MEDICAL PROFESSIONAL LIABILITY

Information Paper

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INTRODUCTION

In today's litigious society, both private and public providers of products and services are at increased risk of legal and financial liability for damages resulting from personal injury. The American College of Physicians is keenly aware that physicians are particularly at risk for malpractice lawsuits. To protect themselves from such risk, physicians must be able to obtain malpractice insurance. A major contention is that the malpractice system is in the midst of another crisis, one of insurance affordability, due to the high cost of malpractice insurance in some states and for some specialties. Coalitions of provider and industry groups have been organized to enhance the public's awareness of the impact of high insurance costs on the delivery of medical care. State legislatures and the Congress have been pressured for additional reforms to alleviate this situation. Some states have enacted reforms, notably Florida and Illinois, and others are considering new proposals. Congress has before it a number of malpractice reform bills that act as models or provide states incentives for appropriate reforms.

However, opinion as to the existence of a crisis is not unanimous. Others, such as the Association of Trial Lawyers of America, have argued that there is no affordability crisis and see a problem with continued negligence and excessive insurance profits.

Clearly, a number of questions can be raised. Is there sufficient evidence of a new crisis? What have been offered as proposed solutions? What is internal medicine's malpractice experience? What should be the College's role in addressing medical malpractice on behalf of internists?

The College has developed a number of papers to address these questions. This particular paper provides a background on medical malpractice law, the crisis of the 1970's, the legislative response to the crisis, and an evaluation of that response. Current Congressional tort reform proposals are also presented. Post reform malpractice studies are summarized, including previously unpublished data on internal medicine's liability experience. In order to provide insight into the current malpractice situation, the opposing positions of the American Medical Association and the Association of Trial Lawyers of America are presented.

A second paper presents a series of recommendations for College action on malpractice outlining educational, research, and coalition activities. Additional papers to be drafted will present an analysis of specific tort reforms and alternative liability systems.

BACKGROUND

Under the medical malpractice laws, the failure of a health care provider to meet the profession's customary standards of adequate care constitutes a "tortious" act. Like other forms of negligence, the "tortious" act creates in the person injured a right to sue for compensation under the relevant body of personal injury law known as "tort" law. Most individual and institutional health care practitioners insure against such suits. Although doctors, hospitals, and other practitioners have been subject to them for centuries, until recently, such actions have been relatively rare.

In the early 1970's, both the frequency of medical malpractice suits and the dollar amounts awarded to successful plaintiffs rose at unprecedented rates. Professional liability insurance premiums increased dramatically--in some states more than 300% in a single year (1). In other states the crisis of price became a crisis of availability as traditional insurers restricted coverage or withdrew from the market entirely, leaving health practitioners to choose between forming their own companies, seeking coverage from state-mandated insurance pools, or "going bare" (going without insurance coverage). Fear became widespread that failure of the liability insurance system might cause a disruption or even a temporary collapse of some elements of our health care delivery system.

State legislatures were under intense pressure to take steps to resolve the crisis. While opinions differed as to both the causes and appropriate cures, there was consensus that something had to be done. Most state legislatures responded by reforming tort law and/or revising state insurance regulations to assure the availability of malpractice insurance. Legislative modifications to tort law were diverse, though all of the states did not uniformly adopt the many reform provisions. The major reforms are summarized below.

TORT REFORMS

Statute of Limitations

All states have statutes of limitations, or procedural laws cutting off a cause of action (lawsuit), applicable to medical malpractice actions. In many states, the time within which a lawsuit may be filed for malpractice actions (the time limited by the statute of limitations) begins only upon discovery of the injury. Since injuries caused by malpractice may be discovered several years after procedures are performed or treatment rendered, the time period for filing an action may be very uncertain under such statutes. This period of uncertainty is referred to as the "long tail." The "long tail" has been cited by insurance companies as

a major difficulty in establishing medical malpractice insurance premiums on an actuarially sound basis. Some states have sought to eliminate the "tail" by placing an absolute maximum time period within which medical malpractice suits may be brought. Such statutes commonly provide for bringing an action within a certain number of years after the occurrence of the alleged malpractice. An additional time period may be allowed for an injury that could not have been discovered through reasonable diligence of the injured person. Forty states have passed laws modifying such provisions (2).

Limits on Awards

Another change enacted by state legislatures has been establishment of maximum ceilings on the amount of damages that may be recovered. Caps have been placed on non-economic losses such as for "pain and suffering" though a few states have placed limits on the total amount of recovery.

Collateral Source Rule

The collateral source rule prohibits the introduction of evidence that the plaintiff has been compensated or reimbursed for the injury by another source (e.g., health insurance, workmen's compensation payments, disability payments). This rule has been revised by many states in principally two ways. One approach has been to permit the consideration of collateral source payments in determining malpractice awards, while the other has been specifically to deduct those payments from the court's award.

Periodic Payment

Several states enacted legislation that either permitted or required medical malpractice judgments be paid in periodic installments. Under these provisions, payments are structured to be paid regularly over the lifetime of the plaintiff or his period of disability.

Contingency Fee Limits

Some states have also regulated the "contingency fee" practices of attorneys (under which an attorney's fee is a percentage of the amount recovered by a successful plaintiff). In certain states sliding scales for contingency fees have been instituted. Under this arrangement, as the amount of the award increases, the percentage permitted as a contingent fee decreases. Other states instituted court review and approval of only "reasonable attorney fees." Twenty three states have adopted laws to limit or control contingency fees (2).

Standard of Care

States have also revised "locality rules" that prescribe standards of care vis-a-vis similar physicians or health care providers in a designated geographical area. The "standard of care" in a medical malpractice action is that level of care to which a health care provider is held accountable, and is based upon the prevailing level of care practiced

within a particular locality (community, state, or national). In order to prevail in a malpractice action based upon negligence, the plaintiff must establish the standard of care to which the provider is to be held accountable and must establish that the provider failed to meet such standard. In most states the uncodified rule is that the applicable standard of care for general practitioners is statewide, while physicians who hold themselves out as specialists or are board certified as specialists are judged by a national standard (3).

