Annals of Health Law

Volume 13
Issue 2 *Summer 2004*

Article 18

2004

A Physician's Perspective on the Medical Malpractice Crisis

Amanda Craig
Loyola University Chicago, School of Law

A Physician's Perspective on the Medical Malpractice Crisis

*Introduction by Amanda Craig**

Dr. Joseph L. Murphy has practiced medicine in the Chicago area since he graduated from Loyola Stritch School of Medicine in 1965.[1] Upon completion of his residency and internship at St. Joseph Hospital, Dr. Murphy joined the staff in 1969.[2] Dr. Murphy is in private practice specializing in general internal medicine and geriatric medicine. He currently serves as President of the Medical Staff and Chair of the Medical Executive Committee at St. Joseph Hospital.[3]

Dr. Murphy is a Board Member, Fellow and Chair of the Membership Committee of the Institute of Medicine of Chicago, and a member of the House of Delegates for both the American Medical Association (AMA) and Illinois State Medical Society. He is also active in the Chicago Medical Society, American College of Physicians, American Geriatric Society, and the Joint Commission on Accreditation of Healthcare Organizations' Professional Technical Advisory Committee on Long Term Care.

During Dr. Murphy's thirty plus years in the medical profession, he has experienced the cyclical nature of healthcare and medical malpractice issues. This article will expand upon Dr. Murphy's speech at Loyola University Chicago School of Law's Annual Health Law and Policy Colloquium. Dr. Murphy provided a physician's perspective on the current medical malpractice crisis. He discussed rising malpractice premiums, decreased access to patient care, caps on non-economic awards, and proposed legislation to alleviate the crisis. This paper will first address physician concerns relative to the crisis, including rising malpractice insurance premiums, decreased access to patient care, and the negative effects of the litigation system on healthcare. The paper will then discuss the AMA's proposed solution to the current medical malpractice crisis.

---

* Student, Loyola University Chicago School of Law, class of 2005. Ms. Craig is a member of the *Annals of Health Law*.

1. Resurrection Health Care Website, *at* http://www.reshealth.org/findadoc/docprof.cfm?ID=1931.
2. *Id.*
3. *Id.*

I. PHYSICIAN CONCERNS

A. Rising Malpractice Insurance Premiums

As Dr. Murphy noted, the malpractice crisis is a concern to all physicians, even to those who do not have any lawsuits or claims against them, because of rising malpractice insurance premiums which increase the cost of practicing medicine. Although Dr. Murphy is among the group of physicians who have never had a claim filed against them, he still experienced a forty-one percent increase in his premiums over the past year.

While the forty-one percent premium increase Dr. Murphy faced is dramatic, other physicians have been faced with even greater increases. For example, specialists in Arkansas have seen premium increases of 112% in one year.[4] Another example includes an obstetrics and gynecology physician practicing in Las Vegas who was forced to move her practice to West Los Angeles, leaving behind thirty pregnant women, after her insurance rates rose sharply from $37,000 to $150,000 a year.[5] A physician in North Carolina saw his rates jump from $7500 to $37,000 a year, and therefore decided to take an early retirement.[6] A vascular surgeon in Las Vegas left his practice after he determined it would cost him $1.2 million over a three-year period for insurance.[7]

These examples provide only a snapshot of the medical liability insurance premium increases that physicians all over the country are experiencing. As a result of skyrocketing medical malpractice premiums, physicians are forced to make certain decisions about their futures which can impact the healthcare system at large.

B. Decreased Access to Care

Early retirement and relocation of their practices are two of the options physicians are resorting to because of increasing medical malpractice premiums. As noted by Dr. Murphy, these two options lead to decreased access to care for healthcare patients, which is another major concern of physicians. Blue Cross Blue Shield Association (BCBSA) conducted a survey that showed the effect of physicians moving or taking early

4. *See* U.S. DEP'T OF HEALTH & HUMAN SERVS. (HHS), ADDRESSING THE NEW HEALTH CARE CRISIS: REFORMING THE MEDICAL LITIGATION SYSTEM TO IMPROVE THE QUALITY OF HEALTH CARE 18 (Mar. 2003), *available at* http://www.aspe.hhs.gov/daltcp/reports/medliab.htm [hereinafter HHS, REFORMING THE MEDICAL LITIGATION SYSTEM].

