



**AN EASY PILL
TO SWALLOW**

**Confronting the Root Cause
of our Medical Malpractice
Crisis and Vastly Improving
Our System and Quality
of Care too**

**by Dennis Lazof
and Project EINO**

www.EverybodyInNobodyOut.org

AN EASY PILL TO SWALLOW:

Confronting the root causes of the medical malpractice crisis and vastly improving our system and quality of care too.

produced by Project EINO
June 2003

Project EINO is based at www.EverybodyInNobodyOut.org and is dedicated to the autonomous state organizations which have taken on the enormous task of grassroots organizing for Universal Health Care. We believe that these organizations and the activists within them constitute the critical leadership of the movement for Universal Health Care in the USA.

Project EINO is in great need of funding, being funded for several years by two state activists of only moderate income. As of June 2003 the project has received no more than a few hundred dollars over the 5+ years of operation towards expenses. The project is actively seeking serious foundation support to support staff and expansion of services. In the meantime the project also greatly appreciates any individual donations (large or small) to help us continue our work until some initial funding is found.

You will soon come to understand why Project EINO has had more difficulty in finding funding than some other organizations which pretend to focus on universal health care, but believe that incremental reforms of our patchwork system is sufficient and the only feasible road. This latter analysis while faulty, is obviously much more friendly to the insurance industry.

Donations are tax-deductible and can be sent to:

Project EINO
1815 MLK Parkway, Ste #2, PMB 142
Durham, NC 27707

Tele: 919.402.0133
Email: director@ProjectEINO.org

TABLE OF CONTENTS

A critical aspect of our failing health care system	4
Caps on Awards to Victims	4
Why we have malpractice lawsuits with large awards.....	5
Fixing the Malpractice Mess: small fixes	7
Getting at the Root of the Malpractice Mess	8
Absolute Inclusion.....	9
Drastically reducing conflicts of interest	11
Relationship building	11
Conclusion	12

An Easy Pill to Swallow

A critical aspect of our failing health care system

Our nation is facing a crisis with regard to escalating medical malpractice. In West Virginia large swaths of the state have no obstetrician and in New Jersey physicians massively walked out a few weeks agoⁱ. An obstetrician in Illinois pays \$110,000 a year in malpractice premium, even though in neighboring WI one would pay about 75% less. Nationally, premiums for malpractice insurance, rose by more than 50% on average in 2002-3ⁱⁱ. The increases were much harsher in certain specialties and states. Physicians must either abandon those states, or leave their practices. Based on a recent poll, more than one fourth of all practices in the U.S. are planning to restrict services in some fashion to adjust to rising malpractice premiums.ⁱⁱⁱ Furthermore, some small practices where physicians are serving communities with special needs are being billed as much half their annual gross receipts for their malpractice insurance, even though they have never received a complaint, or have been targeted as particularly high-risk.^{iv}

Besides the liquidation of otherwise viable and needed medical services, there are, at least, two additional serious breaches of our health care system resulting from the crisis in malpractice insurance. First, due to the runaway costs of malpractice insurance, medical students are avoiding those specialties worst-hit by malpractice premiums.^v The students are making their lifetime commitments based on predictions of insolvency, rather than on the basis of community need, or rewarding service. The result will be a scarcity of needed services for decades to come. Second, the vast majority of U.S. physicians believe that the quality of their care is already seriously compromised by the need to adjust care to minimize the likelihood of future lawsuit.^{vi} This adjustment in care includes medically unnecessary tests and referrals to specialists and even unwarranted invasive procedures such as biopsies. Not only is the current quality of care compromised by the resulting "overutilization", but expenses for the whole system are further increased (leading to higher premiums and increases in the uninsurance rate).

Caps on Awards to Victims

The insurance industry and the Bush Administration would have us believe that the problem can simply be laid on the doorstep of trial lawyers, who find profit and livelihood in huge awards and settlements resulting from frivolous lawsuits waged against medical personnel and institutions. Recent evidence indicates that malpractice premiums, however, have been rising and falling over the last few decades as the stock market falls and rises (i.e. they are inversely related). The premiums increase as the insurance industry attempts to recover their losses from investments in the market.^{vii, viii} They want to pay dividends to their own stock holders despite enormous stock losses. Insurance corporations,

of course, have enormous stock holdings based on premiums paid against the probabilities of future policyholder losses.

