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Report to Congressional Requesters

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MEDICAL MALPRACTICE

No Agreement on the Problems or Solutions

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Human Resources Division

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The Honorable John Heinz
Chairman, Special Committee
on Aging
United States Senate

The Honorable John Edward Porter
House of Representatives

In response to your requests and later discussions with your offices, we have undertaken a major effort to review the medical malpractice situation in the United States. In this report we have developed information on the views of major interest groups on the existence of medical malpractice problems, the need for federal involvement, and alternative approaches for resolving claims. Subsequent reports will deal with the economic costs attributable to malpractice, primarily for physician and hospital malpractice insurance; the malpractice situation in selected states, and how these states have attempted to deal with it; and the characteristics of a sample of malpractice claims closed during 1984.

As arranged with your offices, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days from its issue date. At that time, we will send copies to interested parties and make copies available to others upon request.

Sincerely yours,

Richard L. Fogel

Richard L. Fogel
Director

Executive Summary

Media reports over the last year have indicated that medical malpractice is having a significant impact on the cost and practice of medicine. The interest groups having a stake in this issue have differing views about (1) the specific nature of any problems, (2) the appropriate solutions, and (3) whether the solutions require federal involvement.

This review was undertaken at the request of Representative John Edward Porter and Senator John Heinz, Chairman, Senate Special Committee on Aging, to develop current information on

- the existence of medical malpractice problems and the need for federal involvement and
- alternatives for resolving malpractice claims.

This report, the first of a series GAO plans to issue on this subject, presents the perceptions of 37 nationally based organizations representing medical, legal, insurance, and consumer interests on the medical malpractice issue and what to do about it. The report also discusses the advantages and tradeoffs of a number of alternatives to the current system for resolving claims.

Background

During the mid-1970's, virtually every state made changes to its systems for resolving medical malpractice claims. Generally the changes were designed to reduce the number of claims filed and the size of awards and settlements, which together had increased the cost and decreased the availability of malpractice insurance.

The present system for resolving medical malpractice claims operates primarily through the state court systems and requires a claimant to establish that the injury was due to the health care provider's fault, usually negligence. As it relates to medical malpractice cases, the present fault-based system provides a framework for compensating individuals injured and discouraging substandard medical care. Critics of the fault-based system have charged that (1) considerable time and effort are required to establish provider fault, (2) legal fees consume too high a percentage of awards and settlements, (3) the outcome of claims and the size of awards are unpredictable, and (4) awards and settlements are frequently excessive, particularly for noneconomic losses such as pain and suffering.

Results in Brief

Medical malpractice is a complicated problem with no easy answer. GAO found no agreement among the major interest groups surveyed regarding the problems, their severity, their solutions, or the proper role of states or the federal government.

There was also no consensus among the interest groups that any of the reforms implemented in response to the situation experienced in the mid-1970's has had a major effect. Some of the reforms have been declared unconstitutional by state courts, while others have been repealed or allowed to expire. The few empirical studies that have evaluated the impact of these state reforms found that only a few reforms have had a major impact.

Principal Findings

Concerns about various aspects of the present system for resolving medical malpractice claims have generated various alternative proposals for changing the system. These proposals involve both fault-based and no-fault-based approaches. Some are only conceptual; others have been used for years. GAO found no widespread support among the interest groups surveyed for any one approach.

Three of the interest groups surveyed agreed, however, that the threat of malpractice suits has had both positive and negative effects. For example, these groups believed that while the threat of suits has increased the cost of health care, decreased patients' access to care, and changed the way physicians practice medicine, it has also improved the quality of medical care and led to more hospital and physician risk management programs to reduce the incidence of malpractice. However, the groups surveyed had distinctly different opinions on the nature and severity of the problem and what, if anything, should be done about it.

Table 1 shows the extent of agreement, and the lack thereof, among the interest groups on 10 problem areas.

Table 1:Majority Views of Interest Groups

	Interest groups							
	Professional provider		Hospital affiliated		Legal		Consumer	
Problem areas	C	F	C	F	C	F	C	F
Availability of medical malpractice insurance		X	X	X				
Cost of medical malpractice insurance	X	X	X	X				
Number of claims filed	X	X			X			
Size of awards and settlements	X	X	X	X				
Length of time to resolve claims	X	X	X	X			X	X
Equity of awards and settlements	X	X	X	X				
Legal expenses and attorney fees	X	X	X	X				
Responses by physician groups and hospitals to reduce or prevent malpractice events							X	
Individual physician actions to reduce or prevent claims	X						X	X
Individual hospital actions to reduce or prevent claims							X	X

Legend
C=Major problem in the current year (1985).
F=Major problem expected to continue or develop in the future (1986-90).
X=Majority of organizations completing questionnaire in this group had major problems with some aspect of area.

