RESTRUCTURING THE MEDICAL PROFESSIONAL LIABILITY SYSTEM

Position Paper

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The medical malpractice system in the United States is designed to both compensate and to deter medically induced injury. It performs these functions through the civil justice system, which allows individuals to seek redress for injury caused by medical negligence (improper or substandard medical care), and the liability insurance industry, which charges premiums to providers in exchange for financial protection against the cost of compensating malpractice claimants.

In theory, liability for negligence serves to monitor the quality of health care delivery by penalizing the practitioners who fail to meet standards of care established and shared by the profession. However, in today's climate of skyrocketing insurance premium costs, steady growth in the numbers of claims filed, and the increasing frequency of multi-million dollar jury awards for pain and suffering, the perception has developed that the malpractice system is not achieving appropriate compensatory and deterrence goals, and is in a state of crisis. In addition, there is growing concern that physicians are defensively altering their professional practices, by refusing to take certain high-risk patients and by ordering medically unnecessary tests for their patients to protect themselves in case of lawsuit (1).

In light of these fears about changing practice patterns, and the disturbing increase in the frequency and severity of malpractice claims, the feasibility of current mechanisms for compensating and insuring against medical injury is being hotly debated. Increasingly, policy makers have begun to question whether current civil justice and liability insurance mechanisms can guarantee the continued availability and affordability of adequate insurance, while providing appropriate disincentives to unreasonable medical conduct and insuring appropriate compensation for individuals who are injured due to medical negligence.

Several states have sought to combat problems in the medical liability area through enactment of legislation insurance regulation and changes in the disciplinary policies of medical licensing boards. The College applauds the initiative of these states in taking steps to resolve the multiple problems involved and supports further action at the state level, while recognizing that the issues are also of national proportion and interest.

In general, two approaches have been identified as possibilities for reforming the current medical malpractice system. The first, broadly labeled "tort reform", involves changes which make the process of bringing malpractice suits against physicians more difficult legally and less appealing economically. They include provisions limiting the amount of financial

recovery plaintiffs may receive and the proportion of recovery their attorneys may receive, and provisions circumscribing the conditions under which a law suit may be brought to court.

The second approach is one which has only recently begun to emerge in the national debate to resolve the medical liability problem. It involves the examination of insurance industry financing and operations, with a view to identifying the sources of industry difficulty with predicting loss and setting actuarially appropriate rates. Understanding the payout and investment practices of liability insurers should help the medical profession more effectively predict and prepare for critical changes in the availability and affordability of malpractice insurance. Furthermore, oversight of industry business practices would reveal any existing industry mismanagement or inappropriate stewardship of premium funds; alternatively, if examination revealed neither improper management nor excessive profiteering, there would be impetus to approach reform through changes in the legal system rather than the liability insurance system.

Tort reform has attracted the organized medical community because it appears to reduce the arbitrariness and inefficiency embodied in the current compensatory scheme. However, it must be recognized that because tort reform measures limit the opportunity for malpractice plaintiffs to seek and obtain recovery for injury, they can promote unjust and unfavorable outcomes. The impulse to endorse remodeling of the tort system must not guide the profession toward a self-serving public policy which ignores other crucial dimensions of the malpractice problem. The American College of Physicians believes that every tort reform measure should be assessed according to its capacity for lowering liability insurance premiums or reducing the frequency and severity of malpractice claims without denying injured patients appropriate redress for physician negligence.

The current professional liability and compensation scheme involves a complex of interacting players: the medical and legal professions, the insurance industry and the medically injured patient. The American College of Physicians is concerned that reform proposals crafted solely to attack inequities for physician-insureds in the current civil justice system may result in additional and serious harm to patients who have suffered at the hands of negligent or incompetent medical practitioners. To the extent that tort reforms would result in speedier and more equitable damage awards, and discourage frivolous or nonmeritorious claims, they would seem to be desirable. However, to the extent that they curtail the right to seek just redress for medically caused injury, they hamper rather than promote a fair malpractice compensation/deterrence system.

Protecting the opportunity of patients to obtain full compensation through the judicial system becomes a more compelling consideration in light of the poor evidence relating most tort reform measures to decreasing malpractice insurance premiums (2), and the tentative nature of available data associating most tort reform measures with reduction in the frequency and severity of claims (3,4). Given the lack of empirical evidence that tort reform alone will cure the malpractice problem, the College supports further investigation of the relationship of legal changes embodied in tort reform proposals to the availability of affordable insurance, and to the elimination of inappropriate and excessive malpractice awards.

Until such a relationship can be established with greater certainty, the College believes that the endorsement of legislative proposals which work to restrict judicial access by those alleging medical injury, and which limit the opportunity to obtain compensation, should only be undertaken with extreme caution. The College favors initiation of the second approach to the malpractice problem -- the investigation and oversight of insurance carrier business practices. This approach, which has received increasing support from consumer groups (5,6) and Congress (7), may, in conjunction with other quality assurance mechanisms, provide a solution to some of the problems besetting the current malpractice system without destroying its deterrent function, and without infringing the right of negligently injured patients to fair and adequate compensation.

