Misdiagnosis
Behind the Rhetoric of the Malpractice Insurance "Crisis"

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OVER THE PAST YEAR, a growing national campaign has publicized the existence and effects of a "crisis" in medical malpractice insurance. The insurance industry and medical trade associations claim that "skyrocketing premiums" and "runaway jury verdicts" are driving doctors out of business. Work slowdowns, doctor strikes, and rallies have been used as tactics to influence state legislatures.

In North Carolina, healthcare lobbying groups have demanded action from the General Assembly. In order to defuse the alleged crisis, these advocates propose placing a cap on noneconomic damages—i.e., damages for human losses—awarded to victims of medical errors. Yet close scrutiny reveals no basis for instituting such a radical change in our legal system.

Foundation For the "Medical Liability Crisis" Claim

The "crisis" argument is based on the idea that rapidly increasing medical liability insurance premiums are forcing physicians to limit their practice, retire early, or relocate to a state with lower liability premiums, resulting in reduced healthcare access for North Carolinians. The increases in premiums, crisis proponents argue, are driven by an increase in the number of medical malpractice lawsuits and large jury awards. Increasing awards, according to this theory, also drive increased payments in cases that are settled between victims and insurance companies.

The evidence shows, however, that North Carolina physicians across the board are not facing massive premium hikes. There is no widespread crisis in our state. If problems do exist, they are generally limited to a group of high-risk specialties and are not endemic to the entire medical community.

Doctors Are Flocking to, Not Fleeing from, North Carolina

North Carolina has experienced an influx of population over the past two decades for a number of reasons, including our state's relatively low cost of living, growth in employment opportunities, and an environment that makes this state an ideal place to live and raise a family. From 1979 through 2001, the state's total population increased approximately 41%, with 91 of the state's counties experiencing population growth during that period.[1] While the total population increase has been significant, the increase in our state's physician population has been far more dramatic. From 1979 through 2001, North Carolina experienced a physician growth rate of 126%, more than three times the rate of total population growth (see Graph 1).[2] The number of physicians as a share of the total population increased from approximately 12 per 10,000 citizens in 1979 to 20 physicians per 10,000 North Carolinians in 2001.[3]

The pattern of growth holds true within specific medical specialties, as well. Between 1993 and 2001, North Carolina's total population increased 16.4% while the number of doctors specializing in internal medicine grew 40.4%. The increasing population of obstetrician-gynecologists also outpaced the total population growth rate, rising 21.5% in that nine-year span. Growth among neurosurgeons, a specialty often cited as part of the current "crisis," also outperformed population growth, increasing 17.5%.[4] Throughout the past decade, physicians have been flocking to North

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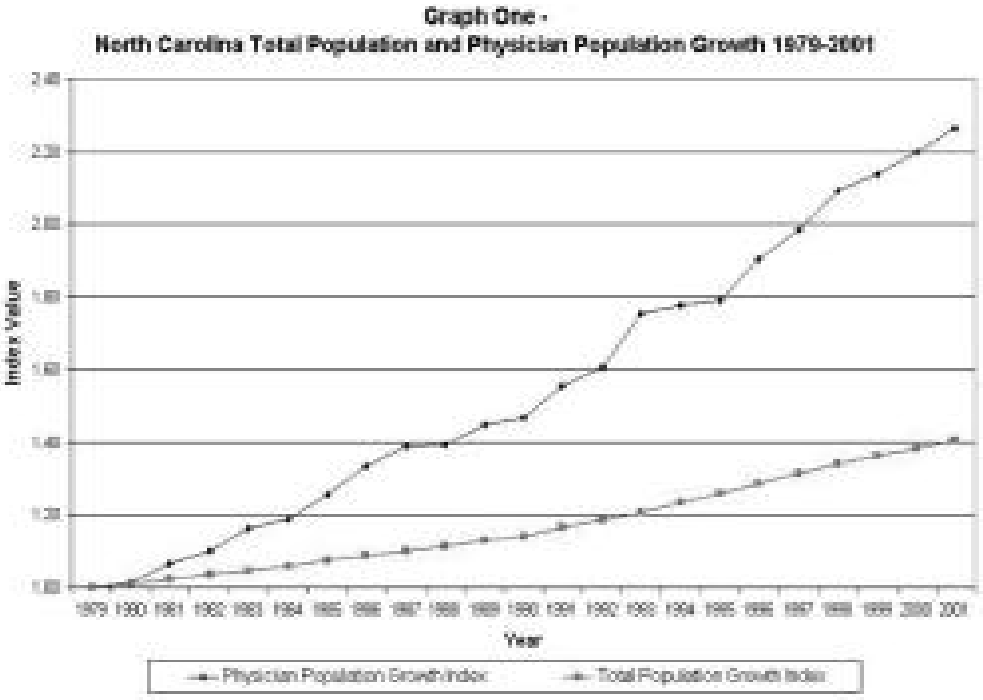
Carolina, not leaving this state because of high malpractice insurance premiums.