Health Care Provider Concerns

Health care providers believed the cost of malpractice insurance is too high, awards are excessive, the time required to settle claims is too long, and the legal costs to defend against claims are excessive. In addition, hospital-affiliated organizations, such as the American Hospital Association and the National Council of Community Hospitals, were concerned about the continued availability of malpractice insurance.

One provider organization commented that increasing premiums in certain specialties were causing physicians to retire, change to another type of practice, or refuse to perform certain procedures. Another organization stated that some patients were delaying their recovery, at the encouragement of their attorneys, to maximize damages. Still another provider organization said that a major problem was the "outrageous" awards being made for noneconomic damages, such as pain and suffering, which is a nebulous and nonquantifiable loss.

Consumer Views

The consumer group agreed that the long time required to settle claims is a major problem. Consumers also expressed major concern with the lack of adequate action on the part of physicians and hospitals to reduce or prevent malpractice incidents. Consumers believed that physicians

and hospitals have not done an adequate job of ensuring that all practicing providers are competent to provide high-quality medical care. One consumer organization expressed concern with physicians who are barred from practicing in one location but move to another jurisdiction to practice.

Attorney Concerns

The legal group was concerned about the large number of medical injuries and meritorious claims being filed. One legal organization believed this was largely the result of medical negligence. This organization also commented that when viewed in terms of percentage of physician gross income, the cost of malpractice insurance was not a major problem.

Recommendations

GAO is making no recommendations.

Contents

Tables

Introduction

Medical malpractice was in the news frequently during most of 1985 for various reasons. The media have reported that:

- Physician and hospital insurance premiums have risen significantly.
- Physicians are refusing to take certain high-risk patients or to practice in certain specialty areas (such as obstetrics) because of the threat of being sued.
- Some physicians are retiring early or changing specialties.
- Some physicians are running checks on prospective patients to assess their likelihood of filing a lawsuit.
- Some physicians are practicing defensive medicine (estimated by the American Medical Association to cost $15 billion annually) and ordering more tests than would ordinarily be considered necessary to defend themselves in case of a lawsuit.
- The number of claims filed has risen steadily (American Medical Association data show an average of 8.6 claims for every 100 physicians per year during the period 1980-84).
- Jury awards have risen dramatically (more awards in excess of $1 million).

What is happening has been labeled by many experts as a crisis.

At the request of Representative John Edward Porter and Senator John Heinz, Chairman of the Senate Special Committee on Aging, we undertook a review of medical malpractice issues. The objectives of our review were to develop information for the Congress on:

- The views of major medical, legal, insurance, and consumer interest groups concerning the existence and nature of any current or impending malpractice problem and proposed solutions, if applicable, and the need for federal involvement.
- Alternative approaches to resolving medical malpractice claims.
- The economic costs attributable to medical malpractice, primarily the direct costs of malpractice insurance for physicians and hospitals.
- The medical malpractice situation in selected states.
- The characteristics of a national sample of malpractice claims closed during 1984, including the allegations of negligence leading to claims, severity of injuries, economic losses of injured patients, compensation paid, and time required to close the cases.

This is the first of five reports we expect to issue on this subject. This report presents the opinions and perceptions of nationally based organizations representing medical, legal, insurance, and consumer interests

concerning (1) the medical malpractice situation, (2) the effectiveness of various mid-1970's state tort reforms, (3) the impact of the threat of malpractice suits on several aspects of the health care system, (4) alternatives for resolving malpractice claims, and (5) an appropriate federal role, if any, in the malpractice area. In addition, this report outlines our review of studies assessing the impact of tort reforms, as well as literature describing alternative approaches for resolving malpractice claims, supplemented by discussion of these approaches with knowledgeable individuals. Later reports will provide information on the costs of medical malpractice insurance for physicians and hospitals, the current malpractice situation in selected states, and the characteristics of malpractice claims closed in 1984.

Background

What Is Medical Malpractice?

Medical malpractice involves

"bad, wrong, or injudicious treatment of a patient, professionally and in respect to the particular disease or injury, resulting in injury, unnecessary suffering, or death to the patient, and proceeding from ignorance, carelessness, want of proper professional skill, disregard of established rules or principles, neglect, or a malicious or criminal intent."[1]

Incidence of Malpractice

The incidence of medical malpractice in the nation is unknown. Few studies on the incidence of medically caused injuries are available, and they are based on data that are over 10 years old. However, the studies suggest that the number of medically caused injuries is much greater than the number of claims filed or the number of injuries caused by provider negligence. One study of records at two hospitals selected to be reasonably representative of American hospitals in 1972 estimated that 7.5 percent of the patients discharged from the hospitals were injured from their medical treatment. Of these medically caused injuries, the study estimated that 29 percent were due to the provider's negligence but that only about 6 percent of the injuries involving negligence would