A third approach to changing the malpractice system involves the implementation of alternative, nonlitigious methods for compensating patients who allege negligent injury. These alternatives include 1) offers by health care providers to pay injured patients' economic losses; 2) arbitration of injury claims by an administrative panel of medicolegal experts; and 3) individualized contractual arrangements between providers and patients which can alter the system by, for example, limiting recoverable damages, or substituting a no-fault scheme with a schedule of damages in lieu of a negligence-based compensation system. In contrast to the current malpractice scheme, alternative liability systems can avoid the length, stress, and exorbitant cost of litigation currently needed to resolve and prove complex issues of negligence and causation. The College favors an examination of the feasibility of alternative approaches to injury compensation. Any mechanism for providing recovery to those who are injured as a result of medical negligence or misadventure should allow for appropriate remuneration of medically induced injury, while providing a strong deterrent to professional conduct that falls below medically established standards of care.

SUMMARY OF POSITIONS

1. The American College of Physicians advocates that adoption of any tort reform proposal be based upon evidence of its ability to meet the goal of reducing the cost of physicians' liability insurance without depriving negligently injured persons of their right to adequate compensation. Among those proposals that on balance the College favors are a reasonable limitation on non-economic damages, abolition of the joint and several liability rule, introduction of structured or periodic payment of damages, and abolition of the collateral source rule.

2. The American College of Physicians supports an examination of malpractice insurance carrier operations,in order for the, medical profession and the public to better assess the sources of problems with the availability and affordability of liability insurance. The College favors systematized collection and reporting by medical liability insurance carriers of information on insurance industry practices such as the number, types and costs of all claims paid out and the standard used to determine extent of exposure. The College also supports collection and analysis of data concerning the malpractice experience of individual insureds, and examination of the merit of setting rates according to providers' prior experience.

3. The American College of Physicians urges the medical community to employ practices designed to reduce the incidence of malpractice, including setting standards of care based on efficacy assessment data, implementing risk management programs in all health care institutions, reviewing current and prospective medical staff members' malpractice and professional disciplinary records, and restricting or denying clinical privileges to unqualified or incompetent physicians.

4. The American College of Physicians recognizes the need for more efficacious disciplinary procedures within the medical profession to identify and penalize physicians who practice substandard medicine. In this regard, the College supports aggressive monitoring by state medical boards of physicians' competence and credentials.

5. The American College of Physicians encourages an investigation of alternative mechanisms for compensating individuals who have been injured due to provider negligence or medical misadventure which do not entail the expense and duration of litigation. Physician offers of compensation for physical and economic injury, arbitration of injury claims, and private contractual compensation arrangements between provider and patient should be examined as possible alternatives to the malpractice tort scheme.

POSITION

1. The American College of Physicians advocates that adoption of any tort reform proposal be based upon evidence of its ability to meet the goal of reducing the cost of physicians' liability insurance without depriving negligently injured persons of their right to adequate compensation. Among those proposals that on balance the College favors are a reasonable limitation on non-economic damages, abolition of the joint and several liability rule, introduction of structured or periodic payment of damages, and abolition of the collateral source rule.

RATIONALE

There is considerable disagreement among representatives of the medical and legal professions, the health consumer community, and the insurance industry as to the nature and the source of the medical liability insurance crisis (1). Individual and institutional providers concerned about the nonavailability and rising cost of liability insurance point to the exorbitant increases in the number and cost of malpractice suits and the financial incentives inducing attorneys under the contingency fee system to seek excessive awards (8).

Many physicians are concerned about the pressure placed on practitioners by their insurance companies to settle cases that are clearly unmeritorious for a "nuisance value" rather than to incur the costs of litigation. A related concern is the widespread practice of malpractice plaintiffs' lawyers to name medically uninvolved practitioners in a lawsuit solely on the basis of their affiliation with the unit or institution. These unfortunate named parties must then expend considerable time and money extricating themselves from a suit in which they had no reason to be named.

The insurance industry contends that several unanticipated changes in the health care delivery system -- including the increase in sophisticated technology and the escalation in number and size of malpractice claims -- have created an unstable environment for writing medical liability insurance and have resulted in underwriting losses which, in turn, require carriers to either raise premium rates or leave the market entirely (9). Lawyers that provide counsel to injured patients (10), and consumer interest groups (5,6), believe that physicians have triggered the medical liability crisis because they have not responsibly implemented quality assurance programs in health care institutions to curtail the rate of malpractice, and have not taken steps to insure that adequate disciplinary procedures exist for policing incompetent practitioners. These groups perceive the constant threat of law suits inherent in the current tort system as serving a positive deterrent function. Consumer groups also point to the profiteering motives of medical liability insurance carriers as a substantial cause of the rising cost of insurance premiums and of the erratic nature of the insurance business cycle. Some call for increased public control of the insurance industry (5,6).

