains below the national average for personal injury awards, medical malpractice awards and claims per doctor”; and “Mississippi Medical Association could not provide specific data to support its claims against the legal system.”

Los Angeles Times, August 3, 2002: “California’s law, and damage caps in particular, should not be viewed as a panacea for other states, says Cheye Calvo of the National Center for State Courts. Physicians in Massachusetts and Montana, which have damage caps, haven’t avoided large rate increases, he said. At the same time, doctors in Minnesota, which doesn’t have a cap, aren’t having problems. ”

Wall Street Journal, June 24, 2002: “[A] price war that began in the early 1990s led insurers to sell malpractice coverage to obstetrician-gynecologists at rates that proved inadequate to cover claims.... Some of these carriers had rushed into malpractice coverage because an accounting practice widely used in the industry made the area seem more profitable in the early 1990s than it really was. A decade of short-sighted price slashing led to industry losses of nearly \$3 billion last year.” Moreover, “[i]n at least one case, aggressive pricing allegedly crossed the line into fraud.”

Wall Street Journal, June 24, 2002: The litigation statistics most insurers trumpet are incomplete. The statistics come from Jury Verdict Research, a Horsham, Pa., information service.... But Jury Verdict Research says its 2,951-case malpractice database has large gaps. It collects award information unsystematically, and it can’t say how many cases it misses. It says it can’t calculate

the percentage change in the median for childbirth-negligence cases. More important, the database excludes trial victories by doctors and hospitals —verdicts that are worth zero dollars. That’s a lot to ignore. Doctors and hospitals win about 62% of the time, Jury Verdict Research says. A separate database on settlements is less comprehensive. A spokesman for Jury Verdict Research, Gary Bagin, confirms these and other holes in its statistics.”

The State (South Carolina), June 18, 2002: “Doctors and hospitals routinely use the court system to make secret payouts to victims of medical mistakes; Hospitals don’t always tell patients and their families about mistakes that injure or kill. Sometimes, hospitals don’t tell coroners; Secrecy about medical errors may lead to more such errors.” (After the *State*’s findings were reported, South Carolina’s 10 federal judges voted unanimously for an outright ban on sealed, court-sanctioned settlements.)

Morning Call (Allentown, Pa.), March 24, 2002: Contrary to reports of fleeing doctors, in the year 2000, “Pennsylvania ranked ninth-highest nationally for physician concentration, a top-10 position it has held since 1992. There were 318 doctors for every 100,000 residents in 2000, according to the American Medical Association.” Ann Wlazelek, “Doctors’ ad campaign baseless; They’re not fleeing Pa., but malpractice straits create ‘hostile’ climate,” *Morning Call*, March 24, 2002.

Charleston Gazette, February 25, 2002: [Insurance company] Medical Assurance has paid the state Medical Association at least \$ 115,000 a year since 1995, or an estimated \$ 690,000 to date, as part of a confidential agreement. This secret deal requires association members to lobby legislators on the company’s behalf ... As part of this agreement, Medical Assurance offers individual doctors reasons to lobby. Association members can reap a share of the \$ 208 million company’s annual profits, as well as a series of breaks on their premiums —provided they buy their policies from Medical Assurance.

Charleston Gazette, February 25, 2001: “Despite claims from the West Virginia Medical Association that the lack of “tort reform” had caused a mass exodus of doctors from the state, the number of doctors in West Virginia had increased yearly, with the state seeing a 14.3 percent increase in its number of doctors between 1990 and 2000. This increase is at a rate about 20 times greater than the population.” Martha Leonard, “State has seen sharp increase in number of doctors,” *Sunday Gazette Mail*, February 25, 2001.