[1]Henry Campbell Black, Black's Law Dictionary, Revised Fourth Edition, West Publishing Co., St. Paul, MN, 1968, p. 1111.

result in a medical malpractice claim.[2] Another study of over 20,000 records from 23 hospitals in California for patients hospitalized in 1974 found that 4.65 percent of the hospitalized patients incurred medically caused injuries. The study found evidence of provider liability in 17 percent of the medically caused injuries.[3]

Mid-1970's Crisis

During the period 1974-76, malpractice claims were driving up the cost of malpractice insurance so quickly that premiums in some specialties rose several hundred percent in a single year. Notwithstanding the increases in premiums, many insurers pulled out of the market entirely. These circumstances combined to create a situation—labeled by the medical profession as a "medical malpractice crisis"—in which both the affordability and availability of malpractice insurance were problems for health care providers.

Two factors were primarily responsible for the increased underwriting risk that contributed to the problems regarding the availability and cost of malpractice insurance: (1) an unexpected increase in the number of claims filed and (2) an unexpected increase in the size of malpractice awards and settlements.

Sustained profitability for companies writing malpractice insurance depends on their ability to estimate potential claim losses. Because a long time may elapse after an injury occurs before a claim is filed and settled, it is difficult for insurers to estimate potential losses and set accurate premium prices. Many insurers found, somewhat abruptly, in the mid-1970's that they had underestimated their potential claim losses and that, as a result, the premiums charged in prior years were inadequate to pay the losses resulting from malpractice incidents occurring in those years.

In addition to the underwriting losses resulting from increases in the number of claims filed and size of awards and settlements, insurance companies reportedly experienced losses in their investment portfolios. The volatility of malpractice losses and the unpredictability of profits from continuing to write medical malpractice insurance prompted some

[2]Leon S. Pocincki, Stuart J. Dogger, and Barbara P. Schwartz, "The Incidence of Iatrogenic Injuries," Appendix: Report of the Secretary's Commission on Medical Malpractice, Department of Health, Education, and Welfare, DHEW Publication No. (OS) 73-89, January 16, 1973, pp. 55, 62, 63.

[3]Don Harper Mills, Summary Highlights of the Medical Insurance Feasibility Study, California Medical Association, 1977; Don Harper Mills, Report on the Medical Insurance Feasibility Study, California Medical Association, 1977.

major commercial insurers to discontinue writing this line of insurance. The withdrawal, or threatened withdrawal, of insurance companies from the medical malpractice insurance market decreased the availability of insurance in a number of states, including Florida, New York, California, Hawaii, Massachusetts, Nevada, Maryland, Idaho, and Pennsylvania.

Even where insurance was available, health care providers faced concerns about its affordability as insurance companies dramatically increased the medical malpractice insurance premiums. For example, between 1974 and 1975, rates increased 145 percent in California, 193 percent in Tennessee, 191 percent in Wyoming, and 286 percent in Florida.[4] In New York, the average annual malpractice insurance cost per hospital bed increased 316 percent in 1 year (1974/75 to 1975/76).[5]

Responses to the Crisis

As the medical malpractice crisis peaked in 1975, health care providers in several states pursued state legislative changes to deal with the crisis. Most of the responses dealt with changes in the insurance industry to increase the availability of insurance and in legal procedures to reduce the cost of insurance.

Two major changes occurred in the mid-1970's to increase the availability of medical malpractice insurance. One involved creating new sources of insurance; the other involved changing the type of insurance policy form being offered.

Except for West Virginia, every state enacted some form of change in its statutes to respond to the medical malpractice crisis.[6] The number of changes enacted varied considerably from state to state. The statutory changes concerning legal rules can generally be grouped into those that affect (1) filing claims, (2) determining amounts recoverable, (3) defining standards of medical care or burden of proof, and (4) using courts in resolving malpractice claims. Most were intended to have some impact on the tort system and were generally designed to indirectly reduce the cost of malpractice insurance by directly reducing the

[4]Nancy T. Greenspan, "A Descriptive Analysis of Medical Malpractice Insurance Premiums, 1974-1977," Health Care Financing Review (Fall 1979), pp. 65-71.

[5]Report of the Special Advisory Panel on Medical Malpractice State of New York, January 1976, p. 103.

[6]American Medical Association Special Task Force on Professional Liability and Insurance, Professional Liability in the 80's, Report 2, American Medical Association, November 1984, p. 13.

number of claims filed, the size of awards and settlements, and the time and costs associated with resolving claims. Since the statutory changes were enacted, some have been tested and upheld as constitutional, while others have been declared unconstitutional, repealed, or allowed to expire.

Appendix I describes the malpractice insurance system, the malpractice legal system for resolving claims, and responses to the mid-1970's crisis. Appendix II gives the status of state reforms as of July 1985.