The Amount of Litigation Is Stable

Three years ago, the National Academy of Sciences' Institute of Medicine concluded that between 44,000 and 98,000 Americans die each year in hospitals because of preventable medical errors.[5] These data suggest that 1,200 to 2,800 North Carolinians die in hospitals each year because of preventable medical errors—an average of up to eight deaths every day.[6] Additional research suggests that preventable errors occur in about two percent of hospitalizations.[7] Based on these statistics, it can be estimated that as many as 18,000 North Carolinians are injured by medical mistakes each year.[8]

In view of this extrapolated incidence of medical errors, the number of malpractice lawsuits filed in North Carolina is remarkably small. In 2002 the number of medical malpractice cases filed actually declined 10% from the previous year. Over the past five years, North Carolina has averaged only 611 medical malpractice cases each year.[9]

One factor that limits the number of malpractice lawsuits is the high cost of preparing and pursuing a case. The injured victim must secure legal counsel, acquire medical records and documents, obtain expert witnesses to testify in court, and depose the defense witnesses. These steps routinely cost tens of thousands of dollars, often for victims with no financial resources because of the impact of their injuries. The current contingency fee system allows these victims to bring their cases forward through an agreement with the plaintiff's attorney providing that costs will be paid out of any judgment or settlement. Without the contingency system, victims would be expected to pay the legal costs up front, a requirement that would allow only wealthy injured patients to pursue their claims.

The North Carolina General Assembly has already given healthcare providers special protection from "frivolous" lawsuits. Under Rule 9(j), a procedural rule that applies only to medical malpractice cases, a qualified medical expert must review the case before a lawsuit is filed and must agree to testify that the patient received substandard care. A patient who fails to meet this requirement cannot file suit.

North Carolina Juries Are Conservative in Malpractice Cases

In medical malpractice cases, North Carolina juries are conservative in assessing liability and awarding damages. Empirical research has confirmed that juries routinely rule in favor of doctors and hospitals; malpractice plaintiffs in North Carolina win at trial in roughly one out of five cases.[10] In cases where the victim prevails, if the jury's award is unsupported by the evidence, the trial judge may order a new trial.

Data from the state Administrative Office of the Courts indicate that 3,055 medical malpractice lawsuits were filed between 1998 and 2002.[11] Of these, approximately 2,151 had been resolved as of the beginning of 2003. Among the resolved medical malpractice lawsuits, 67 had reached a jury trial (3% of resolved cases). Only 13 of those cases (19%) were decided in favor of the plaintiff. The median jury award was $250,000, with only two verdicts of more than $1 million.[12]

Liability Insurance Premiums Are Moderate for Most Doctors

The "crisis" argument maintains that in the face of increasing lawsuits and exploding jury awards, insurers have been forced to raise rates in order to stay in business. However, data on North Carolina's experience do not support this claim. Medical Mutual Insurance Company of North Carolina is the largest malpractice insurer in the state, covering about half of North Carolina doctors. Medical Mutual's

premium increases have been moderate since the late 1980s, and, on average, lower than inflation in the cost of medical care. From 1989 through 2002, Medical Mutual's base premium rate increased at an average annual rate of 3.8%.[13] Over the same period, the consumer price index for medical care increased at an average annual rate of 5.3%, a growth rate nearly 40% higher than physicians' premium increases.[14] Thus, victims of malpractice faced sharper increases in medical costs for treating their injuries than physicians experienced in their liability premiums.

Medical Mutual's rate filings with the North Carolina Department of Insurance confirm that average premium rates are moderate. The company's most recent publicly available rate filing indicates an average collected rate of $9,192 per insured for 2002.[15] This restrained trend is also true for other insurers across the state, according to NC Commissioner of Insurance Jim Long. In testimony before a legislative committee, Commissioner Long presented materials compiled by his office, demonstrating that the statewide average earned premium per physician was $6,353 in 2002.[16]

Premiums May Have Increased More Sharply for Some Providers

Two categories of "high-risk" providers have experienced sharper premium increases: doctors or facilities with poor claims history and doctors who perform procedures more likely to result in complications.