Based on this superficial analysis of the crisis, some states, and at the federal level, the "solution" is being discussed of capping awards that can be made to plaintiffs for "pain and suffering" resulting from malpractice injuries. This, like so many short-sighted fixes in our patchwork health care system, fails to address the root problems and may well wind up costing us far more in the long run. Never to our knowledge has it been discussed along with capping the rates that the malpractice carriers can charge a medical practice (a possibility would be to fix a maximum for each specialty like 10% of gross receipts). It would be more accurate therefore to describe the capping of awards as an adjustment in who will be paying the costs of uncontrolled medical errors. As usual, the new "fall guys" will have limited "political leverage" to defend themselves, as opposed to insurance industry with its lobbyist minions. In the few states where the "pain and suffering" component of malpractice lawsuits have already been capped malpractice premiums have not been reduced.^{ix}

Another way to evaluate the effectiveness of the capping "solution" is to acknowledge that less than 40% of malpractice awards actually goes to payment of the victims.^x Some 62% of the cost is expense to insurance companies, lawyers (plaintiff and defendant). None of the proposals being discussed, as far as we can ascertain, restricts the portion of malpractice claims going to these other sources. As we said, its all about who is set-up to defend themselves in the halls of power. To thoroughly evaluate the idea of capping it is necessary to review the rationale behind jury awards in the first place.

Why we have malpractice lawsuits with large awards

There are two reasons why there are trials by juries and awards, even apparently large awards.

(1) There is in our current health care system no alternative mechanism for forcing powerful medical institutions and their personnel to take responsibility for their actions. The cost benefit analysts (who can be found at major medical centers accompanying doctors on their rounds) and their supervising administrators are frequently involved in calculating how services and patient stays at the hospital can be restricted. If the costs from malpractice suits are removed there is little to inhibit further, possibly harmful, cuts to the quality of service. The cost of lowering quality must be raised to the dollar level of the savings which will accrue to the hospital or clinical practice from delivery of substandard care. Even non-profit community hospitals have found themselves forced just like the for-profit hospitals, with whom they compete, to cut costs wherever possible. The "free market" and "competition" do nothing to regulate high quality into health care. Health care cannot ever work that way because so few people need and use the most costly services. The vast majority of

Americans have no real basis upon which to judge the quality of care, as we experience little more than checkups and routine procedures, while just 20% of the US population uses 80% of the health care resources (due to chronic and grave illness). The quality of the "pocket change" type of care the rest of us regularly use has no bearing on how a health plan or medical institution will serve us during, for example, a protracted battle with cancer in which the really significant costs to insurers occur.

(2) The overwhelming majority (some 85%) of people harmed by medical malpractice receive no compensation whatsoever^{xi}. First of all someone has to realize that they, or their family member, are likely to have suffered a poor outcome due to poor care. Then those that have such a realization have to be motivated to litigate and to relive their tragedy in court under hostile cross-examination. Next, those that are so motivated to litigate have to actually make the effort to contact and meet with an attorney, and be able to communicate the case clearly enough to interest the attorney. Next, their attorney must find that the case is not only believable, but that there exists convincing evidence of malpractice, otherwise the attorney would be wasting their own time - as they are paid only on the contingency of winning the lawsuit. All instances of malpractices which do not evolve to this final stage are neither settled, nor go to court. The comparatively few cases that go to court must, then, end in large enough awards to make the cost benefit analysts hesitate in risking substandard care or early discharge of future patients in similar circumstance. The likelihood of a malpractice event going to either settlement or jury award is calculated by the institution, in designing where to cut back on quality (extending duties of nurse's aides while cutting nursing staffs, for example). Indeed for each patient added to a hospital nurse's workload mortality increases 7%.^{xii}

We consumers of healthcare and possible future patients need some way of threatening the for-profit institutions if they should go too far in their admitted quest for profits (their fiduciary responsibility). Otherwise we will incur the costs in further erosion of care quality - the "fall guy" will be the patient already victimized once by the medical practice or institution. It is obvious to most of us already that there is far less nursing staff on the wards and physician attention to detail during exams, than there was before the era of "managed care" in which the insurers and HMO's gained overwhelming dominance in engineering how health care would be delivered. The loss in quality costs us both in our health and in our pocketbooks as we progress more quickly (and at times unnecessarily) towards serious medical conditions that were not appropriately treated at an early stage. How else shall we threaten them? And who else stands ready to work with us, other than trial lawyers? The Bush Administration proposes to merely remove our ability to threaten them, so that they can bear down upon us with still greater cost-saving measures.