Objectives, Scope, and Methodology

Our objectives were to develop information on

- the existence of medical malpractice problems and the need for federal involvement and
- alternative approaches to resolving claims.

To accomplish these objectives we obtained and compared the viewpoints of national organizations representing various interests or perspectives regarding

- the existence and severity of a broad range of possible medical malpractice problems in the current year, and anticipated in the next 5 years;
- the impact of various tort reforms enacted by states to address malpractice problems,
- the impact of medical malpractice suits or the threat of such suits, and
- alternative approaches to resolving malpractice claims, and various actions to reduce the incidence of medical malpractice including the role, if any, the federal government should assume in addressing medical malpractice problems.

To obtain their viewpoints, we sent a questionnaire to 54 organizations asking for their perceptions on the existence and severity of a number of possible problems relating to the

- availability of medical malpractice insurance,
- cost of medical malpractice insurance,
- number of medical malpractice claims filed and injuries for which claims were not filed,
- size of awards/settlements for medical malpractice claims,
- length of time to resolve medical malpractice claims,
- equity of awards/settlements for medical malpractice claims,
- legal expenses/attorney fees for medical malpractice claims,

- responses by physician groups and hospitals to reduce or prevent medical malpractice events,
- individual physician actions to reduce or prevent medical malpractice claims, and
- individual hospital actions to reduce or prevent medical malpractice claims.

Since the questionnaire was intended to obtain the perceptions of the organizations, we did not attempt to validate the existence of the problems they cited.

We also asked the organizations to give us their perceptions on the impact of a number of tort reforms enacted by states to address medical malpractice problems. We included selected tort reforms cited in the American Medical Association's State Health Legislation Reports. For each reform or action, we listed a number of possible effects and asked respondents to indicate (1) whether their organizations had knowledge of the reform or action being taken by some states and (2) the type and extent of impact of the reform or action.

In addition, we asked the respondents for their opinions on the impact of medical malpractice suits, or the threat of suits, on several aspects of health care.

We also asked respondents to identify the extent to which they supported either federal or state actions to implement approaches for resolving malpractice claims and to address other malpractice problems.

The questionnaire was initially mailed on May 17, 1985. We selected the 54 organizations receiving the questionnaire from various sources, including the Encyclopedia of Associations, 1985, 19th Edition; suggestions from various individuals; and organizations requesting to participate. We selected only organizations that have a national membership or perspective and that would appear to have a knowledge of and a stake in the medical malpractice issue. Of the 54 organizations that received the questionnaire, 37 completed all or a major portion of it from a national perspective. (See app. III for a list of organizations surveyed.)

The questionnaire used a five-level severity scale. For analysis purposes, we considered "very great" or "substantial" responses as major, "some" or "little or no" as minor, and "do not know" or "N/A" as don't know for sections of the questionnaire concerning the malpractice problems and the impact of tort reforms. Regarding the degree of support for

alternative approaches and the role of the federal government in addressing malpractice problems, we considered "very great" or "substantial" as strong support.

In analyzing the responses, we categorized the 37 organizations completing the questionnaire into six interest groups. We required a majority of the organizations responding within each group to have the same response before we considered it the predominate view of the group. Because there were only three organizations in the medical malpractice insurer group and two in the health care insurer group, we required a unanimous response among the organizations in each of those groups before we considered it the group's predominate view. The six interest groups, the number of organizations completing the questionnaire in each group, and the number of organizations needed for a majority view are shown in table 1.1.

Table 1.1:Organizations Responding in Each Interest Group

Group	Number of organizations responding	Number needed for a majority
Professional provider	14	8
Hospital affiliated	5	3
Legal	6	4
Consumer	7	4
Medical malpractice insurer	3	3[a]
Health care insurer	2	2

[a]One organization in this group did not answer certain questions, which precluded a unanimous opinion for these questions.

Our second objective was to identify possible alternative approaches for resolving malpractice claims and to describe and compare the key features of each. To accomplish this objective we obtained descriptive information about the various approaches from studies and reports identified from a literature review and from discussions with knowledgeable persons. We did not independently evaluate the feasibility of proposed approaches or assess the effectiveness of approaches being used. We searched the literature using the DIALOG and SCORPIO automated information systems for studies, articles, and reports published primarily between January 1975 and February 1985. We discussed the characteristics and operation of specific alternative approaches with the individuals noted in the following items whom we identified as having extensive knowledge of the approach.

- For arbitration, Dr. Irving Ladimer, Director of Research, Medical Quadrangle, Inc., and Dr. Richard Lerner, Associate General Counsel, American Arbitration Association.
- For medical adversity insurance, Mr. Clark Havighurst, Professor of Law, Duke University.
- For the proposed Medical Offer and Recovery Act and elective no-fault insurance, Mr. Jeffrey O'Connell, John Allan Love Professor of Law, University of Virginia Law School.
- For the workers' compensation-type approach, Mr. Eric Oxfeld, Manager, Health Care & Employee Benefits, Chamber of Commerce of the United States.