Competing theories about the nature and source of the malpractice problem have provoked debate as to what the appropriate emphasis of reforms for resolving the malpractice crisis should be. The various proposals for reform focus on four main types of solutions:

- reforming the laws governing medical injury litigation [tort reform] (11), including the imposition of ceilings for non-economic damages, the reduction of damage awards by amounts received from collateral sources, structured periodic payment of damages, limitations on the size of contingency fees charged by plaintiffs attorneys and pre-trial screening of malpractice claims;

- improving the efficacy of the medical profession's self-policing function, including the establishment of risk management and quality assurance procedures in health care institutions, and the strengthening of disciplinary procedures by state boards and medical societies;

- investigating the medical liability insurance industry, particularly the process by which it determines premium rates for physicians, in order to assess whether rates are currently set at unreasonably excessive levels and whether managerial or operational changes could be expected to reduce them.

- substituting an alternative mechanism for compensating individuals who claim to have suffered medically related injury, such as physician settlement offers, arbitration panels, or private compensation arrangements, in lieu of tort litigation.

In the last decade, state legislatures largely responded to the malpractice problem by implementing omnibus tort reform acts incorporating a broad range of legal changes intended to decrease judicial access to persons with questionably meritorious claims and to reduce the awards injured persons can receive, as well as the share their lawyers can receive. The influence of tort reform at this stage is uncertain. The expected reduction in the

number and severity of professional liability suits against physicians and hospitals has not happened in the past few years (12,13). There is some evidence that states which enacted legislation placing a cap on damages and mandatorily offsetting collateral compensation had reduced claims severity in the short-term; however, the methodology employed to obtain this data does not account for potential influential differences among state statutes and does not account for delays between the time statutes were enacted and when they became effective. Under these circumstances, the data should be regarded as tentative (13).

Likewise, there is scant evidence linking specific tort reform measures to improved availability or reduced cost of liability insurance (2). Mandatory use of pre-trial screening panels is the only tort reform that has been associated with reduced premiums (2), yet even this measure may be disadvantageous in the long run. The hearing panels may actually add to the overall cost of resolving claims in cases which proceed to trial and are not settled during the screening hearing. In addition, the existence of an informal and initially less costly mechanism for resolving malpractice disputes may actually encourage the filing of claims (2,14). Though pre-trial screening could yet prove to be a valuable mechanism for reducing the filing of frivolous suits and for eliminating the unfortunate legal practice of attempting to involve vast numbers of medical personnel in litigation though their actual connection to a malpractice incident is unconfirmed, it is too early to tell if this reform will really remedy the interlocking legal and insurance problems besetting the tort system.

In addition to serious doubts as to the efficacy of tort reform, the likelihood that several of these restrictive proposals can be deemed unconstitutional provides further cause for questioning their validity. Some state supreme courts have held that the right to sue and recover for medical injuries cannot be infringed by rules which restrict judicial access, deny the right to a jury trial, interfere with the freedom of contract between attorney and client and discriminate against malpractice claimants by making their cases less attractive to the plaintiff's bar (15,16).

Finally, it is clear that tort reform proposals can work unjust hardships on injured patients, shifting to them the burden of bearing responsibility for outcomes of medical negligence and incompetence. Ceilings on non-economic damages, for example, limit the amount of recovery for monetarily intangible but, nonetheless, major injury such as permanent debilitation and disfigurement. On balance, however, the College believes that a reasonable limitation on non-economic damages would be appropriate, with such damages bearing a closer relationship to the injury suffered. In addition, judges should be encouraged to discontinue the traditional policy of deference toward juries who award damages disproportionate to actual injury[1]. As the American Bar Association has advocated, (17) judges should use their powers to review fee arrangements and modify those that do not meet standards of reasonableness.

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[1] In Florida, the legislature has lowered the common law standard allowing judicial modification of excessive jury awards, so as to invite more frequent review; the older standard allowed for modification of awards "shocking to the judicial conscience," while the newer and lower standard permits review of awards which are "clearly excessive or inadequate in light of the facts and circumstances." Manne, H. Medical Malpractice Policy Guidebook, Florida Medical Association (1985).

The proposal to abandon the contingency fee system, like the proposal to cap damages, poses added burdens on injured individuals, particularly indigents. The contingency fee system allows persons who might otherwise be unable to pay for counsel to obtain access to judicial redress for their injuries. Thus, contingency fee limitations would seem to prejudice an extremely vulnerable population: persons unable to afford an attorney who have been injured due to medical incompetence.

Other proposed tort reform measures, however, promote a more favorable balance between the rights of individual patients to receive just compensation caused by malpractice and the interest of the public in guaranteeing that its physicians are able to obtain affordable liability insurance.

Abolition of the joint and several liability rule, which requires malpractice co-defendants who are negligent to pay the full amount of compensation awarded by jury if other co-defendants are insolvent or immune from suit, is one reform proposal which sanctions a more equitable dispensing of the costs of compensation among those liable for a plaintiff's injury.

Periodic or structured payment of damages is another reform proposals which appears to meet appropriate compensatory goals, and which aids insurers by making the cost of paying out claims more predictable, without jeopardizing the deterrent effect imposed by the stigma and cost of jury awards. Structured awards are designed to meet the needs of an injured party by allowing for future periodic payment of damages as their impact is actually felt.