5. *Id.* at 4.

6. *Id.*

7. *Id.*

retirement.[8] The Association surveyed forty-two health plans about the impact of rising medical malpractice premiums on their communities.[9] The survey reached Blue Cross Blue Shield (BCBS) plans covering eighty-four million people, nearly thirty percent of the U.S. population.[10] The survey found that nearly eighty-eight percent of BCBS plans believed that rising malpractice premiums were leading to decreased access to patient care.[11] A majority of the plans reported that physicians were cutting back certain aspects of patient care.[12] In crisis states, fifty-six percent of the plans reported that physicians are not only cutting back on patient care, but are also refusing to perform certain high-risk procedures.[13]

As Dr. Murphy highlighted in his speech, the BCBSA survey reported that fifty-six of the plans that provide insurance in crisis states believed that more physicians were leaving their practices or retiring.[14] Also, thirty-one percent of crisis-state plans found that physicians were moving their practices to another state.[15]

Providing real life incidents of the crisis, a recent *Time Magazine* article accounted startling examples of decreased access to patient care in all regions of the country as a result of high medical malpractice premiums.[16] Due to high malpractice rates in Arizona, six obstetricians in a 6000 square mile area have stopped delivering babies.[17] Officials in Jacksonville, Florida, have activated an emergency response system because nearly 100 physicians have stopped performing elective surgeries.[18] Senior citizens in parts of Pennsylvania have to travel an hour or two in order to visit a neurosurgeon.[19] In Joliet, Illinois, three neurosurgeons stopped performing brain surgery and, therefore, head-trauma patients have to be flown forty-five miles away in order to receive the critical care they need.[20] Three weeks before her due date, an expectant mother's obstetrician in Mississippi

8. *See* Blue Cross Blue Shield Ass'n, *The Malpractice Insurance Crisis: The Impact on Healthcare Cost and Access, at* http://vocuspr.vocus.com/VocusPR30/Temp/{2d6de5ed-f077-4436-9529-4153797e6b36}/Malpractice_Ins_Crisis0127.pdf.

9. *Id.* at 1.

10. *Id.*

11. *Id.* at 2.

12. *Id.*

13. *Id.*

14. Blue Cross Blue Shield Ass'n, *supra* note 8, at 3.

15. *Id.*

16. *See* Daniel Eisenberg & Maggie Sieger, *The Doctor Won't See You Now*, TIME, June 9, 2003, at 46.

17. *Id.*

18. *Id.*

19. *Id.*

20. *Id.*

stopped practicing, resulting in the mother having to drive over 100 miles to Tennessee in order to receive care.[21] The magnitude and number of physicians leaving their practices is troubling, and as Dr. Murphy noted, it is affecting access to healthcare.

The crisis is affecting not only private practitioners but also hospitals. Because of premium increases of over 250% in the last three years, sixty-five percent of hospitals in New Jersey reported that physicians are leaving.[22] After insurance premiums for some surgeons at the University of Nevada Medical Center increased from $40,000 to $200,000, the surgeons quit, causing closure of the trauma center for ten days.[23] The nearest level one trauma center is five hours away.[24]

As the above examples indicate, access to care is being hindered because of physicians leaving the practice altogether or restricting certain procedures. If this pattern continues in the future, patients may have difficulties locating the care they need within their own communities. America may be facing issues of not only trying to provide healthcare for those who are unable to afford the high prices, but also trying to provide healthcare for those who can afford it, but are unable to locate physicians because they have retired or moved out of their communities.