As malpractice has grown to be a greater burden on practices and medical centers, further cutbacks in services and facilities ensue. This is due, in part, to

the extraction of funds for malpractice premiums, which then leads to further deterioration in quality of care, which leads to further increases in medical errors. The main factor in increases in medical errors during the last two decades has been the medical speed-up and understaffing.^{xiii} The media have gone along with the myth that hospitals are understaffed because of a "nursing shortage". If the reservoir which feeds your town is suddenly diverted to water golf courses in the neighboring suburb, its a bit disingenuous to call that a "water shortage", even though there may no longer be enough water to drink or bathe. Similarly, nurses have been overextended, subjected to deteriorating conditions, diverted to other occupations, so that the "shortage" of nurses is an expected consequence.

Nurses have been leaving their profession due to being over-extended, over-stressed and getting less satisfaction on the job.^{xiv} Nurses as the primary hands-on providers of care could recognize immediately that they were not being allowed to care adequately for their patients. The deterioration in care and increasing errors as nurses become overextended and physician time with patient has become cut, has been well-documented.^{xv, xvi} What plan has the Bush Administration proposed for standardizing and protecting nurse staffing levels on the wards, or the number of patients a physician is expected to examine per day? How much interest has the Bush administration shown in reducing medical errors at the root cause and so directly reducing malpractice suits? Well none since the problem is a simple one for them - being all the fault of the trial lawyers.

We have reason to doubt that the recent increases in malpractice premiums result from increased insurers payouts from malpractice suits. Recent government data indicates that increases in these premiums from 2001 to 2002 were accompanied by decreases in the number of malpractice awards by 8.2% nationally, while total awards decreased by 6.9%.^{xvii} Awards over \$1 MIL dropped by more than 11% also. This lack of correlation cannot be explained by geographic distributions, since West Virginia saw a relatively great number of practices close due to malpractice insurance costs (100) even though damages paid out in the state dropped by fully 31% in 2002. As mentioned a few paragraphs earlier, a strong and consistent correlation is found, however, between increases in malpractice premiums and losses insurers suffer due to declining stock values.

Fixing the Malpractice Mess: small fixes

Recently, Dr. A. Verghese addressed runaway malpractice costs in "Hard Cures"^{xviii}. The two suggestions he made are likely to provide some relief. Dr. Varghese suggested that experts testifying in cases be drawn from a pool of authorities in the relevant medical specialty - that they not be professional "malpractice witnesses". This would seem fair, provided the same restrictions apply to medical experts who testify for the plaintiffs. He also suggested that

regional panels be established comprised of consumer advocates and medical professionals to review cases prior to trial. The purpose of the panels would be to distinguish those cases built solely on bad medical outcomes - without any evidentiary, or testimonial basis for demonstration of substandard care having had a role in that outcome.

Another small fix, would be for physicians' professional societies to improve their own policing of physician qualifications and closer cooperation with state licensing boards in developing new procedures, requirements and periodic review of medical board certifications. Note that just 5% of physicians are responsible for the majority of malpractice award payouts^{xix} and that many of these physicians are repeat offenders who are still not under review or suspension.

While these small fixes seem to promise relief, it was Dr. Varghese's closing comments which are much more interesting. The article closes with the thought that "a sound physician-patient relationship is a powerful antidote to frivolous lawsuits". For those of us who have been dedicated advocates of a new universal health care system (UHC) for this nation, his closing paragraph is directly on target. Advocates of UHC have been involved in rethinking the very foundation and essential design of our health care system, so we tend to be more interested in the root causes of this crisis, than in partial fixes.

Getting at the Root of the Malpractice Mess

Elsewhere there have been eloquent arguments presented for the economic feasibility of, the ethical urgency to develop a medical system which would include all Americans, just as exists in every other industrialized nation.^{xx,xxi} How, though, could a system in which all Americans have a "Right to Health Care" be expected to affect the crisis of malpractice? Is there a connection to this uniquely American problem of malpractice and our unique market place solution to medical coverage?