Expert Witness

Many medical malpractice cases involve difficult and complex medical issues that can be explained only through the use of expert witnesses. Because of the importance expert witnesses play in the outcome of medical malpractice actions, several states have enacted legislation relative to the qualifications and use of these witnesses.

Other Reforms

Other tort reforms included creating pre-trial screening panels and permitting voluntary binding arbitration. Many states also prohibited any mention of the dollar amount demanded in damages (ad damnum clause) and limited the applicability of the doctrine of res ipsa loquitur, which establishes a rebuttable presumption of negligence.

Legal Challenges to Tort Reform

The constitutionality of these reforms has been challenged in the states, and court decisions have been somewhat varied. For example, a statutory limit on non-economic damages was found unconstitutional by the New Hampshire Supreme Court as violative of equal protection guarantees. However, the California Supreme Court recently upheld that state's limit ($250,000). In October 1985, the U.S. Supreme Court permitted that decision to stand when it dismissed a challenge to California's statutory limit. In November 1985, the U.S. Supreme Court also permitted the retention of California's statutory limit on attorney contingency fees in medical malpractice cases. Revisions to the collateral source rule have withstood legal challenges except in New Hampshire, North Dakota, and Pennsylvania where the courts have found that the different treatment of medical malpractice cases is discriminatory. Courts in California and Wisconsin have upheld periodic payment of damages provisions as an assurance for the continued availability of funds to meet future medical and other needs. However, New Hampshire and North Dakota courts have held differently (4).

INSURANCE REFORMS

The legislative response to the problem of assuring the availability of medical malpractice insurance has varied from state to state, but generally has followed one of two directions: an organizational approach, designed to ensure that there is some entity available to provide liability insurance or reinsurance to health care providers; or a regulatory

approach, designed to provide more effective and equitable coverage through existing carriers. Under the organizational approach there have been created, for example, non-profit joint underwriting associations (pooling arrangements composed of all commercial liability insurers in a state) and health care mutual insurance companies, generally formed by state medical societies. These so-called "captive companies" are private, physician-owned and operated insurance companies which are authorized to write medical malpractice insurance for the benefit of their members.

Under the regulatory approach, states have enacted provisions that include: 1) requiring that physicians submit proof of insurance or proof of financial responsibility as a condition of licensure or re-licensure within a state; 2) requiring that malpractice claims, judgments, or settlements be reported to the insurance commission or appropriate licensing board; 3) requiring advance written notice of cancellation or termination of a medical malpractice insurance policy; and 4) permitting hospitals to purchase medical malpractice insurance for physicians on the medical staff.

Reinsurance is the process by which a primary insurer spreads its risk by reselling a portion of its policies to other insurers. Both foreign and domestic companies compete in the reinsurance market. In order to meet the reinsurance needs of the newly formed physician-owned and operated insurance companies, the AMA established in the mid-1970's the American Medical Assurance Company (AMACO). With significant numbers of reinsurers, the primary insurance market can maintain its liability. However, it now appears that many domestic reinsurers have withdrawn from the professional liability insurance market with foreign reinsurers acting cautiously primarily because of the unpredicability of our legal system. As a result, the remaining reinsurers have acquired an inordinate impact on the primary insurance market.

Another important change in the insurance system was the shift beginning in 1975 from "occurrence" to "claims made" underwriting for malpractice insurance. An "occurrence policy" covers all claims whenever filed for injuries alleged to have occurred during the period the insurance policy was in force. However, a "claims made" policy provides coverage only for claims reported while a policy is in effect. Thus, physicians under a "claims made" policy would not be covered for claims filed after the expiration of insurance. These policies remove some of the uncertainty in determining malpractice insurance premiums by eliminating the potentially long interval between the incident and the filing of claims. In the short run it permitted insurers to stabilize their premiums.

EFFECTIVENESS OF TORT REFORM

Overall, the actions taken in the mid 1970's adequately addressed the insurance availability problem. Commercial carriers returned to the market and competed with the newly formed companies for the malpractice premium dollar. However, whether the tort reforms enacted by the states were successful in reducing the frequency and severity of claims is less certain.

In a 1982 report Patricia Danzon addressed the issue of the frequency and severity of claims (3). In her analysis of 1970 and 1975-78 closed claims, Dr. Danzon reported that a number of reforms were found not to show any significant effect on claims frequency or severity. These included voluntary or mandatory pre-trial screening panels, arbitration, restrictions on informed consent, limits on the use of the doctrine of res ipsa loquitur, and periodic payments of future damages. However, it was found that the legislative tort reforms designed to limit recoveries, particularly caps on awards and mandatory offset of compensation from collateral sources, had apparently reduced the severity of malpractice claims. Within two years of becoming effective, it was estimated that collateral source offset and recovery caps reduced severity by roughly 50 percent and 20 percent respectively. However, the different distributional effects of these reforms were noted: "Caps on recoveries affect exclusively the few severely injured patients, whereas collateral source offset reduces small awards, because medical expenses, which are widely covered by health insurance, constitute a larger fraction of small awards" (3).

In comparing frequency of claims across states, Danzon found that between 1970 and 1975 the median average annual rate of growth in claim frequency was between 20 and 30 percent. However, between 1975 and 1976, total claims fell from 23,240 to 17,683, with a 27 percent median rate of decrease, though paid claims decreased only 14 percent. In 1977, total claims fell to 15,556, with a 9 percent median rate of decrease and an 11 percent decrease for paid claims. In 1978, total claims increased to 17,238, with a 2 percent median increase, but no increase in paid claims.

