Finding the Truth

The Medical Malpractice Crisis in North Carolina

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A MEDICAL MALPRACTICE INSURANCE crisis has infected our nation. Pennsylvania, West Virginia, New Jersey, Mississippi, Texas, Florida, Illinois, Oregon, and other states have made headline news as doctors have walked off the job and legislatures have convened to address the affordability of insurance for their doctors and access to healthcare for their citizens. Indeed, North Carolina has been labeled a "state in crisis" by the American Medical Association, the American Neurosurgical Association, and the US Department of Health and Human Services.

Meanwhile, the trial bar has flexed its political muscle and vigorously opposed medical liability reforms, proclaiming that the trial lawyers are "the champions of the little people." Blaming the insurance companies for duping the doctors, the trial attorneys have paraded patient "victims" to Raleigh and started so-called "patient advocacy" groups, underwriting the costs of these "independent" spokesmen. Skilled at shaping the argument to their own advantage, the trial attorneys point the finger of blame at everyone except themselves.

So where are the truths in this discussion? Who can be trusted to give you a straight answer? Without an agenda? Without a motive for personal gain?

As Chairman of the North Carolina Medical Society's (NCMS) Taskforce on Professional Liability Insurance (PLI) Reform, I might be viewed as one of those who stands to gain by a drop in medical malpractice premium costs and a narrowing of medical liability for my future acts. But that is not the case. It is true that I practiced urological surgery in Eastern North Carolina for about 10 years, ending in 1990. I also graduated from the School of Law at the University of North Carolina at Chapel Hill in 1990, having received a classical liberal education that focused on individual rights and protections within an organized society. As the President and CEO of a public company in Austin, Texas, for much of the late 90s, I learned the business side of the healthcare industry but largely fell out of touch with the NCMS and the issues that were important to North Carolina doctors. Indeed, as I read about the early medical malpractice insurance crisis on a national level, I was skeptical. Yet, because of my legal education, I had more than a passing interest.

In early 2002, however, I was shocked to hear a local group of doctors speaking passionately about the toll the medical malpractice environment had taken on them and their practices. Both young and old, generalist and specialist, hot-headed and temperate doctors described a common dilemma: decreasing reimbursements, rising costs, and skyrocketing medical malpractice premiums were all forces driving them towards the precipice of having to limit their liability by reducing their risks. Nevertheless, when the NCMS subsequently called to ask me to chair the PLI Taskforce, I remained unsure. To obtain an objective view of the situation, I asked an independent researcher for a report on the PLI situation across the nation.. We studied the reforms of other states, asked questions of both pro- and anti-reform proponents, and weighed whether a true crisis existed or whether the PLI crisis was a fiction of major medical organizations and politicians. At the conclusion of this research period, I was convinced not only that the PLI crisis was real, but also that North Carolina was on a course to become the next West Virginia or Pennsylvania unless we did something proactive to change our medical malpractice insurance system.

But I am here not because I think that doctors are about to go out of business but because I fear that North Carolina citizens are the ones that stand to be harmed if we maintain the status quo. Because of the PLI crisis, the *invisible healthcare safety net* that the healthcare professionals of this state provide to thousands of the working poor and uninsured every day is in jeopardy. North Carolina mothers, injured children, accident victims, our sickest friends—anyone in need of specialty care risks being vulnerable to the unchecked impact of the current PLI crisis.

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How Is It Supposed To Work?

The current medical malpractice liability system is supposed to serve multiple functions. First, the negligently injured patient is supposed to be compensated for injury. Second, the litigation is supposed to deter future acts of negligence by the practitioner. Third, the insurance is intended to bring predictability and stability to the healthcare delivery system so that the economic uncertainty of liability claims will not derail these vital services. Unfortunately, the current system fails on all accounts.

Several studies have demonstrated that most negligently injured patients do not sue their doctors. While most of these patients will be fully recovered in six months and 90% suffer no permanent injury, most of the others still do not sue their physicians, because either they value their relationship with their doctor above an opportunity to sue, a lawyer refuses to represent them because they are not "sympathetic plaintiffs," or they do not believe that they have been negligently treated. So, in fact, most negligently injured patients receive no compensation for their injury.