From our discussions with these individuals, we identified additional studies related to alternative approaches. In examining the alternatives, we used an approach similar to the one used by the Institute of Medicine in its March 1978 report Beyond Malpractice: Compensation for Medical Injuries, in which the alternative approaches were compared by common system elements. Our examination of the approaches included a comparison of system elements, such as those related to the objective, the claims resolution process, types of losses compensated, estimated costs, method of financing, system incentives to reduce medical injuries, extent to which the approach has been used, and perceived advantages and tradeoffs.

Although not all data referred to in this report appear to be current, they are the most recent available.

Few State Tort Reforms Perceived As Having a Major Effect on Claims or Awards

In response to the mid-1970's crisis, virtually every state enacted legislation modifying one or more aspects of its tort laws governing medical malpractice claims. These reforms were generally designed to counteract the perceived causes of the crisis—the increased number of claims filed and the increased size of awards and settlements, which together resulted in an increased cost and a decreased availability of medical malpractice insurance. Some of these reforms have been declared unconstitutional by state courts (see app. II). Others have been repealed or allowed to expire. A number of reforms have been upheld as constitutional. With few exceptions, the reforms were perceived by the organizations surveyed as having no major impact on the number of claims filed or the size of awards and settlements. Further, although few in number, empirical studies have also found, with few exceptions, that the reforms have not had a significant effect on the number of claims filed, size of awards, or cost of malpractice insurance.

Organizational Views on the Impact of Tort Reforms

There was no consensus among the six interest groups that any of the 14 tort reforms included in our questionnaire (see pp. 110-119) has had a major impact. However, a majority of professional providers believe that caps on awards have had a major impact on decreasing the size of awards and settlements and that periodic payment of awards has had a major impact on decreasing insurers' total cash outlay for awards or settlements. A majority of the consumers believe that pretrial screening panels have had a major impact on decreasing the time required to close claims and on decreasing the number of claims that go to trial.

Empirical Studies on the Impact of Tort Reforms

We identified three studies addressing the effects of mid-1970's tort reforms; however, we did not independently evaluate the appropriateness of each study's design or the validity of its conclusions. Two studies reported lower amounts of awards from selected reforms, while the other reported that the reforms, except for pretrial screening panels, had not reduced malpractice insurance premiums. The key findings of each study are presented below.

Danzon and Lillard Study

This 1983 study used data from medical malpractice claims closed in 1974 and 1976 to predict several aspects of the disposition of claims, including the potential award at verdict, the probability of the plaintiff winning, the amount which the plaintiff would have accepted to settle,

and the amount at which the defendant would have offered to settle.[1] The study also examined the impact of (1) states modifying the collateral source rule (see p. 79) to admit evidence in court of collateral compensation, (2) limits on plaintiff attorney contingent fees, and (3) laws limiting malpractice awards (i.e., limits on awards, periodic payment of awards, or limits on the plaintiff stating dollar damages as part of initial pleadings). The study stated that the malpractice claims included in the study were broadly representative of claims against physicians and hospitals, although they were not strictly randomized.

Regarding the impact of the tort reforms, the study stated that its conclusions were tentative. Those conclusions were:

- Modification of the collateral source rule reduced awards by a statistically low percentage.
- Limits on plaintiff attorney contingency fees reduced the size of settlements by 9 percent, reduced the percentage of cases litigating to verdict by 1.5 percentage points, and increased the percentage of the cases dropped by 5 percentage points.
- Limits on awards (caps on awards, elimination of plaintiff's ad damnum (see p. 79), and periodic payments) reduced potential verdicts by 42 percent and reduced size of settlements by 34 percent.

The study noted that its simulated effects regarding the limits on awards were rough and represented only short-run effects.

anzon Study

This 1982 study examined the impact of several post-1975 tort reforms on the frequency of medical malpractice claims per capita, the amount per paid claim, and claim cost per capita (product of amount per paid claim and frequency of paid claims per capita).[2] The study used data from claims closed from 1975 to 1978 by all insurance companies writing malpractice premiums of $1 million or more in any year since 1970. Although several states enacted the same types of tort reforms, the nature of specific reforms may vary among states. For purposes of this study, individual reforms in each state were treated as though they were the same.

[1]Patricia Munch Danzon and Lee A. Lillard, "Settlement Out of Court: The Disposition of Medical Malpractice Claims," Journal of Legal Studies, Vol. XII, June 1983, pp. 345-377.