Interestingly, Danzon found no connection between the post-1975 decline in claims frequency and any of the tort reforms, but indicated that this did not justify a conclusion that these laws will have no effect. Because of the lag between filing and closing a claim, the closed claims data from 1975-1978 were, in her view, less likely to show effects of reforms on frequency than on severity, particularly the effects of a shorter statute of limitations. She predicted there may even be a reverse effect if claim filings are accelerated in response to a shortening of the statute of limitations. It may be, suggested Danzon, that other factors contributed to the decline in claims frequency. First, the expansion of tort liability in the early 1970's may have actually reduced the number of injuries due to negligence because of the increased risk of suit. In addition strengthened quality control mechanisms were developed and more selective underwriting may have played a part. Second, pro-plaintiff trends combined with a long statute of limitations had created a large backlog of potential claims that would have had little chance of success or low expected payoff under earlier rules. Once this backlog has worked through the system, claims frequency should attain a new equilibrium level that could be higher or lower, depending upon physician response to the increased risk of lawsuits.

In a separate 1982 study, using as a data base 6,000 closed claims from 1974 and 1976 and applied to a behavioral model, Danzon and Lilliard provided somewhat different findings. They found that "Dollar caps on awards, elimination of specific dollar requests by the plaintiff, and authorization of installment payment of large awards have significantly

reduced verdicts and settlements in the states where they were enacted. Modification of the collateral source rule to admit evidence that the plaintiff is eligible for compensation from other sources has had a much weaker effect. Statutory limits on the contingent fees charged by plaintiffs' attorneys appear to have had moderately depressive effects on settlement amounts and on the number of cases that go to verdict, while somewhat increasing the proportion of cases dropped" (1).

CURRENT TORT REFORM PROPOSALS

Malpractice tort reform entered a new arena in 1985 with the introduction of several reform bills in Congress. Generally, this legislation attempts to provide either a federal model for state tort reform or to provide the states federal financial incentives to enact specific malpractice reforms.

For example, H.R. 3084, the Medical Offer and Recovery Act of 1985, introduced by Representatives Moore (R-LA) and Gephardt (D-MO), provides an alternative liability system for medical malpractice that is to serve as a model for state programs. The bill would provide a mechanism for prompt payment of a patient's economic loss (defined to include wages, hospital and medical care, rehabilitation, etc.) where patient injury has occurred. A health care provider would have the option to make a binding offer to pay the economic loss within 180 days of the occurrence. If that offer is made, the injured patient is foreclosed from using the conventional tort system except where the provider intentionally caused the injury or a wrongful death occurred. Binding arbitration may be requested by an injured patient if no offer is made. The bill also requires the notification of state licensing authorities when health professionals have their hospital privileges terminated. Confidentiality and immunity from lawsuit would be afforded those that provide information on incompetent or impaired health professionals. In the event states fail to enact this or similar systems by 1988, the program would become available to beneficiaries of federal programs -- Medicare, Medicaid, Federal Employee Health Benefits, Veterans Adminstration, and CHAMPUS.

A state incentive approach to malpractice reform is contained in H.R. 2659, the Medical Malpractice Reform Act of 1985, introduced by Representative Mrazek (D-NY). The bill would create a federal program that provides payments to states that revise their state medical malpractice laws in order to establish screening panels. These panels would have sole jurisdiction over medical malpractice claims of all health professionals. Payments for non-economic damages would be limited to $250,000, periodic payments of awards over $100,000 would be permitted, and attorney contingency fees would be limited on a sliding scale. States would be encouraged to establish risk management programs and insurers would be permitted to raise the premiums for health professionals who have a history of medical liability.

Another example of a state incentive program is provided in S. 1804, the Federal Incentives for State Health Care Professional Liability Reform Act of 1985, introduced by Senators Hatch (R-UT), Abdnor (R-SD), and

Inouye (D-HI). This bill, which was drafted by the American Medical Association, also provides federal financial incentives for state adoption of a list of reforms. These are:

- o periodic payments for future damages over $100,000
- o elimination of the collateral source rule
- o capping non-economic damages at $250,000
- o limiting attorney contingency fees
- o allocating an amount equal to that collected from physician licensing fees to the state agency responsible for disciplinary actions
- o requiring all health care providers to have in effect risk management programs
- o providing state licensure or disciplinary agencies malpractice claims data from liability insurers
- o mandating health professional participation in risk management programs as a condition for continued liability insurance
- o permitting, through state agency agreements, the review by state and county professional societies of individual malpractice actions and patterns of treatment, and protecting such review from anti-trust law actions

The AMA recently released an actuarial analysis of its tort reform bill (5). Using an estimated total of professional liability premium costs of $3.6 billion in 1986, it was calculated that the initial four reforms (periodic payments, collateral source offset, award caps, attorney fee limits) would provide approximately $1 billion in premium cost savings for that year. However, several cautionary notes were added to the estimate. First, to realize the potential savings, it was necessary that these reforms have the same impact on claim settlements as on court awards. Second, savings will vary from state to state. Third, potential initial savings might not be fully reflected in premium cost reductions immediately since insurers might be reluctant to decrease rates by the full amount of potential savings until the effectiveness of the laws could be tested. The most significant effect on claims severity was determined to be the cap on non-economic damages. The actuaries believed that the reduction in this trend over the 1986-89 period for a typical state would approximate 4% per year.