Worse, those patients who do receive compensation from a liability claim are not necessarily the ones who have been negligently injured. Brennan et al., in their 1996 study, showed that the only reliable predictor of an award was the patient's degree of disability, regardless of whether a doctor's negligence caused the injury. Essentially, the current system rewards the lawyer who can pick a sympathetic client who suffers *either* a bad outcome or negligent care from a healthcare provider. The study by Brennan et al. also showed that awards go to patients 43% of the time where no negligence is involved. Doctors are understandably confused: either they have to be perfect without bad results (impossible), or they must limit their vulnerability to lawsuits by eliminating high-risk patients and procedures, relocating, or quitting the practice of medicine.

The current system's deterrence mechanism fails as well. As noted above, healthcare providers become paranoid knowing that any bad result could lead to a potentially bankrupting award larger than their insurance coverage. Patients come to doctors and hospitals because they suffer from disease or trauma that threatens their well-being, and healthcare providers have been trained to attack that disease process, for which they bear no responsibility, rather than worry about the risks of a bad outcome. Yet today's system makes them try to avoid risk of suit, regardless of the skill with which they perform. As long as the legal system demands that reporting and discussion of bad results and errors be made public and available for use at trial, doctors will be reluctant to discuss freely how to improve the systems that the 2000 national Institute of Medicine study says are the core of our medical mistakes today.

Finally, the economic stabilizing function of the system has failed as well. As medical malpractice insurance premiums have increased dramatically over the past eight years, doctors have found themselves in a "perfect storm" environment, characterized by decreasing reimbursement, increasing costs, and significantly rising medical malpractice premiums. Hospitals have seen their PLI costs increase by 200% in some instances, and self-insured entities have seen even more radical increases. The nursing home industry, with the most compressed reimbursements and no flexibility, faces 189% increases in PLI costs without any real escape route. Repeated surveys show that nearly 70% of doctors admit to the practice of defensive medicine: the ordering of tests and procedures for the primary purpose of avoiding litigation. Kessler and McClellan, economists at Stanford University, concluded that 5%-9% of hospital costs could be eliminated if doctors did only what the patient needs. Furthermore, in this unpredictable environment, the St. Paul Insurance Company and others have pulled out of the PLI business altogether, leaving at least 2,100 physicians in North Carolina trying to find coverage. Some physicians just quit, as the long-standing medical director of Forsyth County Emergency Medical Services did, because his reimbursement would not cover his new insurance premiums.

So Where Does North Carolina Stand?

The experts hired by the medical malpractice trial attorneys to testify before the North Carolina Senate Select Committee on Insurance and Civil Justice Reform have repeatedly testified that there is no crisis. Despite the fact that Senator John Edwards, a trial attorney himself, disagrees with that analysis, the trial bar continues to cite studies from "independent" groups that suggest that the real problems are insurance manipulation of the market, California-type reforms that do not really work, and doctors making too many negligent mistakes. All the while, these attorneys are trying to deflect attention from the exorbitant fees they collect while maintaining the status quo.

As mentioned earlier, several national organizations have labeled North Carolina "a crisis state." No crisis? Try telling that to the CEO of Medical Mutual Insurance Company, a North Carolina insurer formed by the doctors of this state in 1975 to ensure that medical malpractice insurance coverage would be available to our physicians no matter what. While insuring almost 6,000 physicians, Medical Mutual turns down 85% of the obstetricians and neurosurgeons and 70% of the emergency room physicians who apply for coverage.

No crisis? Try telling that to St. Paul Insurance Company, which after 50 years as the leading medical malpractice insurer in the United States abandoned the PLI market because it was too risky and unpredictable. St. Paul abandoned the PLI market but *not* the rest of its insurance programs. The 2,100 physicians they covered in North Carolina were forced to seek other coverage, if available and affordable.

No crisis? Try telling that to the other medical malpractice insurance carriers who have remained in the market, or

who have not gone into receivership. As Conning Research states in a recent report, these insurers' future is not bright because, "[b]arring significant and rapid reform, we forecast no end to the industry's current financial problems." Standard & Poor's adds this warning: "If severity trends continue to escalate in the absence of effective tort reform, we could arrive at a point where the whole industry structure is in peril." And, in response to the monotonous trial bar claim that it is investment losses that are driving this crisis, both Standard & Poor's and Conning disagree. "Improved investment returns are not the answer, nor do we expect them. In the national media debate, poor investment returns are regularly cited as the reason for rapidly rising medical malpractice prices. We disagree. While we find a lower level of investment income, we cannot envision the conditions required for investment income *to offset the staggering level of underwriting losses.*" (Emphasis added)

No crisis? Try telling that to our university health centers, like UNC and Wake Forest, where their self-insured PLI program costs have risen $3-$5 million in the past three years. They now have to make difficult decisions about faculty hires and whether to continue high-risk patient care. In a recent decision, Duke decided to end an experimental protocol, even though it was potentially life-saving for patients in the future, because of the liability risks and costs. The AHEC programs that are vital to the education of our future doctors have begun to cut back teaching staff because they cannot afford the liability premiums.