It would be convenient for me, as a UHC advocate, if there were some automatic consequence of implementing UHC that required high quality medicine, enormous decreases in medical errors and the virtual disappearance of the malpractice crisis. There is little direct and readily available evidence for this though. The studies which could provide this have not been done, nor proposed, as far as I know. Still there is an enormous body of indirect evidence that there is a connection between our malpractice crisis and our system of unbridled profiteering within health care coverage.

Complicating any clear analysis, some of the existing UHC systems in the world are sorely underfunded and thus cannot achieve the quality that professionals and patients demand. However, we spend approximately twice what any other nation does per capita (even though they have everyone fully insured). Additionally, our two-fold higher expenditure has not brought us even

on a par with most other nations with respect to quality of care.^{xxii,xxiii} Malpractice awards (and premiums) in Canada, for example, are a small fraction of what they are in the U.S. both due to lower awards and due to much reduced numbers of awards.^{xxiv} Furthermore, while the Canadians do have private insurers selling medical malpractice, this is done entirely through medical professional societies by which means physicians can still exercise some control and there is some degree of public accountability. The professional societies are motivated to regulate quality of care to a greater extent and to sanction or exclude physicians who are repeat offenders or have had too many significant complaints. Also in Canada there are no out of court settlements. There is no incentive to press a case forward that has small chance of success against a seriously defended physician. Do these differences though fully account for the gulf between us and our northern neighbor with respect to malpractice costs (and in fact with all other modern UHC systems)? How strong are the arguments and indirect evidence suggesting that lower malpractice costs are a consequence of a universal system of care?

The following three characteristics are present to a high degree in all current UHC systems. These characteristics each very clearly contribute to the sort of system in which medical errors would be decreased and/or malpractice suits would become much less frequent.

- 1) ***Absolute inclusion*** means a system in which everyone feels themselves and their family will always be included. A system of which the very design and existence is geared to the purpose of caring for everyone.
- 2) ***No conflicts of interest*** means a system where providers (physicians, nurses, PA's, therapists etc.) are never compromised by financial incentives to either overutilize or underutilize care.
- 3) ***Relationship building*** means a system where patients could choose their providers from the full list of practicing providers in their area and where they would not be coerced by plans and coverages to change physicians for the convenience of their insurer, or employer.

Absolute Inclusion

A UHC system with everyone enjoying the high quality care our nation can afford, would engender much greater trust. It has been shown that malpractice events are suffered by the uninsured with at least 30 - 35% greater frequency than suffered by the insured.^{xxv} Furthermore, disparity in access to care contributes to the lack of trust among ethnic minorities who are disproportionately uninsured. Ethnic minorities, along with those working at low pay and at multiple part-time jobs, are well aware of the risks they and their families are running for uncovered illness or injury. After all they talk with their neighbors, friends and family some of whom suffer with chronic or grave acute illness. Surely

awareness of the exclusionary nature of our system engenders distrust of a health care system which devalues their lives and those of their families.

Even working people who are relatively more privileged must be aware that there are others for whom there is no secure access to care. I know several physicians retired from long careers at major medical centers whose grown children are without health coverage and in some cases suffering with chronic illness. A recent report highlights that more than 30% of Americans under 65 were uninsured for some period during 2001 - 2002 and nearly two-thirds of these were uninsured for six months or more.^{xxvi} Not many of us could be far removed from everyone affected directly by our uninsurance crisis. Furthermore, the prevalence of underinsurance (lack of coverage for all one's medical needs) is estimated to affect directly again as many Americans as uninsurance.^{xxvii}

At some deep level even those of us who, for the time being, are covered for possible future health threats must be aware that this is currently a "privilege" not enjoyed by everyone. Therefore, it must be a risk, to some extent, for all working Americans. There are very few of us for whom it is unimaginable, that we should be out of work, disabled, or between jobs for some period in our life. Even aside from the "trust issue", it is important to remember that people struck with grave (expensive) illnesses need to seek large settlements not only to cover their immediate health care expenses, but also seek large awards that will put them out of risk later in the course of their disease. These motives would essentially be erased once every one is covered for their medical needs without need to legal recourse.