MEDICAL MALPRACTICE SINCE 1975

The question of whether a new crisis exists requires a review of additional studies. There is limited information beyond the Danzon reports. However, a significant study on medical malpractice was prepared in 1980 by the National Association of Insurance Commissioners (NAIC)(6). The NAIC data base included information from the claims files of 128 insurance companies and consisted of nearly 72,000 malpractice claims closed between July 1975 and December 1978. The indemnity paid over the 3 1/2 years covered by the study totaled $876 million, of which 39% was paid

in 1978. From 1975 through 1978 the average award per injury increased 70%, from $26,565 to $45,187, with inflation accounting for 28% of the increase. The percentage yearly increase in average indemnity for the

years 1976-1978 was 30%. If future losses (indemnity) are projected at a 30% growth rate, the report indicated they would approach $1 billion annually in only a a few years.

The NAIC report noted that a major factor contributing to the growth of indemnity was the increase in large settlements. In 1975 only 5 awards of $1 million or more were reported, (an average 1 per 1,000 paid claims) but in 1978, 23 such awards were reported (3 per 1,000 paid claims). Also, defense costs and other associated expenses increased 73% over the study period.

Hospitals were reported as the site of injury in 78% of all paid claims. However, 60% of all paid claims involved physicians as defendants, 31% involved hospitals, and 9% involved other health care professionals and other institutions. Indemnity payments on behalf of physicians amount to 71% of total reported indemnity, with hospital defendants share of total indemnity at 25% and the others at 4%. Thirty-five percent of the reported paid claims related to allegations of improperly performed procedures, 27% to diagnostic errors and 10% to drug injuries. Significantly, by Insurance Services Office specialty classification, the "physician minor surgery" class accounted for the most paid claims and the largest percentage of indemnity paid on behalf of physicians, followed by the classification "physician no surgery."

More recent information has been developed by the AMA in a series of reports and related studies. These support the position that a malpractice crisis exists. On the other hand, the ATLA and others posit there is no crisis. Both positions are presented here.

AMA Position

The American Medical Association Special Task Force on Professional Liability and Insurance issued a series of reports, beginning in October 1984, addressing the issue of professional liability in the 1980's (7). Report I presented data on the scope of the problem, Report II a round-table discussion on medical malpractice, and Report III, an AMA action plan.

According to AMA Report I, medical malpractice losses (indemnity) reached nearly $2 billion in 1983. Professional liability insurance yearly losses have exceeded premiums since 1979 with losses approximately $430 million over paid premiums for 1983. Best's Insurance and Management Reports (January 2, 1984) cited in AMA Report I stated "Medical malpractice is reaching the point of no return in terms of producing investment income from loss reserves that exceeds the underwriting loss."

Report I also projected a significant increase in the number of claims and suits against physicians, comparing NAIC total claims of 14,074 for the period July 1, 1975 - June 30, 1976 with a projected 42,018 claims against physicians in 1983. Physician owned insurance companies reported

increases in claims frequency during 1979-1983. In 1979, 9,915 claims were filed against 17 companies which insured 71,310 physicians. By 1983, 21,104 claims were filed against 23 companies which insured 87,715 physicians.

Significantly, AMA Report II noted that approximately 3 out of 4 claims against physicians are closed by their professional liability insurance companies without payment. However, the rate at which claims were closed has fallen behind the filing rate and has led to a sharp increase in the number of accumulated claims still open. The report concluded that "because of the increasing severity of professional liability claims, the longer a claim stays on a company's book, the greater the chances are that it will be more costly to resolve."

Based on AMA data (Report I), the average incidence of malpractice claims has increased against all physicians. General/Family Practice claims incidence per 100 physicians increased to 8.2 from 3.8 per year during 1978-83; medical specialties, (including internists, pediatricians, cardiologists, gastroenterologists, dermatologists and allergists) claims incidence increased to 4.5 per 100 physicians from 2.3; and for surgical specialties the increase was to 11.8 from 4.8 during the same period. Also, national severity trends (average paid losses) for physician-owned companies tied to medical societies showed an increase from an average of $20,396 per paid loss in 1979 to $72,243 in 1983. Median and average verdicts against physicians increased significantly since 1975. According to data from Jury Verdict Research and used in AMA Report I, the median of a typical verdict against a physician in 1975 was $48,500 and the average $94,947. For 1983-84 the median verdict was reported to be $200,637 and the average $338,463. Physician-owned liability companies reported a median indemnity paid on liability claims of $9,227 in 1979 and $49,871 in 1983 according to data from the American Medical Assurance Company (AMACO), also cited in Report I. Finally, the report noted that there have been 196 million-dollar verdicts in medical malpractice cases, 45 of which occurred in 1982.

Report I presented information that malpractice insurance premiums have increased. An AMACO survey of physician-owned companies in late 1983 revealed 22 of 29 had raised rates that year an average of 17%. The average increase in rates over the past 3 years was found to be 47%. Further, it was reported that in July, 1984 the St. Paul Companies had advised their physicians of an average increase of 32%, depending on their specialty and where they practice. Medical Protective Company of Fort Wayne was also reported to plan a rate increase.

Finally, Report I estimated the cost of "defensive medicine" at $15.1 billion annually. This calculation was based on an AMA Socioeconomic Monitoring System Study and other surveys alleging that defensive medicine constituted 25-50% of the cost of treatment.

Two other AMA studies have a bearing on this debate. In a September, 1985, paper by the AMA Center for Health Policy Research, the cost of medical malpractice was estimated using two different methodologies (8). The first approach used data on specific defensive practices and premiums

paid by physicians to directly derive estimates of the major elements of malpractice costs. The second approach employed a multivariate analysis to determine the effects of malpractice risk on physicians' fees and utilization rates. The two approaches provided estimates of malpractice costs in 1984 of $13.2 billion and $10.9 billion respectively. These costs were viewed as responsible for between 14.5 and 17.5 percent of the $75.4 billion spent on physicians' services in 1984.