[2]Patricia Munch Danzon, "The Frequency and Severity of Medical Malpractice Claims," Rand, R-2870-ICJ/HCFA, Santa Monica, CA, 1982.

The study found:

- States enacting a cap on awards had 19 percent lower awards 2 years after the statute became effective.
- States mandating the offset of collateral sources had 50 percent lower awards 2 years after the statute became effective, whereas there was no significant effect of states admitting evidence of collateral compensation without mandating offset.
- States eliminating plaintiff's ad damnum had lower total claim costs, but there was no significant effect on the frequency or amount paid per claim.
- States with limits on attorney contingent fees had a somewhat lower amount paid per claim and total claim cost, but the significance level was low.

The study also found no significant effects on frequency of claims or amount of awards from voluntary or mandatory pretrial screening panels, arbitration, restrictions on informed consent, restrictions on the use of res ipsa loquitur (see p. 80) and periodic payment of future damages.

Sloan Study

This 1985 study examined the impact of several tort reforms on the levels and rates of change in medical malpractice insurance premiums paid from 1974 through 1978 by general practitioners who do not perform surgery, ophthalmologists, and orthopedic surgeons.[3] Malpractice insurance premiums were for a policy with coverage limits of $100,000 (per occurrence)/$300,000 (annual aggregate). Tort reforms included in the study were (1) limiting provider liability, (2) limiting provider payments to plaintiffs, (3) establishing a patient compensation fund, (4) limiting the use of the res ipsa loquitur doctrine, (5) tightening the statute of limitations, (6) clarifying informed consent, (7) imposing contingent-fee regulation, (8) adding collateral-source provisions, (9) eliminating the ad damnum clause, (10) imposing a locality rule (see p. 80), (11) mandating use of a pretrial screening panel, (12) allowing for binding arbitration, (13) creating joint underwriting associations (see p. 67), and (14) forming a health care mutual insurance company.

Of the tort reforms studied, only mandatory use of pretrial screening panels had a statistically significant association with lower malpractice

[3]Frank A. Sloan, "State Responses to the Malpractice Insurance 'Crisis' of the 1970s: An Empirical Assessment," Journal of Health Politics, Policy and Law, Vol. 9, No. 4, Winter 1985, pp. 629-646.

insurance premiums. The study stated that its empirical results ". . . give no indication that individual state legislative actions, or actions taken collectively, had their intended effects on premiums."[4]

[4]Ibid, p. 629.

Wide Diversity of Views Concerning Medical Malpractice Problems

Physician, hospital, malpractice insurer, health care insurer, legal, and consumer groups are concerned about the medical malpractice situation and its impact. However, the groups view the type and severity of malpractice problems differently. For example, providers of medical care view the problems quite differently than those that receive care and those that provide legal counsel to injured patients. Physician, hospital, and consumer groups agreed that the threat of medical malpractice suits has had both positive and negative effects.

Major Concerns of the Interest Groups

The medical care provider groups focused on problems associated with (1) the availability and cost of malpractice insurance, (2) the size and equity of awards, and (3) the length of time and the legal costs associated with settling malpractice claims. Essentially, these respondents felt that the cost of malpractice insurance is too high, awards are excessive, the time to settle claims is too long, and legal costs are excessive. Both the physician and legal groups believed the large number of medical malpractice claims filed posed major problems.

The consumer interest group agreed with the medical care providers that the long time to settle claims is a major problem. The consumer group also expressed major concerns with the lack of physician and hospital actions to reduce or prevent medical malpractice events and claims. Generally, the consumer group believed that physicians and hospitals have not done an adequate job of ensuring that all providers are competent to provide high-quality medical services. Additionally, the physician group had some major concerns with some physician actions to reduce or prevent medical malpractice claims, specifically the strong incentives to perform medically unnecessary tests or treatments to reduce their risk of liability.

Table 3.1 shows the lack of agreement among the different interest groups concerning current malpractice problems and anticipated problems during the next 5 years.

Table 3.1: Major Interest Group Concerns

	Interest groups							
	Professional provider (N=14)		Hospital affiliated (N=5)		Legal (N=6)		Consumer (N=7)	
Problem areas	**C**	**F**	**C**	**F**	**C**	**F**	**C**	**F**
Availability of malpractice insurance		X	X	X				
Cost of malpractice insurance	X	X	X	X				
Number of malpractice claims filed	X	X			X			
Size of awards and settlements for malpractice claims	X	X	X	X				
Length of time to resolve malpractice claims	X	X	X	X			X	X
Equity of awards and settlements for malpractice claims	X	X	X	X				
Legal expenses and attorney fees for malpractice claims	X	X	X	X				
Responses by physician groups and hospitals to reduce or prevent malpractice events							X	
Individual physician actions to reduce or prevent malpractice claims	X						X	X
Individual hospital actions to reduce or prevent malpractice claims							X	X

Legend
C=Current year (1985).
F=During next 5 years (1986-90).
X=Majority of responding organizations in this group had major problems with some aspect of area.
N=Number of organizations responding in each group.