With respect to the concept of all working Americans being at risk it should be remembered that COBRA coverage between jobs is expensive, especially given limited income when unemployed^{xxviii} and few workers avail themselves of COBRA despite the obvious risk to their security^{xxix}. Furthermore, workers in small businesses (less than 20 workers) are not offered COBRA. If any of us should become chronically ill during even a brief period of uninsurance (or a member of our family be so unfortunate) then we could be looking at financial ruin and being denied access to high quality care. Thereafter we would be denied affordable coverage, given our pre-existing condition. All this pertains, irrespective of our preference not to think about distant threats while things are "going well" for us.

To the extent we realize that the system could have us suffering terribly and at the same moment faced with financial ruin for our family - we realize that the system is an adversarial one. We are not members of a caring society which values our lives. We are merely taken care of as long as fate smiles and it is convenient. This can't engender much trust in the health care system of which our direct providers are a part. It is difficult to imagine how this lack of trust can be overcome short of adopting a UHC system. ***This adversarial system which is ready to abandon us when we most need it, is a bitter pill to swallow, not***

the new system in which we know that we and our loved ones will always find quality care.

Drastically reducing conflicts of interest

Oversight and regulation of physician practice would likely increase substantially under a UHC system. This would likely occur to whatever extent the government becomes the main or sole source of funding for the health care of the nation. Just as savings would accrue from bulk negotiation of pharmaceuticals and recommendations about which pharmaceuticals are the most effective and appropriate for treating particular cases - so would we expect that there would be oversight of overutilization of referrals, tests and procedures - because this would be just another case of accountability expected from all government operations. This restraint on "overutilization" however would be viewed by patients much differently than the decisions of "managed care" bureaucrats, or HMO "medical directors", who are heavily influenced by the bottom line of their corporate employers to restrict care ("underutilize"). It would be foolish for any patient to trust a corporate administrator to consider their health needs ahead of the company's profitability, or ahead of that administrator's advancement and year-end bonuses. There is no similar distrust of public oversight in systems such as public education where government oversight is greater.

To the extent that provider (physicians, nurses etc.) reimbursement would be regulated by the state and standardized for the type of examination or procedure delivered, there would be far less opportunity for influencing the provider's medical decisions by anything other than the best course for the patient. To maintain a high quality UHC system, provider reimbursements would have to be based on fair negotiation and realistic assessment of time and effort going into patient care. This would be a far cry from current arbitrary reimbursements set by the health insurer's and medicare's current inadequate and irregular schedule of reimbursement. ***It is the current system of conflicting provider interests and the insurance industry's opposition to expensive care, even when needed, that is the bitter pill to swallow, not developing a new system built on public accountability.***

Relationship building

Patients are much less likely to sue practices where they have been treated for many years and where their case histories are well-known by the providers. Any businessperson would agree that they stand little chance of being sued by satisfied customers who they have been serving and calling by name for several years. This is no less true in medicine and may account for some of the variability in lawsuits within certain specialties, as certain specialists get little "face time" with the patients and their family.

UHC proposals usually include some provision for patient choice of provider.^{xxx} As most Americans have learned during the managed care era, it is no longer a simple undertaking to find a physician who is accepting new patients, in whom we have some initial confidence, who is on our insurer's approved list and who continues to be on such list over several years. Younger workers may not remember how it used to be, with a physician one knew and on whom one could rely throughout most of one's adult life. Besides the issue of building a relationship with one's health care provider, there is also an efficiency in having a physician follow complicated patients over an extended period, rather than a having a new primary care provider needing to study the case history anew every year. ***It is the current system in which we are prevented from selecting and retaining the providers we choose that is the bitter pill to swallow, not a new system in which our trust of providers will be well-warranted.***

Conclusion

Correcting the current patchwork health care system in such a way that our malpractice mess is corrected along with the scourge of uninsurance and underinsurance is not a "hard cure" after all. It is an easy pill for the patient to swallow, although we can expect that the insurance industry and their political allies will be anything but eager to embrace a rational and thorough cure. The difficulty of pushing the solutions past insurance industry lobbyists does not qualify as making this a difficult pill for the society at large, nor even for corporate America generally. Here, it has been argued that rethinking our health care system, providing universal coverage, making the system publicly accountable and erasing the injustice of health care for the priveleged only - all these would also set us up to resolve the malpractice insurance crisis. Malpractice and medical errors could be reasonably handled, as they are in other nations. Our crisis is so terrible only because we assume that first and foremost our system exists to protect those reaping tremendous profits and secondarily to provide care to some Americans, whenever this latter goal does not conflict with the former.