Structured payment helps to insure appropriate compensation levels where future medical costs or lost wages anticipated to be incurred are uncertain. Payment by installment, according to the patient's current needs, avoids payment of either insufficient or excessive funds in a lump sum before needs are truly known. Furthermore, payment of awards by periodic installment reduces their cost to defendants and insurers, and thus, in theory, should reduce the cost of the malpractice system to all patients. In contrast to lump sum recoveries, which are calculated to cover maximum possible life expectancy, including all reasonably possible losses, structured settlements allow the insurer to purchase an annuity or trust fund designed to provide payments for expenses as they are anticipated to occur based on the <u>expected</u> longevity of the patient (3). Though there is insufficient data currently to suggest that structured settlements have had an appreciable impact upon claims reduction or insurance premium levels, periodic payment would seem to meet the criteria of benefit and fairness which make it an appropriate way to instigate reform of the malpractice system.

Another potentially beneficial and equitable reform is the proposed abolition of the collateral source rule. The collateral source rule prohibits the lowering of damage awards to account for funds the plaintiff is receiving for his injury from collateral sources, such as worker's compensation or insurance money. It is estimated that if evidence of collateral source payment were admissible at trial or if malpractice awards were offset by the amount of collateral benefits plaintiffs received, malpractice costs would be reduced between 11 and 18% (3).

Abolition of the collateral source rule furthers the goal of appropriate compensation. The aim of the civil justice system is to award damages sufficient to return the plaintiff physically, financially and psychologically to his or her status prior to the injury. The collateral source rule encourages excessive recoveries for patient's who receive compensation from secondary sources because collateral fees in part reduce the need for compensation from malpractice defendants. Thus, abolition of the collateral source rule promotes adequate and fair compensation.

In the controversial arena of medical malpractice, the civil justice system balances an intricate complex of rights and duties in an attempt to provide necessary compensation to the injured and to the insure appropriate punishment as a deterrent for wrongdoing. Prevailing and recurrent difficulties for all physicians seeking to obtain affordable liability insurance are prompting modification of current practices in order to reduce the cost of providing compensation and the cost of penalizing incompetent practitioners. Some tort reform measures may yet prove to be effective. Others, however, are not merely ineffective but also unfairly burdensome to negligently injured persons. It is clear that prudence and caution must be exercised when considering reform of the malpractice laws, and that each measure must be individually examined in terms of its efficacy and its ability to preserve the right to recover just compensation for injury.

POSITION

2. The American College of Physicians supports an examination of malpractice insurance carrier operations, in order for the medical profession and the public to better assess the sources of problems with the availability and affordability of liability insurance, The College favors proposals calling for uniformly systematized collation by medical liability insurance carriers of detailed information on insurance industry practices such as the number, types and costs of all claims paid out and the standard used to determine extent of exposure. The College also supports collection and analysis of data concerning the malpractice experience of individual insureds, and examination of the merit of setting rates according to providers' prior experience.

RATIONALE

Due to the lack of data linking most of the proposed tort reform to reductions in medical liability premiums, and the constitutional and policy shortcomings inherent in proposed tort reform measures, the College favors further examination of alternative malpractice system reforms. In the wake of suggestions that the availability/affordability crisis in malpractice insurance may be related to actuarially unsound underwriting practices on the part of insurance carriers (5), the College endorses a thorough investigation of the medical liability insurance industry through collection and analysis of information detailing the rate setting practices, claims paying practices and investment activities of all medical malpractice carriers (7).

Data illuminating insurance company payment practices including the number and amount of premiums collected, the standard used to assess risk of exposure, the number and amount of claims paid out per unit of exposure, the cost of selecting each type of claim, the amount of reserves per unit of

exposure and the amount of investment income earned should be documented by carriers and available to public policymakers. Evaluation of insurance industry operations data -- particularly data which sheds light on the relationship between the legal aspects of the compensation system and insurance rates -- will enable conclusions to be drawn about the relative merit of tort reform versus insurance regulation approaches to resolving the medical liability problem. It will also reveal the reasons for the instability of the liability insurance industry.

There is a growing perception that premium rate increases, in light of the sizeable reserve funds insurers have built up in recent years, reflect excessive profiteering rather than appropriate estimates of future liabilities (5). Insurance industry critics argue that the profit motive has induced carriers to set premium rates artificially high, as evidenced by the fact that premium income alone (i.e.--without consideration of investment from reserve funds) far exceeds reported loss and loss expense payments [2]. Liability insurers counter that premium increases and large reserve funds are necessary to meet anticipated losses from the high number of pending claims (9,18). Evaluation of insurance industry operations will provide greater insight into the source and scope of industry profits, and enable conclusions to be drawn about the need for industry-wide reform.