Physician response to medical malpractice was recently studied and reported in the Fall, 1984, issue of Health Affairs in an article by Stephen Zuckerman, Research Economist of the AMA's Center for Health Policy Research (9). Data from a third quarter 1983 survey of the AMA Socio-economic Monitoring System (a survey of 1240 physicians) revealed the following changes in physician practice behavior:

		Specialty		
Percent of physicians who:	All Physicians	General/ Family practice	Medical	Surgical
maintain more detailed patient records	56.7	65.6	47.4	62.1
refer more cases to other physicians	44.8	59.5	40.3	50.6
prescribe additional diagnostic tests	40.8	55.0	32.8	50.3
spend more time with their patients	35.9	41.6	27.0	45.0
provide additional treatment procedures	27.2	39.9	18.1	35.4
hire additional office support staff	11.1	12.8	8.9	15.1
increase their fees	31.4	36.7	23.2	43.5
do not accept certain types of cases	34.6	51.4	26.8	42.0
discontinue their professional liability insurance completely	2.6	5.0	1.8	1.6
self-insure through an individual trust or escrow account	3.9	3.6	2.2	4.4

In the author's view, certain of these changes would also increase health care costs. These were a) keeping more detailed medical records, b) referring more patients, c) prescribing additional diagnostic tests, d) spending more time with patients, and e) providing additional treatment procedures. In comparing the three specialty groupings, the author found that medical specialists tend to respond less than general and family practitioners and surgeons. He concluded that this result "appears to be consistent with the finding that medical specialties have incurred claims at the lowest rate over the last five years. One would expect those physicians who experience the fewest claims to be least motivated to undertake defensive responses."

ATLA Position

The Association of Trial Lawyers of America (ATLA) responded to the AMA reports by stating that there is no medical malpractice insurance crisis (10). ATLA claims that between 1976 and 1983 the cost of malpractice insurance has been steadily declining as a percentage of total health care dollars, to less than one half of one percent of total health care costs ($1.5 billion compared to $355.4 billion). Further, in 1983, while the average American spent $1,500 on health care, only $6.08 went to malpractice insurance premiums.

Second, ATLA believes medical malpractice insurance companies are profitable, particularly because of investment income. For the period 1978-83, ATLA indicated that the medical malpractice insurance industry earned approximately $300 million more in investment income on assets encumbered by reserves than it paid in losses ($1.761 billion versus $1.465 billion).

Third, ATLA argues that the average physician pays a very small percentage (2.9%) of gross income for malpractice insurance. Neurosurgeons, who pay the highest percentage, pay 5.8% of gross income for malpractice insurance. Finally, ATLA data indicate that 57% of physicians spend less than $5,000 on malpractice premiums, with only 12% spending over $15,000 per year.

Fourth, ATLA argues that "defensive medicine" is merely "careful medicine" that can save money. Even if AMA estimates of the cost of defensive medicine ($15 billion), were accepted as accurate, ATLA indicates that the cost would only be $1.19 per week for the average American. Thus, ATLA posits, to the extent "defensive medicine" constitutes improved health care it must not be discouraged, and to the extent it represents treatment that is unnecessary it cannot be excused by claims that the burden of malpractice insurance drives health care providers to practice it.

In response to the ATLA report, the AMA Special Task Force on Professional Liability and Insurance issued a special report (11). It addressed the above-mentioned ATLA statements attacking their factual basis and conclusions, including the opinion that a malpractice crisis does not exist.

In a recent article, Bovbjerg and Havighurst question the seriousness of the situation (12). They note that according to AMA data, the average physician paid $7,100 for coverage in 1983 with fewer than one in four paying over $10,000. Total physicians' premiums were only 3.8 percent of their gross revenues, a proportion, they allege, that has changed little in the last ten years. Malpractice premiums, $2 billion in 1983, combined with self-insurance funding, equal only one percent of total national health care spending. This percentage has grown little over the last decade because underlying medical spending has grown rapidly. In the authors' view, this one percent does not pose an immediate financial threat to the health care system. Further, they argue that although some physicians are withdrawing from high risk practices such as obstetrics, there is as yet no systematic evidence that patients cannot receive needed care because of the effect of malpractice premiums on fees or on their willingness to serve.

COMMENT

While the available data have been variously interpreted, certain disturbing trends can be noted. The frequency and severity of malpractice claims have clearly increased for all specialties. Many recent million-dollar verdicts have been rendered by juries. Malpractice premiums have been steadily adjusted upward. There has been a sharp increase in the number of accumulated open claims subjecting insurers to future vulnerability. Preliminary evidence indicates that some physicians may be modifying their practice behavior in ways that increase overall health care costs. Some physicians may also be withdrawing from high risk practices. If these trends continue unabated, there may be cause for real concern.

MALPRACTICE IN INTERNAL MEDICINE

What is the experience in internal medicine? Information on malpractice in internal medicine is derived from the CMSS patient injury prevention program (NAIC data)(13) and from information developed by commercial and physician-owned, medical-society-linked liability insurance companies. The CMSS program discussed major areas of patient injury in internal medicine resulting in lawsuits. Those events and the reasons therefore are listed below.

Malpractice Event	Reason
I. Misdiagnosis of cancer	
A. Breast cancer	Lack or a failure to follow one's own protocol for the follow up of lumps.
B. Lung cancer	Failure to review and compare chest X-rays.

C. Cancer of the colon	Failure to perform digital exam and stool guaiac; gastrointestinal complaint-failure to follow up with flexible proctosigmoidoscopy.
II. Misdiagnosis of myocardial infarction	The misreading of chest pain; failure to use adequate consultation; incorrect orders to coronary care unit.
III. Drug injuries	Insufficient and infrequent reassessment of patient's drug needs, including drug interactions.
IV. Misdiagnosis of pulmonary emboli	Lack of a high index of suspicion for patient on birth control pills or for post-op patients with a cough.
V. Misdiagnosis of acute abdomen	The misreading of signs of ulcer and gallbladder disease.
VI. Misdiagnosis of ectopic pregnancy	Failure to review pathology report.
VII. Cardiac catheterization injuries	Complications from procedure.