C. The Litigation System's Negative Effects on Quality of Care

The U.S. Department of Health and Human Services (HHS) stated in a recent report that the litigation system is responsible for the crisis and furthermore the system is affecting quality of care.[25] In that report, HHS outlined several factors that are contributing to quality impairment.[26] First, physicians are practicing "defensive medicine" by ordering excessive procedures for fear of liability.[27] Defensive medicine occurs when physicians order tests or procedures not based on their clinical judgment, but rather to "protect or cover" themselves from potential litigation. In a recent study, seventy-nine percent of physicians stated that they ordered

21. HHS, CONFRONTING THE NEW HEALTH CARE CRISIS: IMPROVING HEALTH CARE QUALITY AND LOWERING COSTS BY FIXING OUR MEDICAL LIABILITY SYSTEM 3 (July 2002), *available at* http://www.aspe.hhs.gov/daltcp/reports/litrefm.htm [hereinafter HHS, IMPROVING HEALTH CARE QUALITY].

22. *Id.* at 4.

23. *Id.* at 2.

24. *Id.*

25. *See generally* HHS, REFORMING THE MEDICAL LITIGATION SYSTEM, *supra* note 4, at 1-2.

26. *Id.*

27. *Id.* at 7.

more tests than usual due to fear of litigation.[28] Increasing the number of tests and procedures on a patient for fear of litigation is expensive, exposes the patient to additional risks, and impairs the quality of care.

Furthermore, the HHS report noted that the litigation system does not lead to improved quality of care.[29] The report stated that "because its results are largely random and unpredictable, the litigation system often does not accurately identify negligence, deter bad conduct, or provide justice."[30] The report further noted that the evidence showed that injuries from negligent medical treatment did not correspond with malpractice claims.[31] This results in physicians losing faith in the purpose of the system and lacking trust in the system. Additionally, with unpredictable outcomes, physicians are unsure of how the results of verdicts should impact their clinical practice.

Finally, the report found that the litigation system discourages open communication among physicians concerning quality improvement efforts.[32] Due to fear of litigation, physicians are reluctant to discuss quality improvement openly and participate in voluntary reporting systems.[33] The report noted that only five percent of physicians, nurses, and hospital administrators feel comfortable discussing medical errors with their colleagues.[34] However, collaboration dealing with medical errors is just as important as sharing medical triumphs and is crucial to learning from past experiences. Patients are the ones ultimately injured by stifled conversations amongst physicians concerning medical errors.

The litigation system is not entirely effective in achieving the goal of increased quality of care. Physicians need to be able to rely on the results of medical malpractice cases in order to improve their clinical practices. Furthermore, physicians and the community need to trust that the litigation system is going to enhance quality of patient care.

D. Culture of Fear

Dr. Murphy also touched on the culture of fear that is currently present in today's medical community. A Harvard Study found that the physicians' perceived risk of being sued was three times greater than the actual risk.[35]

---

28. *Id.*
29. *Id.* at 8.
30. *Id.*
31. HHS, REFORMING THE MEDICAL LITIGATION SYSTEM, *supra* note 4, at 8.
32. HHS, IMPROVING HEALTH CARE QUALITY, *supra* note 21, at 9.
33. *Id.*
34. *Id.*
35. PATIENTS, DOCTORS, AND LAWYERS: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION IN NEW YORK: THE REPORT OF THE HARVARD MEDICAL

Physicians perceive themselves to be a target and some even view every patient interaction as a potential liability threat.[36] Furthermore, as mentioned above, the fear of litigation impedes the improvement of quality of care.[37]

An open and collaborative environment among physicians is crucial in order to identify areas of improvement and to make steps towards improvement. The Institute of Medicine's report on medical errors noted that voluntary reporting systems are crucial to quality improvement.[38] However, as mentioned earlier, physicians are reluctant to utilize reporting systems for fear that they will become tools used against them in a lawsuit.[39] Experts believe that the number one barrier to effective patient care improvement methods is fear of medical malpractice liability.[40]

A culture of fear is debilitating not only to the physicians, but also to patient care. The litigation system should enhance patient care and lead to improved quality of care. However, fear within the medical community is a negative aspect of the malpractice litigation system, which is a concern for many physicians and subsequently all healthcare patients.