Maintaining an affordable malpractice insurance system is not a challenge unique to this decade. In the mid-seventies, sharp increases in commercial malpractice insurers' premiums and the withdrawal of major commercial carriers from the market produced an availability and affordability crisis similar to the one physicians are experiencing today. At that time, state medical societies, hospital associations and other physician groups responded by sponsoring self-run insurance organizations to make primary insurance available to physicians and institutional providers. Today, professional sponsored companies operate successfully by retaining relatively low amounts of cash reserves and ceding the remainder of their liability risk to a reinsurance company (19). Most reinsurers are foreign-based companies; the dominant player in the liability reinsurance market is Lloyds of London. Since foreign-based reinsurers are governed by external economic regulatory forces that may not be consonant with domestic policies, primary carriers are often forced to raise premiums due to increases in their own reinsurance rate, irrespective of the claims experiences of their physician-clients.

An affordable and stable medical liability insurance market is fundamental to the proper functioning of the health care delivery system. When insurance is unavailable or becomes prohibitively expensive, physicians may begin to alter traditional practice patterns by refusing to perform inherently risky medical procedures, ordering additional and costly tests to avoid

2 From 1978 through 1983, medical liability insurers received net premium income of 7.3 billion dollars, but paid losses of only 1.5 billion dollars. Source: Association of Trial Lawyers of American, Washington, DC. "What Legislators Need to Know About Medical Malpractice," National Conference of State Legislators.

liability, or even declining to practice medicine in certain high-risk subspecialty areas (1,20). Stabilization of the medical insurance market is therefore an important public interest (5,21).

The market equilibrium in the medical malpractice insurance industry is inherently destabilizing. There is constant pressure to keep premium rates competitively low, a strategy which increases the number of premiums written and, therefore, increases carrier exposure; yet, because of the "long tail" - the long period of time it takes to discover and resolve medical malpractice claims,[3] a carrier which sets an actuarially inadequate premium rate can attract new policyholders and still appear to be profiting highly in the short-term, before it is forced to pay out any claims. Competing carriers must either meet low premium rate levels or leave the market entirely. Thus, an artificially low premium rate will evolve into the market insurance rate, and when the long-tail comes due, carriers face severe underwriting losses.

In addition to the market instability resulting from economic forces inducing artificially low premium rates, the insurance business cycle is further destabilized because it is heavily influenced by prevailing interest rates (5,22). Insurance carriers rely substantially on income from investments in order to maintain solvency and to preserve the capacity to pay out claims. Because of the long delay between the occurrence of a malpractice incident and the resolution of the claim, investment income is a major factor in insurer profitability. When interest rates are high and the income to be derived from investing policyholder premiums is correspondingly high, there is pressure to lower rates in order to increase the number of polices written so that investment funds can be obtained. Conversely, when interest rates are low, there is no financial pressure to attract new policyholders and obtain funds to invest, so premium rates will stay high. Because prevailing interest rates have an impact on the setting of premium rates, insurance prices will tend to peak and fall in relation to the state of the investment market.

The erratic cost cycle of medical liability insurance suggests that increased oversight of the rate setting process could be necessary to insure a stable market. In order to investigate the benefits of greater regulation of the insurance market, comprehensive data on carrier operations needs to be collected and assessed. There is need for more empirical information on how insurers form expectations about anticipated outlays and how these expectations affect premium setting (2).

Data concerning the malpractice experience of individual insureds should also be collected by insurance carriers. This information should be made available to institutional health care providers for use in determining whether to grant clinical privileges to staff applicants, or to extend, restrict or renew privileges to staff members. It should also be available

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3 According to the National Insurance Consumer Organization, 50% of malpractice claims are not paid until about 8 years after a policy is written.

to state boards of medical examiners to assist them in identifying incompetent practitioners and developing systems for monitoring and eradicating incompetent professional behavior.

There is currently no comprehensive database containing health care providers' malpractice experience available for carriers to study when setting premium rates for their clients. Thus, the effect that the claims experience of individual practitioners and hospitals has on insurance carrier exposure is not taken into account in setting premiums. The inability to effectively rate insurer exposure based on the risk posed by individual insureds makes sound underwriting virtually impossible. In order to accurately assess the risks of underwriting, an insurance carrier must adequately predict the chance of loss. Knowledge of the conduct and characteristics of potential insureds are essential for anticipating overall extent of exposure.

A comprehensive study of the medical malpractice insurance industry in Pennsylvania (21) concluded that the current absence of adequate malpractice experience information induces a very strong tendency among carriers to charge inadequate rates. According to the study, incomplete information about provider malpractice experience results in carrier uncertainty as to appropriate premium levels. Coupled with the competitive pressure in the industry to reduce premium rates, the effect of incomplete information is to generate chronic industry-wide insufficient rate setting.

Obtaining a comprehensive record of the claims experience of insureds is difficult for individual policyholders. Due to the "long tail" associated with the span of time between the actual occurrence of a medical injury and the closing of a claim, claim outcome records take several years to document. Furthermore, due to the growth in medically owned or state created insurance entities in response to the decline in private insurance availability in the 1970's, many carriers have not been in operation long enough to have produced substantial records of the claims experience of their insureds. In Pennsylvania, for example, 60% of premiums written are by insurance companies that are less than 9 years old, which have not yet closed the books on their first year of operation (21).