No crisis? Try telling that to the obstetrician/gynecologists (Ob/Gyns) who have quit delivering babies to minimize their risks and avoid financial disaster. A seven-member Ob/Gyn group in Salisbury saw their medical malpractice insurance premium double, from $150,000 to $300,000, in one year. As caregivers for the entire area, including the indigent and Medicaid population, how can they continue to fulfill their mission when they get less than $1200 for many of their deliveries? The story of Dr. Mary-Emma Beres of Alleghany County was well chronicled in a recent *Time* Magazine article about the current PLI problem. She did not want to stop delivering babies for her patients, but she was forced to because of St. Paul's withdrawal from the medical liability insurance business and her unsuccessful search for any affordable OB coverage.

No crisis? Try telling that to the neurosurgeons who are paying over $100,000 per year for PLI coverage. Or to the ER doctors who cannot find coverage. Or to the orthopedists concerned that ever-increasing awards, now averaging over $3.9 million in jury trials, will outstrip the limits of their insurance coverage and cause them to have to file for bankruptcy, as happened with a Fayetteville physician.

No crisis? While it is true that physicians have not started to leave North Carolina in significant numbers and the frequency of medical malpractice claims in North Carolina is stable, our PLI insurers spent $1.66 for every $1.00 they collected in 2001 (the latest year for which complete data are available). Eleven of our counties are without physicians. More than a handful of counties in North Carolina have no or only one obstetrician to deliver babies. Neurosurgeons have begun leaving some communities, such as Fayetteville, because of malpractice insurance costs. If we wait for a full-blown crisis, as seen in West Virginia and elsewhere, the doctor departures will escalate and our citizens will be the ones to suffer. Indeed, the only ones to gain will be the very source of the "no crisis" rhetoric: the trial attorneys.

Do Medical Malpractice Insurance Reforms Really Work?

One of the persistent mantras of the trial attorneys has been that the reforms that have been passed in other states, like California, have not worked to stabilize the PLI market. They take aim particularly at the caps on damages as being ineffective, citing a recent study by the Weiss Group in Florida. The NCMS's White Paper, which studied all states' PLI reforms, and those of the RAND Corporation, the US Department of Health and Human Services, the Joint Economic Committee of Congress, AM Best, and Standard & Poor's all disagree with the trial attorneys' claim.

In 1974 California faced a medical liability insurance crisis in which the doctors walked out and the hospitals stopped caring for anyone except emergency patients. The California legislature established a study commission and analyzed the PLI environment in all of its nuances before recommending a set of reforms called the Medical Injury Compensation Reform Act (MICRA), which was passed in 1975. After ten years of challenges by the trial attorneys in California courts, MICRA was finally fully approved by the California Supreme Court and began to gain control of the PLI market. Since its passage in 1975, California PLI premiums have gone up 167% while the rest of the nation's have gone up 505%. MICRA included the cap on noneconomic damages, the periodic payment requirement, the removal of double payments (the collateral source rule), and the limits on trial attorneys' contingency fees, similar to what the NC Medical Society, the NC Hospital Association, and the NC Healthcare Facilities Association are currently seeking from the North Carolina General Assembly. For 28 years, MICRA has worked in California, withstanding the test of time and every legal challenge raised by the trial attorneys. The US House of Representatives has passed MICRA-like reforms and is awaiting Senate consideration.

The trial bar likes to obfuscate the effectiveness of MICRA by claiming that it was an insurance reform, Proposition 103, passed in 1988 that is responsible for the stability of the California market. Quite the contrary, Prop 103 was primarily an auto insurance reform that affected less than 50% of PLI carriers in California. Prop 103 itself got mired in court appeals and did not become fully effective until 1990 or 1991. Since its passage, no requested rate increase by a medical malpractice insurer has been turned down. North

Carolina law already regulates insurers with similar language.