Each of the 10 concerns is further discussed below.

Availability of Insurance

Organizations representing the purchasers of medical malpractice liability insurance (i.e., hospital-affiliated and professional provider organizations) perceived some major availability problems now and/or during the next 5 years (see pp. 88-91). More specifically, most hospital-affiliated organizations believed insufficient sources of basic and excess liability coverage for hospitals and reinsurance for the primary insurers

are currently major problems. Further, most professional provider and/or hospital-affiliated organizations believed major problems will result during the next 5 years from insufficient sources of (1) basic and excess liability coverage for both physicians and hospitals, (2) "tail" coverage against future claims for physicians, and (3) reinsurance for primary insurers.

Table 3.2: Major Problems Perceived Concerning the Availability of Medical Malpractice Insurance

	Interest groups			
	Professional provider (N=14)		Hospital affiliated (N=5)	
Major problems	C	F	C	F
Physicians unable to find a source from which the desired levels of basic liability coverage can be purchased	X			X
Physicians unable to find a source from which the desired levels of excess liability coverage can be purchased	X			X
Physicians unable to find a source from which the desired coverage for future claims (such as "tail coverage" for claims made policies) can be purchased				X
Hospitals unable to find a source from which the desired levels of basic liability coverage can be purchased			X	X
Hospitals unable to find a source from which the desired levels of excess liability coverage can be purchased			X	X
Insurers unable to find a source from which sufficient levels of reinsurance can be purchased	X		X	

Legend
C=Current year (1985).
F=During next 5 years (1986-90).
X=Majority of responding organizations in this group had major problems with specific areas.
N=Number of organizations responding in each group.

The severity of the current reinsurance problem is demonstrated by Lloyd's of London's recent threat to pull out of the U.S. insurance market.[1] This insurance exchange represents a vital source of reinsurance for many medical malpractice liability insurance carriers. Further, Mutual Fire, Marine and Inland Insurance Company refused in June 1985 to renew its malpractice insurance policy for about 1,400 certified nurse-midwives they insured over the past year. The company cited its inability to find sufficient reinsurance as the reason for refusing to continue providing coverage to about half of the nation's certified nurse midwives.[2] The American Medical Association added:

[1]Medical Liability Monitor (September 27, 1985), Vol. 10, Number 9, p. 3.

[2]Midwives Face Insurance Crisis," The Washington Post, July 3, 1985, p. 7.

"The reinsurance market is tightening up. Reinsurance will begin to affect the availability of insurance. No immediate improvement in this situation is predicted by anyone involved with this issue."

The Council of State Governments commented:

"Liability insurance, especially for large sums of protection, is now nearly not available and will be worse in the future. It has gotten much worse in the last 2 years."

Cost of Insurance

Most professional provider organizations believed the cost of basic, excess, and "tail" liability coverage for physicians is too expensive (see pp. 90-93). They viewed these as current major problems that will continue during the next 5 years. They also believed the cost of reinsurance will become a major problem in the next 5 years. Additionally, most hospital-affiliated organizations perceived the most significant current major problems to be the high costs of excess liability coverage for physicians and hospitals, "tail" coverage for hospitals, and reinsurance for primary insurers. They believed that these will continue to be major concerns during the next 5 years, along with the high cost of "tail" coverage for physicians and basic liability coverage for physicians and hospitals.

Table 3.3: Major Problems Perceived Concerning the Cost of Medical Malpractice Insurance

	Interest groups			
	Professional provider (N=14)		Hospital affiliated (N=5)	
Major Problems	C	F	C	F
Cost of basic liability coverage for physicians too expensive	X	X		X
Cost of excess liability coverage for physicians too expensive	X	X	X	X
Cost of coverage for future claims ("tail coverage") for physicians too expensive	X	X		X
Cost of basic liability coverage for hospitals too expensive				X
Cost of excess liability coverage for hospitals too expensive			X	X
Cost of coverage for future claims ("tail coverage") for hospitals too expensive			X	X
Cost of reinsurance too expensive for insurers		X	X	X

Legend
C=Current year (1985).
F=During next 5 years (1986-90).
X=Majority of responding organizations in this group had major problems with specific areas.
N=Number of organizations responding in each group.

Commenting on the high costs of medical malpractice liability insurance, the Council of Medical Specialty Societies stated "escalation of awards has raised insurance costs beyond reasonable or affordable levels." The National Council of Community Hospitals commented:

"Increasing premiums in certain physician specialties, i.e., OB-GYN [Obstetrics-Gynecology], etc., [are] causing a number of physicians to (1) retire, (2) change to general practice, [or] (3) refuse to perform certain procedures."