Although most North Carolina physicians are talented, caring professionals, a few negligent and dangerous doctors repeatedly commit medical errors. Based on an investigation of North Carolina claims reported to the National Practitioner Data Bank, the research group Public Citizen concluded that doctors who made payments in three or more malpractice claims constituted only 1.1% of the state's physician population, but accounted for 20.4% of the total amount paid out.[17] This situation is illustrated by the case of a surgeon who told the Raleigh *News & Observer* that he had experienced a 325% premium increase over two years.

The surgeon said that he had no malpractice claims over the previous 15 years and attributed the increases to his medical practice having adding a new physician whose prior practice group had unresolved malpractice claims.[18] A further examination, however, revealed that this surgeon who claimed to have a spotless record had been sued for malpractice at least nine times since 1989, including one case involving a patient's death. In depositions the surgeon admitted that he had been negligent in three of those cases.[19] Clearly this surgeon's premium increases reflected his claims experience. Just as someone with a poor driving record would expect to pay higher rates for automobile insurance, physicians with poor malpractice records and high error rates should anticipate premium increases.

In addition to physicians classified as "high-risk" because of their claims history, insurance companies may also assign this designation to specialists who perform complex or high-risk procedures. Specialists frequently cited in these high-risk categories include neurosurgeons and obstetricians. The risk factors are compounded in rural areas, where lack of proper nutrition and basic healthcare, among other factors, can increase the likelihood of medical complications. Because of the relatively small number of practitioners in these specialties, they can be particularly susceptible to large fluctuations in premiums. Under the insurance industry's classification system, when fewer physicians are in a class or group, each must share a higher portion of the risk.

Damage Caps Will Not Reduce Premiums

If some specialties face sharp premium increases, experience in other states suggests that a cap on damages for human losses will not solve the problem. The American Medical Association's Advocacy Resource Center provides a compilation of the malpractice damage cap laws across the nation.[20] These include so-called "hard" caps, where damages are limited to an absolute amount, and "sliding" caps, which are indexed to increase with inflation or to correspond with certain timelines or certain types of injury. According to the AMA's materials, 26 states have some form of cap on damages in malpractice actions. If damage caps were the successful element in averting a liability "crisis," one would assume that these states are doing well in the current climate.

However, more than half of the states (14 out of 26) with some form of damage cap are classified by the AMA as "showing problem signs" in their medical liability system.[21] In addition, the AMA's "crisis"-state designation includes six states that have imposed malpractice damage caps. Thus, damage caps have been unsuccessful in preventing "problems" or "crisis" status in three fourths of the states that have implemented these laws. It also does not appear that the "hard" cap states have shown any more success than those with "sliding" caps. Among the eight "hard" cap states, six are classified as "showing problems" and only two are considered "currently okay."

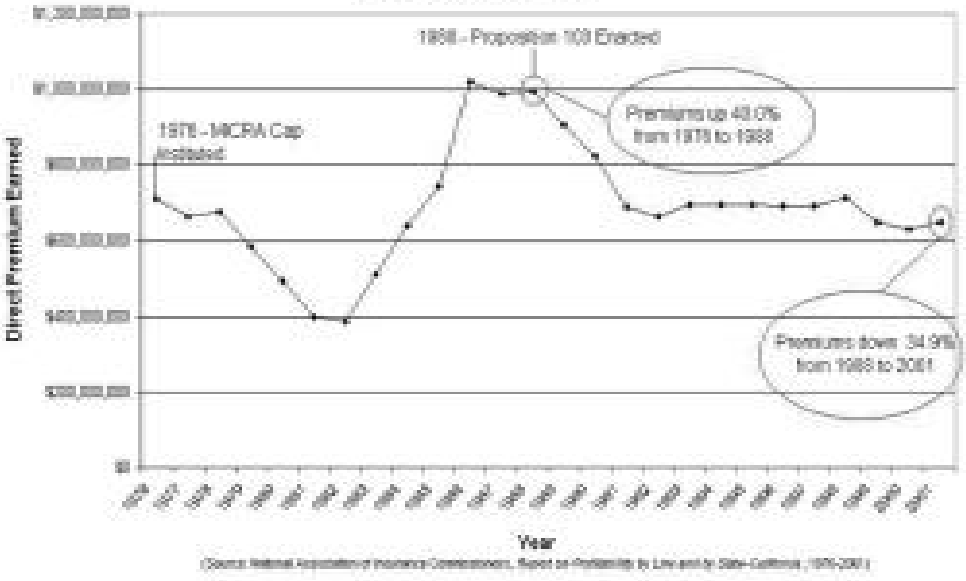
Weiss Ratings, an independent agency that evaluates financial institutions and insurers, recently highlighted the ineffectiveness of malpractice damage caps in limiting physician's premiums. The Weiss study found that among 19 states with limits on noneconomic damages the median payout to malpractice victims was lower and increased more slowly during the 1990s than in states without damage caps. The study also found, however, that median malpractice insurance premiums in cap states increased more than in states without caps. Thus, while insurance companies in cap states were paying out less to victims, they were charging physicians higher rates for coverage. The authors reconcile these seemingly contradictory findings by arguing that other factors, including medical inflation, the insurance business cycle,