II. WHAT IS THE ROOT OF THE CURRENT CRISIS?

Although Dr. Murphy cited several factors that have contributed to the medical malpractice crisis, such as increased medical malpractice insurance rates, increased jury awards, and uncapped damages, the AMA views the "primary" cause of the crisis to be "the unrestrained escalation in jury awards."[41] According to a Tillinghast-Towers Perrin report, medical malpractice tort costs have risen at an annual rate of 11.9%, versus a rate of 9.5% for all other U.S. tort costs.[42] The disparity in increasing tort costs has widened significantly in the last few years.[43] An HHS report also cited rising jury awards for non-economic damages in states without caps as the

---

PRACTICE STUDY TO THE STATE OF NEW YORK 9 (1990).

36. *See* Alan Feigenbaum, *Special Juries: Deterring Spurious Medical Malpractice Litigation in State Courts*, 24 CARDOZO L. REV. 1361, 1372 (2003).

37. *See* HHS, IMPROVING HEALTH CARE QUALITY, *supra* note 21, at 5-6.

38. INST. OF MED., TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 87 (Nov. 1999).

39. HHS, IMPROVING HEALTH CARE QUALITY, *supra* note 21, at 6.

40. *Id.*

41. Am. Med. Ass'n (AMA), *The Medical Liability Crisis: AMA Talking Points*, at http://www.ama-assn.org/ama/pub/article/print/6282-7225.html (last updated Mar. 28, 2003) [hereinafter *AMA Talking Points*].

42. TILLINGHAST-TOWERS PERRIN, U.S. TORT COSTS: 2003 UPDATE—TRENDS AND FINDINGS ON THE COSTS OF THE U.S. TORT SYSTEM 2 (2003).

43. *Id.* at 16.

"major contributing factor" to the rise of liability insurance premiums.[44] Additionally, the U.S. General Accounting Office (GAO) also found that in the long run, the main cause of rising premiums is losses on malpractice claims.[45]

As Dr. Murphy noted in his speech, the median award in a medical malpractice case in 2001 was one million dollars.[46] This represents a dramatic increase from the median jury award in 1996, which was only $457,500.[47] Not only has the median jury award increased, but jury awards over one million dollars have also significantly increased in frequency in recent years. For example, between 1994 and 1996, 34% of jury awards were one million dollars or more.[48] Further, in 1999-2000, 52% of all awards were over one million dollars.[49] The number of verdicts greater than one million dollars reported to the National Practitioner Data Bank between 1991 and 2002 increased from 298 to 806.[50] Furthermore, mega-awards have also increased in recent years. As a state-specific example, Mississippi has handed down twenty-one verdicts of nine million dollars or more since 1995.[51]

Although some may disagree with the AMA's view that increased jury verdicts are the number one cause of the current malpractice crisis, no one would argue that the staggering dollar amounts and dramatic increases in mega awards in recent years has had a significant impact on the crisis. How much longer can the system handle these escalating jury awards?

III. A SOLUTION?

The AMA made liability reform its top legislative priority in 2003 and 2004.[52] As Dr. Murphy mentioned in his speech, legislation dealing with medical liability reform has been proposed as a solution to control rising

44. HHS, IMPROVING HEALTH CARE QUALITY, *supra* note 21, at 12. *See also* HHS, REFORMING THE MEDICAL LITIGATION SYSTEM, *supra* note 4, at 1.

45. *See* U.S. GEN. ACCOUNTING OFFICE, PUB. NO. GAO-04-128T, MEDICAL MALPRACTICE INSURANCE: MULTIPLE FACTORS HAVE CONTRIBUTED TO INCREASED PREMIUM RATES 4 (Oct. 2003), *available at* http://www.gao.gov.