More recent information was provided by commercial and physician-owned liability insurance companies. Failure to diagnose was a major reason for malpractice suits against internists in the St. Paul Companies most recent (5 year opened and closed claim) experience (14). A breakdown of the 15 leading allegations in malpractice claims against internists showed:

St. Paul Companies

CLAIMS REPORTED 1979-1984

Allegation	Count	Avg. Cost	*Total Cost
1. Failure to Diagnose--Cancer	111	$28,730	$3,189,029
2. Improper Treatment--Drug Side Effect	97	26,586	2,578,825
3. Improper Treatment--Lack of Supervision	62	17,992	1,115,483
4. Improper Treatment--Insufficient Therapy	54	23,624	1,275,716
5. Failure to Diagnose--Fracture/Dislocation	44	19,754	869,169
6. Improper Treatment--During Examination	41	30,572	1,253,438

Allegation	Count	Avg. Cost	*Total Cost
7. Improper Treatment--Drug Incorrect	38	39,904	1,516,343
8. Failure to Diagnose--Infection	34	30,327	1,031,120
9. Improper Treatment--Infection	32	23,680	757,753
10. Failure to Diagnose--Myocardial Infarction	30	40,300	1,208,999
11. Failure to Diagnose--Circulatory Problems	28	19,585	548,380
12. Surgery--Postop Complications	28	4,925	137,898
13. Improper Treatment--Drug Overdose	27	39,925	1,077,968
14. Failure to Diagnose--Abdominal Problem	26	25,723	668,811
15. Failure to Diagnose--Tumor Non-Malignant	24	25,528	612,674
All Other Allegations	663		
Total	1,339		

* Includes paid indemnity and reserves for open claims

On a nationwide basis, St. Paul insured approximately 3,600 internists in 1979 and 4,500 in 1982. St. Paul places physicians in eight rate groupings (15). Internal medicine specialists typically fall under the three lowest rate classifications, with rates averaging nationally for $1 million/3 million coverage at:

Class I	$3,257
II	$6,252
III	$7,736

The classes are identified as follows:

Class I: No surgical procedures other than incisions of boils and superficial abcess, or suturing of skin or superficial fascia.

Class II: No major surgery but perform any of the following medical techniques or procedures:

Colonoscopy
ERCP (endoscopic retrograde cholangiopancreatography) Needle Biopsy--including lung and prostate but not including liver, kidney or bone marrow biopsy.

Pneumatic or mechanical esophageal dilation (not with bougie or olive)
Radiopaque Dye--Injections into the blood vessels, lymphatics, sinus tracts or fistulae (not applicable to Radiologists Code 80208)

Class III: No major surgery but perform any of the following medical techniques or procedures:

Acupuncture--other than acupuncture anesthesia
Angiography
Arteriography
Catheterization--arterial, cardiac or diagnostic--other than (1) the occasional emergency insertion of pulmonary wedge pressure recording catheters or temporary pacemakers, (2) urethral catheterization or (3) umbilical cord catheterization for gases in newborns receiving oxygen.
Cryosurgery--other than use on benign or pre-malignant dermatological lesions.
Discograms
Lasers--used in therapy
Lymphangiography
Myleography
Phlebography
Pneumoencephalography
Radiation therapy
Shock therapy

DATA FROM PHYSICIAN-OWNED INSURANCE COMPANIES

Information was solicited and received from five physician-owned-medical-society-linked professional liability insurance companies. These companies generally provide malpractice insurance to individual physicians who practice within a particular state. Data are presented from the Michigan Physicians Mutual Liability Company, Medical Inter-Insurance Exchange of New Jersey, the Medical Mutual Insurance Company of North Carolina, the Medical Mutual Liability Insurance Society of Maryland, and Medical Insurance Exchange of California.

Michigan Physicians Mutual Liability Company (16)

Period: 1980 through 1984
Specialty: Internal medicine
Total claims: 408 open and closed claims

Severity of Incident

Temporary Minor 95
(infections, missed fracture, hospital fall, delayed recovery)
Temporary Major 27
(burns, surgical material left, drug side effect, brain damage)

Permanent Minor	39
(loss of fingers, loss or damage to organs, non-disabled injuries)	
Permanent Significant	30
(deafness, loss of limb, loss of leg, loss of one kidney or lung, etc.)	
Death	176

Misdiagnosis Cause

An inadequate physical or mental examination	26
Failure to request other diagnostic test	38
Misinterpretation of X-ray	13
Misinterpretation of other diagnostic test	14
Misinterpretation of otherwise adequate information acquired by history or physical exam	16

Reason for Injury

Not indicated or contraindicated (treatment)	22
More appropriate alternative	53
Delay in performing procedure	40
Procedure improperly performed	63
Error in diagnosis	81

Location of Incident

Hospital inpatient facility	269
Hospital outpatient facility	24
Nursing home	7
Physician's office or clinic	102
Patient's home	3

Information on selected internal medicine subspecialties was also developed separately for the cardiology, endocrinology, gastroenterology, hematology, nephrology, and pulmonary disease categories for the five year period 1980-1984 (17). Only the cardiovascular and gastroenterology categories showed more than 4 claims filed in the five year period.