declining investment income for insurers, and market supply and demand have a more important role in determining premiums than caps on damages.[22]

Caps Are Not the Reason For "Success" in California

Advocates for a cap on human damages point to the experience in California, where a $250,000 cap was enacted in 1975. However, a closer examination reveals that California's relative "success" in limiting medical liability insurance costs is not due to a damage cap. Following the enactment in 1975 of cap legislation, known as the Medical Injury Compensation Reform Act (MICRA), as indicated in Graph 2, California's total liability insurance premiums rose 190% over the next 12 years (a 40% increase when adjusted for inflation).[23] In 1988, California voters approved Proposition 103, an insurance reform measure that gave the Commissioner of Insurance greater power over rates and mandated hearings to justify large rate increases. Since then, California's medical malpractice insurance costs have stabilized and in 2001 stood 2.4% lower than the year Proposition 103 was enacted (34.9% lower, when adjusted for inflation).[24] Thus, California's stable rates resulted from insurance reform, not caps on damages.

Graph Two -
California Medical Malpractice Direct Premium Earned 1976-2001
(Adjusted for Inflation)



Despite California's success in limiting premium rate increases, some California doctors pay more for medical liability coverage than their counterparts in North Carolina. According to *Medical Liability Monitor*, an independent trade publication, the 2002 base rate for a North Carolina general surgeon insured by the state's largest insurer (Medical Mutual Insurance Co. of NC) was $37,393. General surgeons covered by California's largest insurer (NORCAL Mutual Insurance Co.) paid a base rate of as much as $49,436, 32% higher than the same specialist in North Carolina. California specialists in internal medicine paid rates as much as 153% higher than internists in North Carolina.[25]

No Cause and Effect in Oregon's Experience

Another example frequently cited by supporters of damage caps is Oregon, a state that instituted a $500,000 cap on noneconomic damages in 1987. In 1999, the Oregon Supreme Court ruled that the cap violated the state constitution.[26] Cap supporters claim that while Oregon's damage limits were in effect, premium rates for the state's two largest insurers were stable or declined. In 2001, following the Supreme Court's ruling, rates began to increase by as much as 51%.[27] However, this argument makes a flawed assumption as to cause and effect. The Oregon Court of Appeals had previously ruled damage caps unconstitutional in 1994 and again in 1996.[28] If caps on damages were linked to premium rates, one would expect that insurers—businesses that are closely attentive to the legal environment impacting their market—would have raised rates in response to the 1994 and 1996 rulings. In fact, the insurance companies took no such action. The timing of rate increases in 2001 and 2002 is much more likely to be linked to nationwide insurance trends following the downturn of the investment market and the impact of the September 11th terrorist attacks, rather than the presence or absence of limits on noneconomic damages.

Caps Hurt the Most Vulnerable in Society

Caps on human damages in malpractice cases would impose a fundamental inequality among the victims of medical error. Jury verdicts would continue to compensate for economic damages, including past and future wages lost as a result of malpractice. Our society's most vulnerable citizens, those who are not in the workforce and could not demonstrate lost wages—children, "stay-at-home" women and men, and the elderly—would be assigned second-class status among malpractice victims. In some cases this would mean that a victim's total recovery would be limited to the amount allowed under the cap. The result of such a limit would be to prevent these victims from pursuing their cases because prohibitively high costs would consume a significant portion of the eventual damage award.