As to the claims that caps on noneconomic damages do not work to stabilize the PLI market, multiple studies have refuted that contention. *The US Department of Health and Human Services study showed that states with $250,000 or $350,000 caps on noneconomic damages have medical malpractice premiums that are 30% less than states that do not have caps.* NCMS Task Force analysis found that, once the cap on noneconomic damages exceeded $650,000, it did not work. Hence, West Virginia just lowered its $1 million cap to $250,000, and Idaho lowered its $600,000 cap (a $400,000 cap indexed to inflation) back down to $250,000. Some states, like Nevada, have passed noneconomic caps but created "exceptions" that served to create loopholes used by the trial bar to eviscerate any impact of the caps. Oregon had a $500,000 cap on noneconomic damages that worked beautifully for 12 years to control the PLI environment. After the cap was ruled unconstitutional in 1999 by the Oregon courts, chaos returned along with another PLI crisis. Other states, like Virginia, instigated a cap on *all* damages, which North Carolina chose not to pursue because the NCMS's Task Force on PLI Reform thought it too harsh on the injured party. Indeed, fairness to the negligently injured party was a concern that guided the NCMS Task Force's final decision determining which reforms to seek.

The recent focus on the Weiss Report's claim that caps do not work is unfortunate because of its critical flaws and apparent bias. Three weeks *before* the report was released, the same group published a survey that showed that 70% of Americans believe that the current PLI crisis is caused by greedy lawyers and problems with the legal system. The President of the Weiss Group, however, opined that he thought the people were wrong. The study claiming caps do not work used a "median payout" premium average that has no meaning in the PLI market, and it compared states regardless of what kind of cap they had (West Virginia was used as a cap state when it was in a full blown crisis and lowering its cap) and regardless of how long a cap had been in place (some had just been passed). Weiss also failed to weight their data by size of state and failed to consider market share of insurers, critical to meaningful analysis.

What we do know, however, is that if a state passes a series of reforms, including a cap on noneconomic damages, and if those reforms are "pure," without loopholes, the reforms will work to bring stability to the PLI market and to that state's citizens. As retired California Supreme Court Justice and Democratically appointed Vice Chairperson of the US Commission on Civil Rights Cruz Reynoso stated in the *LA Times*, " What is obvious about MICRA is that it works and works well…. Our doctors and hospitals pay significantly less for liability protection today than their counterparts in states without MICRA-like reforms." What's more, analysis in California has shown that MICRA does not deny people access to court to seek redress for medical negligence and has not prevented the increase of appropriate payment to injured patients for medical costs.

Why the Focus on Caps on Noneconomic Damages?

The easiest way to prevent legislators from taking action is to confuse them about issues that are emotional and immeasurable. Thus, caps on noneconomic damages present profitable fodder for the trial bar's "confuse and muddy" strategy.

First, trial lawyers like to make it appear that *all* damages will be limited if the PLI reforms are passed in North Carolina. Despite repeated explanations and declarations that negligently injured patients will receive fair compensation for all economic harm and that *only noneconomic* harm would be limited, the trial bar recently paraded an out-of-state "victim" from Virginia before the NC General Assembly, lamenting the unfairness of her award. As mentioned previously, however, Virginia has a cap on *all* damages, making this person's appearance irrelevant to the proposed reforms being considered by the North Carolina General Assembly.

Second, few insurers, court systems, or lawyers track damages by category: economic v. noneconomic. Thus the trial bar can claim that no one knows how much these immeasurable damages for pain and suffering contribute to the current PLI crisis. What studies do exist, however, show that these noneconomic damages make up as much as 50% of the total awards given, substantiating the salutary impact of capping these awards.

Lastly, in a *Northwestern Law Review* article in 1989, Duke University Professor Frank Sloan noted, "A tacit role of awards for noneconomic damages is to help pay a plaintiff's legal expenses without cutting into the economic recovery…." As Dr. Sloan suggests, the real reason for the intense opposition to PLI reforms and caps on noneconomic damages lies in their impact on the plaintiff attorney's ability to take 33%-40% of the total award without the lawyer's client complaining about it. So, it's all about the money.

But How Do You Put a Price on Pain and Suffering?

Just as "beauty is in the eye of the beholder," meaning that each of us looks at the same landscape but sees a vastly different picture, pain and suffering vary greatly among individuals. No objective measure, yardstick, or formula can calculate an unquestionably accurate value.