46. *See* Press Release, Jury Verdict Research, Verdict and Settlement Study Released: No Change in Median Medical Malpractice Jury Award, Plaintiff Recovery Rate Up a Fraction (Mar. 20, 2003), *at* http://www.juryverdictresearch.com/Press_Room/Press_releases/Verdict_study/verdict_study2.html.

47. *Id.*

48. HHS, IMPROVING HEALTH CARE QUALITY, *supra* note 21, at 9.

49. *Id.*

50. HHS, REFORMING THE MEDICAL LITIGATION SYSTEM, *supra* note 4, at 12.

51. HHS, IMPROVING HEALTH CARE QUALITY, *supra* note 21, at 9.

52. AMA, *The Medical Liability Crisis: Talking Points*, *at* http://www.ama-assn.org/ama/pub/article/print/9225-7188.html (last updated Mar. 28, 2003).

medical malpractice insurance premium rates. The AMA views this legislation, the Help Efficient, Accessible, Low-Cost, Timely Health Care (HEALTH) Act of 2003, as a solution to the problem.[53] The Physician Insurers Association of America (PIAA), a trade association of more than fifty medical malpractice insurance companies owned and operated by physicians, also supports tort reform and believes that California's Medical Injury Compensation Act (MICRA) reform is effective.[54]

The HEALTH Act[55] is modeled after California's MICRA.[56] The main components of the HEALTH Act include: (1) a three year limit on the statute of limitations; (2) unlimited economic damages; (3) a $250,000 cap on non-economic damages; (4) elimination of joint and several liability; (5) allowance for the defendant to present evidence of the plaintiff's receipt of any collateral source benefits; (6) court supervision of arrangements for payment; and (7) guidelines and limitations on the amount of punitive damages.[57] Each of these components will be explained in detail.

One component of the HEALTH Act sets the statute of limitations for claims either at three years from the date of the injury or one year from discovery of the injury.[58] Allowing claims to be brought only three years after the injury occurred allows for increased access to documents needed to defend a claim.[59]

Another section of the Act provides for unlimited amounts of damages for economic losses.[60] Regardless of the number of parties, non-economic damages such as pain and suffering are limited to $250,000.[61] Also, under this section, the "fair share rule" eliminates joint and several liability.[62] Therefore, physicians will only be held responsible for their proportion of fault. The intent of this provision is to decrease the incidence of cases

53. *See* AMA, *Safeguarding Patients' Access to Care*, *at* http://www.ama-assn.org/ama/pub/article/print/6282-7382.html (last updated Mar. 12, 2003) [hereinafter *Access to Care*].

54. *See* Physician Insurers Ass'n of Am., *Statement by the Physician Insurers Association of America* (Jan. 29, 2003), *at* http://www.thepiaa.org.

55. Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2003, H.R. 5, 108th Cong. (2003), *available at* http://thomas.loc.gov. The legislation was placed on the Senate Legislative Calendar on Mar. 21, 2003.

56. In 1975, California enacted MICRA in response to a medical malpractice insurance crisis. MICRA contains five statutes: CAL. BUS. & PROF. CODE § 6146 (West 2003); CAL. CIV. CODE §§ 667.7, 3333.1(a), 3333.1(b), 3333.2 (West 2003). *See* Jonathan L. Lewis, *Recent Developments: Putting MICRA Under the Microscope: The Case for Repealing California Civil Code Section 3333.1(a)*, 29 W. ST. U. L. Rev. 173, 177 (2001).

57. *See* HEALTH Act, *supra* note 55.

58. *Id.* at § 3.

59. *Access to Care*, *supra* note 53.

60. HEALTH Act, *supra* note 55,at § 4.

61. *Id.*

62. *Id.*

where parties are looking for "deep pockets." Furthermore, with a fair allocation of responsibility, medical malpractice rates may also be reduced.