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A cap on human damages would also create a "one-size-fits-all" system that ignores important distinctions and circumstances in individual malpractice cases. Consider a woman who loses her ability to conceive children as a result of medical error but retains the ability to work, thus eliminating the possibility of economic damages. Certainly this is a drastic loss for anyone, yet the specific circumstances of each case are important in determining compensation. Is the loss of reproductive function in a 45-year-old with three children equal to that of a newlywed 24-year-old without children? Under a cap on human damages, both such cases would be limited to an arbitrary amount determined by politicians and lobbyists. Our current system properly allows juries of our peers and neighbors to weigh the evidence and determine appropriate compensation for each victim's loss.

Medical Inflation and Increased Life Expectancy Affect Increased Payments to Victims

Two important factors in malpractice payments, ignored by advocates of a cap on human damages, are the recent large increases in medical inflation and the increase in life expectancy afforded by new medical innovation and procedures. Given rapid increases in the cost of medical care—a component of economic damages—there can be little doubt that inflation in these costs is a driving factor in any increased verdict and settlement trends. Between 1980 and 2002, the cost of medical care increased more than 280%.[29] By comparison, total inflation was slightly less than 120% over the same period.[30] The effects of medical inflation on medical malpractice payments are magnified when coupled with the availability of new, and often more costly, medical procedures that increase the life expectancy of malpractice victims. These medical expenses are a necessary component of compensation for medical errors. Projected future medical expenses at increased costs each year will unavoidably result in larger jury verdicts and case settlements than five, 10, or 20 years ago.

Improved Patient Safety and Insurance Reform Are Positive Steps

The most effective way to limit medical liability insurance premiums is to reduce the number of medical errors. Although thousands of North Carolinians are injured or die because of medical errors each year, the North Carolina Medical Board rarely takes appropriate steps to investigate errors and discipline physicians. According to the research group Public Citizen, North Carolina ranks 45th in the nation in frequency of serious disciplinary action against physicians.[31] This low rate of discipline persists despite the fact that "frequent offender" physicians account for a disproportionate share of malpractice claims, lawsuits, and payments. By allowing a few careless or undisciplined doctors to continue committing errors without sanctions, the North Carolina Medical Board in effect forces all doctors to pay for the mistakes of a few. Physicians should demand stricter accountability for the sake of their patients, the reputation of the medical community, and their own self-interest.

Along with stricter accountability from the North Carolina Medical Board, physicians should demand greater accountability and disclosure of insurance industry practices. During the investment boom of the 1990s, insurers discounted policy prices in order to maintain or increase market share while covering any underwriting losses through investment income. Once these companies' investment returns began to fall, they were forced to increase rates to maintain their profit margins. Dr. Richard Roberts, former president of the American Academy of Family Physicians, outlined this phenomenon in *Family Practice Management* in October 2002:

> The dramatic premium increases experienced recently by many physicians have much to do with stable or even decreasing premiums paid during the mid-to-late 1990s. At that time, insurers were looking for ways to avoid paying taxes on their reserves, which were growing rapidly as a result of significant gains in their investment portfolios. Rather than maintain excess capital on the books and pay taxes on that capital's investment income, the companies bought or preserved market share by selling policies for less than their actuarially predicted risk. The market was 'soft.' In other words, they sold $10,000 of risk for $5,000 in premiums to sell twice as many policies. At the time, doctors were pleased with stable or declining premiums; insurance company shareholders were happy with their rising share prices and dividends. Eventually, when the under-reserved losses finally came due and the investment economy cooled, a correction was bound to occur. That day has arrived and the medical liability insurance market has 'hardened' dramatically in the past two years.[32]

The current structure of the insurance market and regulations make it difficult for policyholders and the public to determine causes of rate increases. Medical Mutual officials, for example, have testified that individual policyholders may be charged premiums that are as much as 45% higher or lower than the base rate filed with and reviewed by the Department of Insurance.[33] Greater accountability and transparency in underwriting practices would give insured policyholders and public policymakers greater insight into the true condition of the market.

Contrary to the claims of interest groups and lobbyists, North Carolina is not experiencing a medical liability "crisis." Unlike some other states that have genuine problems, average premium rates in North Carolina are reasonable,

the number of lawsuits is stable, and juries are conservative. Physicians are choosing to move into North Carolina, not fleeing to other states because of malpractice premiums.

Caps on human damages will not improve patient safety or insulate physicians against insurance company practices. Just as modern medicine prescribes targeted procedures to cure an illness, the medical community should join with patient advocates in working toward targeted solutions to improve patient safety and implement insurance reform.

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