In medicine, we like to think that we can measure suffering by the dosage of pain medicines we give our patients. My own experience with surgical patients, however, proves to me that pain is so subjective that even a procedure such as lithotripsy, identical shock waves delivered to kidney stones by a sophisticatedly engineered device, creates a wide range of "pain" for different patients. Some would require maximum narcotic analgesia or even general anesthesia, and some

would require nothing for pain. Same procedure, same surgeon, but a different pain threshold.

Twenty-six states have already passed PLI reforms that contain caps on damages, and more than 20 states are currently considering such reform.

Why have so many states arbitrarily defined the limits of pain and suffering? Are these state legislators just callous or insensitive? Or could it be that they have made a policy decision for their citizens, believing the predictability and stability such limits bring to doctors' malpractice premiums are more important than enabling someone to hit the "pain and suffering lottery" via an attorney's ability to appeal to jury emotions? Those states have decided the excesses of noneconomic damages must not threaten their citizens' access to medical care. California, Oregon, and others have shown us that reasonable and fair reforms, such as a cap on noneconomic damages, while allowing measurable economic recovery, can stabilize the insurance market and protect citizen access.

When our society has been forced to define the value of pain and suffering, we have often resisted the temptation to measure the immeasurable. Our Worker's Compensation Laws largely ignore the noneconomic damages of pain and suffering but provide awards of $10,000 to $20,000 for injuries leading to scarring and disfigurement. When our brave military men and women are killed in war, their spouses receive burial expenses, an American flag, and up to $250,000 in life insurance. Are our legislators mean-spirited in not recognizing the pain and suffering of that worker or of that military spouse? Certainly not, but they have been forced to make a value judgment for the benefit of all citizens, not just the few.

We cannot put a price on another's pain and suffering just as we cannot put a price on someone's joy. When your doctor cures your cancer, restores your eyesight, or enables you to walk again, does he try to put a price on your joy of living, of seeing the blue sky, or of playing ball with your child? Of course not.

Why Not Just Eliminate Doctor Mistakes?

As long as doctors try to cure our diseases, there will always be bad results and mistakes. The danger is that they will stop trying because of the liability risk associated with treatment. The nature of medicine and the long years of medical training required to enter the practice of medicine are all aimed at aggressively attacking disease in an effort to render a patient either disease free or at equilibrium with a chronic disease state.

As demonstrated by the recent United Network for Organ Sharing (UNOS) guidelines for transplantation and by the remedial actions taken by Duke and other transplant centers in response to the tragic mistake made by the Duke transplant team, medicine does not need the threat of medical malpractice litigation to try to make our healthcare environment as safe as possible for our patients. To the contrary, the litigation that is bound to follow will only serve to slow down the willingness of practitioners to be open and proactive in changing patterns of practice. We all will pay for the jackpot lottery opportunity of a few lawyers and family members.

We can always do better. We can always improve oversight of our profession, even though medicine is the most regulated and scrutinized profession in society. We can improve our systems to help minimize error. But we will always have some bad results as long as we cut into human bodies to cure disease: the body just does not always heal the way we want. And, unfortunately, we will always make mistakes because medicine remains as much of an art as a science.

Who Are We Protecting Here?

Why do I care so much about this issue? Certainly I care that my peers, who are the healers in this state, have seen their patients become legal adversaries. I care that access for our patients may be jeopardized. And I care about my family and friends who honorably practice law and protect our citizens from injustice. I am not really afraid that most of our doctors are going to close their doors. Doctors are healers and, by and large, they love what they do. No, the real threat here is to the invisible healthcare safety net that exists in North Carolina. And that is what we must protect.

What Is the Invisible Healthcare Safety Net?

Unfamiliar with that term? So are most of the doctors who provide the safety net and who daily perpetuate its existence. Its invisible nature stems from the fact that we all take it for granted, and rarely acknowledge its substantive contribution to the care of our citizens. Yet the current PLI crisis threatens to rupture the safety net as medical practitioners seek to eliminate the risks of suits by patients from whom they have no chance of being paid.

What is this invisible safety net? It is the *pro bono* care that doctors provide to thousands of patients every day—the working poor, the uninsured, the most vulnerable citizens of our state—who come to their offices for help. Women and children make up the majority of this population.