Punitive damages, special and highly exceptional damages, are limited to the greater of $250,000 or twice the amount of economic damages awarded.[63] Also, the Act prohibits punitive damages for products that are approved, cleared, licensed, or comply with Food and Drug Administration regulations.[64] Furthermore, the Act allows courts to order future payments of awards of $50,000 or more to be made in periodic installments.[65] Allowing defendants to make payments over time decreases the risk of the defendant going bankrupt and therefore increases the likelihood of payment in full to the injured plaintiff.[66]

Limitation of attorney fees, particularly contingent fees, is also outlined in the HEALTH Act.[67] In healthcare lawsuits the total of all contingent fees shall not exceed: (1) 40% of the first $50,000; (2) 33 1/3% percent of the next $50,000 recovered; (3) 25% percent of the next $500,000; and (4) 15% percent of any amount over $600,000 recovered by the claimant.[68] A limitation on the amount attorneys receive under a contingent fee system ensures that injured patients are properly compensated for their injuries, which is a goal of the medical malpractice litigation system.

The collateral source rule in medical malpractice cases, which excludes from evidence compensation the plaintiff received from another source,[69] is eliminated in the HEALTH Act.[70] The Act allows the introduction of evidence of any benefits that a plaintiff may have received from another source.[71] However, any provider of collateral source benefits may not recover any amount from the claimant.[72]

In its Cost Estimate of the HEALTH Act, the Congressional Budget Office (CBO) predicts that, if the bill is enacted, premiums for medical malpractice insurance would be an average of twenty-five to thirty percent lower.[73] The CBO also estimates that enactment of the Act would reduce federal spending by more than $14.9 billion over the 2004 through 2013

63. *Id.* at § 7.
64. *Id.*
65. *Id.* at § 8.
66. *AMA Talking Points*, *supra* note 41.
67. HEALTH Act, *supra* note 55, at § 5.
68. *Id.*
69. Lewis, *supra* note 56, at 182.
70. HEALTH Act, *supra* note 55, at § 6.
71. *Id.*
72. *Id.*
73. CONG. BUDGET OFFICE, COST ESTIMATE: H.R. 5, HELP EFFICIENT, ACCESSIBLE, LOW-COST, TIMELY HEALTHCARE (HEALTH) ACT OF 2003, at 4 (Mar. 2003), *available at* http://www.cbo.gov.

period.[74]

Although the AMA views the HEALTH Act as the solution to the medical malpractice crisis because it is based on California's MICRA reform, many opponents of MICRA believe that it has not been the answer to the medical malpractice crisis and has in fact prevented patients from achieving justice.[75] The HEALTH Act was passed by the House of Representatives on March 13, 2003, and is currently stalled in the Senate.[76] The AMA, with the support of President Bush, is working to pass the HEALTH Act in 2004.[77]

IV. CONCLUSION

Although agreement as to the proper solution has yet to be achieved, few would disagree that another medical malpractice crisis has arrived. As Dr. Murphy noted, physicians have experienced a flurry of emotions including fear, depression, and helplessness because of the medical malpractice crisis and the effect it has had on their practice and their ability to provide quality patient care. Despite these negative emotions, physicians such as Dr. Murphy are dedicated to improving the system. Although the end to this current crisis may not be in sight, hopefully with the dedication of the medical community in collaboration with committed government officials and members of the legal community, a solution can be reached before too many physicians are forced to retire early or leave the state they currently practice in.

74. *Id.* at 1.

75. *See generally* David A. Bernstein, Note & Comment, *The Medical Injury Compensation Reform Act (MICRA), Pharmaceutical Malpractice, and Their Detrimental Effects on a Little Girl*, 21 WHITTIER L. REV. 259, 283 (1999). *See also*, Mark A. Finkelstein, Note, *California Civil Section 3333.2 Revisited: Has It Done Its Job?*, 67 S. CAL. L. REV. 1609 (1994).

76. AMA, *Medical Liability Reform*, at http://www.ama-assn.org/ ama/pub/category/ 6087.html (last updated Feb. 3, 2004).

77. *Id.*