The gap in information about claims experience could be bridged, however, if insurance companies communicated an insured's malpractice experience to those carriers which simultaneously are or subsequently become insurers for the provider. If a clearinghouse for health care provider malpractice experience data were made available to all insurance carriers, premium rates could then be tied to prior claims experience.

Under current industry practices, incomplete collection and sharing of information about the prior malpractice experience of policyholders effectively precludes experience-based rating. As a result, insurers use a specialty classification system to estimate their risk of exposure, rather than a system based on the actual conduct of insureds. Under this system, physicians whose specialties entail relatively high morbidity or mortality risks, but who have never been found negligent by a court will pay the same premium as a similar specialist who has been found liable for malpractice several times.

The actuarial adequacy of the existing classification scheme for rate determination has not been well-investigated (21,23). Such a study would be useful for understanding whether, under the current classification system, there is an inequitable concentration of premium costs on those not responsible for the majority of malpractice incidents. If the classification system were to be refined on the basis of individual provider characteristics, relevant data on every physician-insured would need to be collected and assessed, including board certification information, licensing history, insurance history, chemical dependency history and history of significant (i.e. nonfrivolous) malpractice events (24).

The Pennsylvania malpractice insurance study (21) recommends the establishment of a state regulated rating scheme in which providers would be assigned a particular risk on the basis of ongoing malpractice experience, as well as medical specialty. Under such a structure it would be possible, theoretically, for a "risky" general internist to pay higher premiums than a "careful" subspecialist.

An experience rating system which used only genuine evidence of malpractice and screened out nonmeritorious suits and settlements would provide an economic incentive for clinicians to avoid negligent medical practices. Physicians with poor experience ratings would pay higher insurance premiums and could have clinical privileges restricted or revoked if the information were available to institutions where they were on the medical staff.

Besides having this beneficial deterrent function, an efficient experience-based rating system would bring about an equitable allocation of malpractice costs; those health care providers with solid records of competence would pay reduced premiums and providers who were less conscientious would pay higher premiums. Though the relative advantages and disadvantages of an experience-based rating system require further investigation before final conclusions are drawn, experience rating shows promise as a reform mechanism that would further the goal of deterring malpractice in addition to reducing premium levels for practitioners whose good records reflect their caliber as skilled physicians.

POSITION

3. The American College of Physicians urges the medical community to employ practices designed to reduce the incidence of malpractice, including setting standards of care based on efficacy assessment data, implementing risk management programs in all health care institutions, reviewing current and prospective medical staff members' malpractice and professional disciplinary records, and restricting or denying clinical privileges to unqualified or incompetent physicians.

RATIONALE

As professionals, physicians hold a responsibility to critically examine the necessity and benefit of their treatments. To the extent that defensive medicine is simply bad, rather than careful medicine, physicians cannot adopt its practices as a response to the malpractice crisis. Physicians need to address the malpractice problem by initiating objective studies aimed at determining what is optimal care for their patients. Better

identification of clinical risks will lead to improved outcomes and decreased incidence of medically related injury. Through its professional societies and research institutions, the medical community must expand its internal mechanisms to curb inappropriate defensive practices, as well as all other forms of substandard care.

The College encourages continued development of existing efforts within the profession to examine the diagnostic and therapeutic procedures that constitute the physician's art, and to develop guidelines on their use, based on solid data and expert opinion. The formulation and dissemination of such guidelines can aid practitioners in making more medically effective clinical decisions, and can provide them with the assurance of meeting a professional standard of practice -- assurance which will prevent resort to inappropriate defensive practices. The American College of Physicians' Clinical Efficacy Assessment Project is one existing program which seeks to determine the value of particular medical tests, procedures and therapies and to report empirical information on what constitutes appropriate clinical standards of practice.

Most malpractice claims, particularly the successful and expensive ones, occur in hospitals (25, 26). Quality assurance programs should be instituted in all health care institutions to help reduce the likelihood of medical negligence. Numerous types of abnormal or emergency situations recur with sufficient frequency in hospitals to permit the development of standardized optimal responses. There would no doubt be a reduction in the number of medical injuries occurring in hospitals if procedures for dealing with common high risk problems were internally developed and enforced.

A study of closed claims from the Obstetrics Department at the University of Minnesota suggests that risk factor mismanagement can contribute substantially to the type of bad medical outcomes that evolve into claims of medical negligence (27). Developing risk management programs in all health care institutions will help eliminate high risk care that falls below an acceptable standard of practice.

Hospitals can further limit their exposure to malpractice by continually assuring the high quality of their medical staffs. All health care institutions should keep updated records of the malpractice and professional disciplinary experience of their staff. They should also seek to obtain a complete malpractice and disciplinary history of staff applicants, denying privileges to any physician whose record reflects incompetence. No physician should ever be granted privileges by an institution to perform procedures for which he or she is not qualified. Staff privileges should be structured so that proof of ability to competently perform select procedures should be a condition precedent to being granted the privilege to do so.