How do I know it exists? Although I have long believed in its existence, I recently asked my former practice management firm to look at its 500 physician clients in NC and answer two questions: first, what percentage of their doctor clients give charity care and, second, what dollar amount of charity care did the doctors give on an annual basis? Eliminating Medicare, Medicaid, and discounts of any kind from consideration, the management firm found that 100% of their doctors provided charity services. Fur-

thermore, a representative sampling of their physicians, constituting approximately 1% of the MDs in North Carolina, found that, on average, each MD provided about $26,000 of charity services per year. Extrapolated to the entire doctor population of North Carolina, the Invisible Safety Net is providing in excess of $500 million of healthcare services to our most vulnerable citizens.

Our medical schools train the doctors of today and tomorrow to attack disease wherever they find it with a variety of therapies. Yet today, the PLI crisis is forcing these healers to become risk-averse. Defensive costs of medicine, as doctors try to protect themselves from lawsuits, are hard to measure but are real and driving up our healthcare costs. Already we see that some specialists are limiting their high-risk procedures, even though they have taken care of the high-risk patients competently for years. Some indeed are talking of retirement or relocation. The invisible healthcare safety net is the first and most reasonably eliminated service as doctors seek to mitigate their risks.

So What Is This All About?

Money? Certainly, the potential loss of dollars is fundamentally driving the trial bar's visceral reaction to all PLI reforms. The state's nursing homes find themselves in survival mode dealing with the increased costs and decreased reimbursement. Our hospitals struggle with mounting liability and costs, all the while trying to decide which services could be cut. While the doctors also see PLI from an economic standpoint, they must deal with the negative impact of the medical malpractice system on their relationship with their patients and the psychological distortion of the joy of being a healer in our state.

What about the patients? They must be concerned about access to the doctors they need in times of sickness. Will the trauma center be open? Will the surgeons and orthopedists take the liability risk of caring for them? They are also worried about medical mistakes and what can be done to create an environment that induces corrective education and actions without an atmosphere of paranoia. And yes, a few of them are worried about that opportunity to get unlimited awards, a chance at the legal lottery.

All of us should be concerned about the threat to our uninsured's access to the invisible safety net. While not perfect, the safety net provides almost $500 million of care to these patients in North Carolina. In these tough budgetary times, how will we afford to replace this free care, if the doctors decide they can no longer afford to take the risk?

Ultimately, this discussion centers on what makes the best public policy for North Carolina. The public policy issue here is simple: each year North Carolina doctors admit at least 955,000 citizens to our hospitals, perform 1.2 million surgeries, and provide 4.2 million days of hospital care to patients. They give away more than $500 million annually to our uninsured while our hospitals give away multiples of that number. Yet the current PLI crisis—driven by mounting claim losses not insurance fraud—is threatening our access to certain high-risk specialties and creating a probable rupture of the healthcare safety net for thousands of our most vulnerable citizens.

The collection of reforms that the healthcare providers seek have proven successful and stood the test of time for 28 years. These reforms do not limit injured patients' access to court, do not limit economic recovery, and, in fact, try to ensure that more money gets to the injured parties, rather than to their lawyers. The proposed reforms do limit, but not unreasonably so, trial attorney contingency fees, which currently account for about 40% of the patient's recovery.

Who Are the Winners and Losers?

So who wins by maintaining the status quo? Certainly not the thousands who get care through the invisible safety net. Certainly not the 99% of North Carolinians who pay the increased cost of defensive medicine as healthcare providers try to avoid the litigious environment. Certainly not those patients who will die from lack of neurosurgical care or those mothers who will deliver their babies in cars as they travel to the nearest obstetrician. Certainly not the doctors and other healthcare providers who will continue to limit their risks until their presence becomes meaningless, becoming so risk-averse that attacking a patient's disease is less important than attacking their liability problems.

So who wins? A handful of patients who may get a multimillion dollar pain and suffering award, despite the immeasurable nature of these conditions. And, of course, the trial attorneys who will take their "fair share."

Reason demands that we legislate so that *most* North Carolinians will benefit, not just the few. If our legislators cannot muster the political will to address these issues in a timely way, they fail the citizens who elected them. If they choose to demur by "studying" these well-studied issues, they fail again. If they choose to compromise and pass reforms that will not stabilize the markets but will placate some constituencies, we can only hold our collective breath and see whether our healthcare providers are just "whining" in a tough business environment or whether they are drawing a poignant picture of an easily foreseeable harm that we are foolish to ignore.

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