The author, Dennis Lazof, is executive Director of Project EINO based at www.EverybodyInNobodyOut.org which supports the 17 autonomous state grassroots organizations working to realize universal health care.

REFERENCES

ⁱ Carl Winter's "pike in Malpractice Premiums Hurting Access to Care" Reuters Health Information, Feb 3, 2003

-
- ii Karen Pallarito's " Spike in Malpractice Premiums Hurting Access to Care" Reuters Health Information, March 14, 2003
- iii Karen Pallarito's " Spike in Malpractice Premiums Hurting Access to Care" Reuters Health Information, March 14, 2003
- iv A physician in the author's own family has a specialty practice diagnosing and treating patients with lymphedema. There is no other physician in a several state with that expertise, yet they are without recourse in negotiating with the insurance carrier.
- v CBS "60 minutes" of March 9, 2003
- vi " Doctors Say Malpractice Fears Harm Patient Care and Drive up Costs", Reuters Health Information, May 16, 2002
- vii Julie Rovner's "Consumer Groups Say Public Misled About Malpractice Crisis" Reuters Health Information, Jan 14, 2003
- viii Comments by Jay Angoff, former MO insurance commissioner, in Julie Rovner's "Experts Disagree on Cause, Cures for Medical Malpractice Crisis, Reuters Health Information, Feb 26, 2003
- ix See Rutgers Law Review Vol 47
- x Modern Physician, August 6, 2003, article by Leigh Page based on a report from the Employment Policy Foundation of Washington, D.C.
- xi New England Journal of Medicine, Dec 12, 2002
- xii See Data from JAMA. 2003;290:1617-1623 and Medscape Interview with Susan Yox, RN, EdD Oct 2003 was available at <http://www.medscape.com/viewarticle/462039> Additional material on nursing workload at www.EverybodyInNobodyOut.org , click on FAQ and Providers of Health Care.
- xiii Kaiser Family Foundation, Dec 2000, " In Philadelphia, Malpractice Awards have Gone Haywire", Karl Stark
- xiv "Recruitment and Retention Strategies", Valda Upenieks, Nurs Econ 21(1):7-13, 2003
- xv Am J Nurs (1996) 76(11):25
- xvi Kaiser Family Foundation 2002 "Medical Errors: Practicing Physician and Public Views", available at www.kff.org
- xvii see "Malpractice Payouts Declined as Insurance Premiums Spiked" from Public Citizen at <http://www.citizen.org/pressroom/release.cfm?ID=1480>
- xviii New York Times Magazine, Sunday Mar 16, 2003, p. 11
- xix Julie Rovner's "Consumer Groups Say Public Misled About Malpractice Crisis" Reuters Health Information, Jan 14, 2003
- xx Ellen R. Shaffer. "Universal Coverage and Public Health: New State Studies," American Journal of Public Health. January 2003. Volume 93. No. 1. p109-111.
- xxi Multiple references at <http://www.pnhp.org/hcinfo/?go=bibliography>
- xxii Commonwealth Fund Quarterly, Spring 2002, 8:1, "Quality of Health Care in the United States"
- xxiii Health Affairs 21:3, "Inequities In Health Care: A Five-Country Survey"
- xxiv Conversation with and letter from office of James Clancy President of the NUPGE, the second largest Canadian public employee union, March 2003
- xxv Arch Int Med 2000; 1269 -
- xxvi <http://www.familiesusa.org/nearly.htm> Report based on US census data
- xxvii See Myth#2, Chapter 1 in "Health Care Meltdown", Bob LeBow, 2002, JRI Press
- xxviii Kaiser Family Foundation, "Cobra Coverage For Low-Income Unemployed Workers", October 2001
- xxix Commonwealth Fund Quarterly, Fall 2002, "Most Workers Could Not Afford COBRA If They Lost Their Job"
- xxx For example 14 of the 17 grassroots state UHC organizations explicitly mention this principle on their websites. See groups linked to map on homepage of www.EverybodyInNobodyOut.org