Specialty: Cardiology (Cardiovascular disease)

Total claims: 62

Severity of incident

Temporary Minor	9
Permanent Minor	9
Death	31

Misdiagnosis Cause

An inadequate physical or mental examination	6
Failure to request other diagnostic test	4

Reason for Injury

Not indicated or contraindicated	5
More appropriate alternative	7
Procedure improperly performed	19
Error in diagnosis	10
Failure to monitor or supervise	5

Location of Incident

Hospital inpatient facility	56
Hospital outpatient facility	3
Physician's office or clinic	7

Specialty: Gastroenterology

Total claims: 9

Severity of Incident

Temporary Minor	2
Death	4

Misdiagnosis cause

Misinterpretation of otherwise adequate information acquired by history or physical examination	2

Reason for Injury

More appropriate alternative	1
Procedure improperly performed	1
Error in diagnosis	6

Location of Incident

Hospital inpatient facility	5
Physician's office or clinic	4

The Michigan Physicians Mutual Liability Company had, as of August 1984, 4,585 policy holders (18).

Internists are generally placed in class two, general practice, no surgery, or in class three which includes minor surgery. The cardiovascular category, however, includes major surgery. A comparative rate history for class two follows (17).

MPMLC RATE TREND FOR
SELECTED SPECIALTIES
100/300 LIMITS*

TERRITORY 1

SPECIALTY	RATES EFFECTIVE AS OF JULY 1 OF YEAR INDICATED									
	76	77	78	79	80	81	82	83	84	85
GP (2)	1,800	1,800	2,785	2,620	2,620	2,561	2,561	2,740	3,261	4,565
GS (6)	9,850	9,850	10,174	9,665	9,665	8,925	9,461	9,461	11,259	15,763
OBG	11,600	11,600	10,836	10,836	10,249	9,493	10,062	10,766	12,812	24,158

GP (2) = General Practice, No Surgery
GS (6) = General Surgery
OBG = Obstetrics & Gynecology

* MPMLC also provides $1,000,000/1,000,000 coverage. Those rates are determined by multiplying the listed rates by a factor of 2.4.

Medical Inter-Insurance Exchange of New Jersey
(Claims closed with indemnity payment)(19)

I. Internal Medicine (excluding cardiology and gastroenterology)

SURVEY PERIOD (A) 01/80-12/31/84
Total claims paid 104
Total indemnity $5,878,100

SURVEY PERIOD (B) 01/77-12/31/84
Total claims paid 205
Total indemnity $11,766 577

Problem Area	Claims(A)	Claims(B)	Indemnity (A)	Indemnity (B)
Diagnosis error	33	66	$2,119,900	$4,216,784
Decision error	16	23	$1,039,273	$1,372,148
Medication error	12	22	$1,460,842	$2,628,342
Improper management or monitoring	10	29	$ 595,262	$2,172,764

II. Cardiology (Cardiovascular Diseases)

SURVEY PERIOD (A) 01/80-12/31/84
Total claims paid: 8
Total indemnity: $ 454,823

SURVEY PERIOD (B) 01/77-12/31/84
Total claims paid: 22
Total indemnity: $1,592,621

Problem Area	Claims (A)	Claims (B)	Indemnity (A)	Indemnity (B)
Diagnosis error	1	3	$ 150,000	$ 223,750
Decision error	3	5	180,333	375,208
Medication error	1	2	75,000	353,600
Errors in performance	2	3	24,500	27,000
Consultation or referral problems	0	2		26,364

III. Gastroenterology

SURVEY PERIOD (A) 01/80-12/31/84
Total claims paid: 16
Total indemnity: $1,251,580

SURVEY PERIOD (B) 01/77-12/31/84
Total claims paid: 37
Total indemnity: $2,281,690

Problem Area	Claims (A)	Claims (B)	Indemnity (A)	Indemnity (B)
Unintentional iatrogenic injury	7	14	$ 499,500	$1,087,834
Diagnosis error	3	7	630,000	784,000
Decision error	2	4	103,333	126,833
Medication error	0	2		43,500

The New Jersey report concluded that in both numbers of claims and dollars of indemnity paid, diagnosis error was the most frequent cause of loss. A review of the behavior errors contributing to errors in diagnosis involved, for example, 15 instances where there was a failure to perform (8) or a failure to order (7) a test or procedure, 9 instances where there was a delay (5) or failure (4) to refer a patient when appropriate, and 4 instances where patients' complaints were ignored.

However, gastroenterology had a different malpractice pattern, with unintentional iatrogenic injury accounting for the greatest number of claims and indemnity since inception (1977). These cases involved perforations during endoscopy, biopsy or bouginage.

The Medical Inter-Insurance Exchange of New Jersey had, as of August 1984, 6,850 policy holders with a premium range of $3,373-$24,272, and an average premium of $6,700 (18). Internal medicine generally has been placed in Class II except for allergy and oncology which are in Class I. Effective February 1985 gastroenterologists have been moved up one rating to Class (III) due to deteriorating loss experience (19). Annual premiums for the classes are $5,372 and $7,326 respectively for $1,000,000/$3,000,000 coverage (20).

The Medical Mutual Liability Insurance Society of Maryland(21)

Period: 1978-1982
Insured Internists: 3,164 (total for all years, approximately 600 per year)
Claims: 185 claims reported as of 12/31/84, 123 claims closed

Indemnity:

$2,835,000	paid
$3,572,000	reserve on open claims
574,000	defense costs paid
537,000	defense costs reserve on open claims
$7,518,000	total expected cost of known claims
$2,376	average loss per internist

LEADING CAUSE ALLEGATION FOR ALL HOSPITAL BASED CLAIMS (OPEN & CLOSED)

ALL SPECIALTIES 1975-1982

Alleged Causes	% All Specialties	Internal Medicine
Misdiagnosis of Abnormal Condition	23%	24%
Procedure Improperly Performed	20%	3%
Failure to Prevent Complication or Abnormal Condition	19%	11%
Failure to Accomplish Intended Result	11%	5%
Delay in Diagnosis	8%	9%
Inadequate Assessment of Patient	4%	7%
Delay in Procedure	3%	5%
Failure to Obtain Proper Order/Instruction	3%	5%