POSITION

4. The American College of Physicians recognizes the need for more efficacious disciplinary procedures within the medical profession to identify and penalize physicians who practice substandard medicine. In this regard, the College supports aggressive monitoring by state medical boards of physicians' competence and credentials.

RATIONALE

State medical boards have had a difficult time meeting their responsibility to discipline physicians on the basis of malpractice or incompetence. Although the number of disciplinary actions taken against physicians has been increasing, more serious actions such as license revocation, probation and suspension have increased only slightly (28). Informal reprimands represent the bulk of the increase, and these are often confidential agreements which preclude the reporting of information to the Federation of State Medical Boards or to other states. Even boards with broad disciplinary authority to impose fines or penalties for medical negligence have been criticized for not utilizing the powers available to them (29). Boards find such cases difficult to pursue because of the variable and complex range of acceptable practice that legally falls within the purview of standard medical care (28).

Some states have taken initiatives to combat this problem. As of 1985, Wisconsin, for example, allows its medical board to meet a lower burden of proof in disciplinary proceedings than in other board actions, which must meet the rigorous "clear and convincing evidence" standard. (26).

The College encourages an aggressive approach by state boards to the task of disciplining negligent physicians. Boards should enact rules that provide more flexibility than currently exists for investigating and sanctioning incompetent physicians.

A major obstacle to effective disciplinary machinery at the state board level is the inability to obtain information concerning incidents of malpractice. The natural hesitancy to condemn a fellow professional often prevents colleagues of an incompetent or unqualified physician from reporting knowledge of bad medical practice. Consumers, law enforcement agencies and internal investigators at state medical boards provide the information base for most disciplinary actions. Few actions are initiated with the help of medical societies, peer review organizations, health care institutions or individual health professionals (28). The College feels that physicians bear a responsibility to replace this pattern with an effective and professionally responsible peer reporting system.

Fear of liability for damaging the professional reputation of another physician also operates to discourage physicians from speaking out against their colleagues. Since 1982, seventeen states have initiated, expanded or tightened reporting laws, mostly focusing on hospitals. These statutes require hospitals to inform boards of changes in staff privileges granted to a physician, or of a physician's resignation. Some require the reporting of large malpractice judgments or settlements. The College encourages enactment of legislation requiring hospitals to report evidence of incompetence to state medical boards.

It should be possible for a physician to report a likely malpractice incident to the state medical board without fear of embarrassment or reprisal. Legislative approaches to providing appropriate immunity from civil liability to physicians who serve on disciplinary boards and peer review committees may need to be developed to safeguard individual practitioners who communicate knowledge of a colleague's negligent conduct. Disciplinary

proceedings and the records of medical boards should be kept confidential and not subject to discovery or admission into evidence in a legal proceeding.

In addition to improving the administrative process of medical boards in penalizing incompetent physicians, medical boards need to find ways to improve the sharing of information between states about disciplinary actions. A major problem is the fact that action taken by boards against incompetent physicians often precludes publication. Stipulated agreements, wherein the physician agrees to voluntarily restrict medical activity in some way (for example, to surrender a license temporarily, or to waive prescription privileges) in exchange for the board's promise of confidentiality, are a common outcome of the board disciplinary process (28). The advantage of this bargaining process, which allows a physician to leave the state where his or her professional privileges have been restricted and to become boarded elsewhere, should be re-examined.

The lack of interstate cooperation between medical boards is a serious obstacle to an effective disciplinary scheme. In the last two to three years states have begun to provide the Federation of State Medical Boards with regular reports on disciplinary actions taken, which the Federation, in turn, disseminates to other states (28). The Federation should encourage and streamline this practice by developing a unified set of reporting regulations for state boards which delineate categories of reportable conduct and identify a uniform language for reporting incidences of incompetence and appropriate kinds of punitive sanctions. Under current practice, the extent of the actions reported varies from state to state. Many boards do not report licensure denials, and many do not report informal disciplinary actions that do not involve a hearing, or, of course, actions imposed with the understanding that they would remain confidential. The failure to publicize confirmed incidences of physician incompetence prevents other state boards from effectively policing their own medical professionals, since disciplined physicians often decide to relocate (28,30). The Federation of State Medical Boards could help structure an efficient disciplinary system for the medical profession by developing guidelines for its member boards with regard to appropriate sanctions for misconduct.

State medical boards should be encouraged to discontinue the practice of punishing incompetence by informal and confidential stipulated agreement. If budgetary constraints restrict a board's ability to thoroughly investigate and formally prosecute malpractice claims, the medical community within each state should take responsibility for insuring that the expense of making professional self-policing an effective process is supported, through higher licensing fees or some other appropriate financial source.