ALLEGED BASIS FOR HOSPITAL BASED CLAIMS (1975-1982)

Alleged Causes	% All Specialties	Internal Medicine
Death of Patient	21%	59%
Temporary minor conditions which delay recovery of patient (e.g. falls, infections, missed fractures, etc.)	20%	11%
Permanent minor conditions such as non-disabling injuries, minor damage to organs, loss of a finger or toe, etc.	19%	8%
Temporary major conditions which delay recovery of patient (e.g. burns, drug reactions, left surgical material, etc.)	14%	7%
Permanent significant conditions such as deafness, loss of one eye, loss of limb or one kidney or lung	7%	8%
Temporary insignificant conditions which do not delay patient recovery (e.g. damage to teeth, minor scars, rash, lacerations & contusions, etc.)	6%	0
Temporary emotional states, fright, etc.	5%	5%

Alleged Causes	% All Specialties	Internal Medicine
Permanent major conditions as a result of hospitalization (e.g. paraplegia, bilateral blindness, loss of two limbs, brain damage).....	4%	2%
Permanent grave conditions such as severe brain damage, quadraplegia or other conditions occasioning life-long care, or, fatal prognosis	3%	1%

Medical Mutual Liability Insurance Society of Maryland, as of 12/31/83, had 2,900 policy holders with claims made premiums varying from $656 to $12,400 per year for $1,000,000/3,000,000 coverage. The average premium was 6,000 per annum(18). Internal medicine had up to 1984 been rated in the same classification as that of general practitioners--no surgery. In July 1984, internists received a rate relativity of 1.2, placing their premium 20% higher than that of the general practitioner classification. For example, premiums in Baltimore county for general practitioners are $2,788 while for internists they are $3,286. The 1981 premium (1.0) was $1,793 reflecting a 55% increase in 3 years(21,22).

The Medical Mutual Insurance Company of North Carolina (23)

Period: 1979-1984
Claims: 217 reported claims
6 claims settled at an average of $11,320 per claim
96 open claims

Primary allegation of negligence:	
Failure or delay in diagnosis	54
Medication errors or reactions	24

Severity of Claims	
Emotional	25
Temporary or insignificant injury	12
Temporary minor injury	23
Temporary major injury	29
Permanent minor injury	8
Permanent significant injury	18
Permanent major injury	9
Permanent grave injury	11
Death	82

Medical Insurance Exchange of California (MIEC)(24)

The MIEC data system did not have the capability to provide information on the major reasons for the claims.

Report Year	# of Internists	Indemnity Paid	Closed With No Payment	Closed With Payment	Total
75	339	$ 0	5	0	5
76	442	$730,763	29	13	42
77	539	$760,704	69	14	83
78	592	$595,755	71	18	89
79	632	$ 99,486	58	5	63
80	651	$112,575	64	9	73
81	683	$182,735	63	6	69
82	704	$259,124	55	4	59
83	718	$ 2,500	12	1	13

Presently MIEC has 235 open claims with total reserves (indemnity + expenses) of $8,193,147.

The MIEC had as of 12/31/83, 2,900 policy holders, 718 of which are internists. Claims made premiums range from $4,996-$31,648 with the average premium $6,500 for $1,000,000/3,000,000 coverage. Internists are rated in class I, irrespective of the complexity or invasiveness of the procedures they perform(18,24).

COMMENT

The above noted information indicates that the failure to diagnose or misdiagnosis is the dominant allegation in malpractice actions against internists. Failure to diagnose cancer was the leading allegation in national data used by the CMSS and supported by subsequent (1979-1984) data of St. Paul. Where a severity of injury index was reported (the Maryland, Michigan, and North Carolina insurance companies), death was by far the leading indicator. Drug injuries also continue to place high among causes of malpractice, with the CMSS report supported by data from St. Paul, New Jersey and North Carolina. Data from New Jersey indicate a different malpractice pattern for gastroenterology, namely procedure misadventure. Michigan's cardiovascular malpractice pattern indicates improperly performed procedures as the major reason for injury.

The location of malpractice events was reported specifically only by Michigan Physicians Mutual Liability Company. It indicated that the vast majority of claims are hospital-based. The Medical Mutual Liability Insurance Society of Maryland's claim information was solely hospital-based.

The number of malpractice claims against internists must be considered substantial. St. Paul listed 1339 open and closed claims against internists during the last five years. For a similar five year period, Maryland, Michigan, and North Carolina reported a total of 892 open and closed claims. California reported a total of 496 closed claims (197583) with 235 open claims. New Jersey reported 205 closed claims since 1977.

Of particular importance are the costs associated with the claims. For example, St. Paul has paid or allocated as reserves against open claims nearly $18 million for 676 claims. Maryland noted $7,518,000 as total expected costs of its known claims against internists. California has paid over $2.7 million in claims and has held in reserves over $8 million for its 235 open claims. New Jersey has closed 128 claims for $7.5 million. These costs will be translated into rating changes or higher premiums for internists. This has already occurred for Maryland's internists and for New Jersey's gastroenterologists. General premium increases have effected internists. Maryland data showed in the last 3 years a 55% increase in premiums for class I. Michigan showed significant premium increases (78%) between 1982 and 1985 after 4 years of declining or steady premiums. Thus, this malpractice claims data for internal medicine is consistent with the data contained in the NAIC and AMA reports and indicates similar trends.

CONCLUSION

This paper provides background information on the issue of medical malpractice and presents data on the malpractice experience nationally for all physicians and selected information on the recent experience in internal medicine. It shows that physicians, including internists, are facing significant increases in claims frequency and severity as well as in the costs of medical malpractice insurance. The data support concerns within the medical profession that another malpractice insurance crisis may be occurring. The medical profession, including internal medicine, needs to address both the causes of malpractice as well as the spiraling costs of insurance.

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