Medical societies that have disciplinary procedures should also be encouraged to disclose through proper channels of publication the identity of members who have been sanctioned. Such disclosure is ethically obligated to assure the protection of the public. The American Psychiatric Association has incorporated a model reporting provision within its code of procedures for handling complaints about unethical conduct (31). The Association authorizes disclosure of the identity of an expelled or, in certain instances, a suspended member in the Association newsletter and the newsletter of the local district branch, as well as discretionary reporting to any

medical licensing authority, medical society, hospital, clinic or other appropriate institution, where necessary to protect the public. The reporting by medical organizations of sanctions taken against members for improper or incompetent medical acts is an appropriate component of a collective professional effort to curb the incidence of malpractice.

POSITION

5. The American College of Physicians encourages an investigation of alternative mechanisms for compensating individuals who have been injured due to provider negligence or medical misadventure which do not entail the expense and duration of litigation. Physician offers of compensation for physical and economic injury, arbitration of injury claims, and private contractual compensation arrangements between provider and patient should be examined as possible alternatives to the malpractice tort scheme.

RATIONALE

The existing legal framework for handling medical malpractice claims has been criticized as a cumbersome and inefficient device for compensating individuals who are injured as a result of bad medical practice (25,32). The tort of medical malpractice depends upon proof of provider negligence--that is, proof that a physician's conduct breached the professional standard of care--and, additionally, proof that this negligence, rather than other adverse medical factors, actually caused this injury. The process of proving negligence and causation require the use of expert witnesses to explain medical facts to lay jurists, a process that can become extremely expensive.

Furthermore, the adversarial nature of litigation introduces tension into the physician/patient relationship; it may promote uneconomic and undesirable "defensive" practices, and can result in arbitrary and capricious compensation awards which bear no necessary relation to other awards for similar injuries. Finally, the tort system is not a particularly equitable compensation mechanism. Although studies assessing the prevalence of malpractice injury are scant and ten to fifteen years outdated, available data suggest that most medical injuries never enter the system; the number of malpractice claims filed represent only a small proportion of all medically caused injuries (1,17).

In light of these major deficiencies in the current legal framework for resolving malpractice disputes, the positive deterrent aspect of a litigation system which permits the imposition of sanctions against negligent physicians in a public forum may outweigh the disadvantages. Defects in the current tort framework have stimulated discussion of alternative medical professional liability systems.

The American College of Physicians encourages further investigation of the merit of nonlitigious approaches to compensating medical injury. The foreclosure of personal injury suits by physician offers to pay the cost of patient injuries has captured public attention (32,33) as a nonadversarial mechanism which avoids the difficulty and expense of proving medical negligence and allows for the expedient disposition of injury claims. If physi-

cian offers were made promptly and in good faith, and provided adequate compensation to negligently injured persons, they could become appealing alternatives to tort litigation. Any proposal to implement physician compensation offers as an alternative to litigation, however, should not preclude awards for pain and suffering caused by a physician's malpractice to the extent that a patient's loss includes less tangible injuries such as debilitation or disfigurement.

Arbitration of claims for medical malpractice in lieu of a malpractice trial is another promising avenue of reform. Arbitration laws allow patients and their health care providers to make written agreements requiring the submission of any medical liability claims to arbitration in lieu of a jury trial. Pioneering health maintenance organizations in California and Michigan have mandated arbitration of claims for medical malpractice (25).

Arbitration findings include both liability and damages. The statutes in various states differ as to the size, composition and source of arbitration panels. Fundamental to the notion of arbitration is that at least some of these details be left to the parties to iron out in individual agreements; the tribunal chosen to resolve their disputes should be satisfactory to both parties.

Arbitration is associated with lower awards than those resulting from court verdicts, as well as lower defense expenses, as compared to the cost of litigation (34). On grounds of economic efficacy and freedom of choice there is a strong case to be made for permitting patients and physicians to enter into voluntary but binding arbitration agreements (34). In order to avoid constitutional challenges and to meet standards of fairness, an arbitration system should be voluntary and should allow for limited judicial review. With these safeguards, arbitration would appear to be an appropriate surrogate mechanism for resolving malpractice claims and one which avoids the detrimental cost and time length factors inherent in tort litigation.

Individualized arrangements contracted between health care provider and patient for compensation in the event of medical negligence is another possible alternative to litigation. This approach is particularly likely to attract organized groups of health care consumers, such as labor unions or corporate employees. Consumer groups can bargain effectively for the interests of the large groups of patients they represent -- some of whom, it must be anticipated, will become injured through medical malpractice. Institutional providers also stand to benefit from such an arrangement, by settling various issues related to injury compensation in advance, so that they need not be debated repeatedly in every individual case, at great legal expense. Parties might choose to contract for a schedule of damages determined according to the severity of injury, for mandatory arbitration or pre-trial screening, for an altered standard of care that takes into account the particular economic or technological circumstances under which the provider operates, or even for substituting a no-fault compensation scheme guaranteeing minimally adequate recovery for all medical injury, rather than optimal recovery for negligently induced injury.

Alternative mechanisms for compensating individuals harmed through malpractice show promise of saving cost while, at the same time meeting the needs

of injured persons. Alternatives should be explored which not only provide fair and adequate compensation to injured parties but which also encourage quality care by providing disincentives to negligent conduct.

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