The American Hospital Association stated, "certain major underwriters are insisting on 'claims made' coverage which is rapidly becoming as expensive as the more extensive 'occurrence' coverage." According to the American Medical Association, professional liability insurance premiums for physicians in 1984 represented about 8 percent of their before-tax income.[3] The Association of Trial Lawyers of America, however, believed that the cost of medical malpractice liability insurance is not that expensive. For example, it reported that on the average physicians earn a gross income of about $200,000, of which they spend an average of about 2.9 percent on malpractice insurance.[4]

Number of Claims Filed and Not Filed

Most professional provider organizations perceived a large number of frivolous claims being filed as a major current and future problem. Conversely, most legal organizations anticipated major future problems with a large number of medical events (injuries) and meritorious claims (see pp. 92 and 93).

[3]American Medical Association Special Task Force on Professional Liability and Insurance, Response of the American Medical Association to the Association of Trial Lawyers of America Statements Regarding the Professional Liability Crisis, American Medical Association, 1985, p. 10.

[4]Thomas G. Goddard, The American Medical Association is Wrong - There is No Medical Malpractice Insurance Crisis, Association of Trial Lawyers of America, March 5, 1985, p. 4.

Table 3.4: Major Problems Perceived Concerning the Number of Medical Malpractice Claims Filed and Injuries for Which Claims Were Not Filed

	Interest groups			
	Professional provider (N=14)		Legal (N=6)	
Major problems	C	F	C	F
A large number of medical events that could result in malpractice claims				X
A large number of meritorious claims				X
A large number of frivolous claims	X	X		

Legend
C=Current year (1985).
F=During next 5 years (1986-90).
X=Majority of responding organizations in this group had major problems with specific areas.
N=Number of organizations responding in each group.

Reflecting a concern about frivolous claims, the American College of Physicians stated:

"Excess recovery in meritorious cases (the same injury in malpractice being recompensed at several times that injury in other negligence cases) gives substantial incentive to pursue marginal or even frivolous suits."

The American Osteopathic Association pointed out that "the frivolous claims divert attention from more serious matters and cost money to defend against."

Commenting on the increasing frequency of claims, the Defense Research Institute stated:

"More claims will be made because more claims will be successful. Consumers are becoming more sophisticated and more aware of what has and is being done to them. There has always been some malpractice. Although it is not at all clear that the rate of malpractice has increased, patient perception of malpractice has. As verdicts and settlements increase in size it becomes increasingly rational from the patient['s] point of view to pursue claims."

According to the Association of Trial Lawyers of America, there has been no substantial increase in either frequency or severity of malpractice claims. Further, the Association pointed out that there is no clear trend toward an increase in the tendency of Americans to bring a civil lawsuit. The Association added that the fundamental cause of medical malpractice claims is medical carelessness or negligence. The Association also stated that virtually every study that has examined the incidence of malpractice has shown that there is at least 10 times as much

actual malpractice as there are claims for malpractice, and fewer than half of those claims are paid.

The American Association of Retired Persons stated:

"Some studies have indicated that 1 in 10 hospital admissions results in a 'maloccurrence.' Of those, a significant number are potentially actionable. We cannot ignore the fact that malpractice occurs. The reluctance of providers to adequately police themselves and the existence of only 'paper' quality assurance programs in many hospitals has contributed significantly to incidences of malpractice. Additionally, poor provider-patient relations, as evidenced by lack of communication, has served to create misperceptions and heightened expectations on the part of the patient."

Size of Awards/Settlements

Both the professional provider and hospital-affiliated interest groups perceived the excessive size of awards or settlements for medical malpractice claims to be a major problem currently and one that will continue during the next 5 years (see pp. 92 through 95). More specifically, the professional provider interest group saw major current and future problems with the excessive (1) size of awards or settlements paid in relation to the economic costs arising from the injuries, (2) amounts paid for pain and suffering, and (3) number of awards or settlements exceeding $1 million. The hospital-affiliated interest group also perceived major current and future problems with too many awards exceeding $1 million along with major future concerns regarding the excessive awards or settlements in relation to the related economic costs.

Table 3.5: Major Problems Perceived Concerning the Size of Awards/ Settlements for Medical Malpractice Claims

	Interest groups			
	Professional provider (N=14)		Hospital affiliated (N=5)	
Major problems	**C**	**F**	**C**	**F**
Awards/settlements excessive in relation to economic costs arising from the injuries	X	X		X
Amounts paid for pain and suffering excessive	X	X		
Too many awards/settlements over $1 million	X	X	X	X

Legend
C=Current year (1985).
F=During next 5 years (1986-90).
X=Majority of responding organizations in this group had major problems with specific areas.
N=Number of organizations responding in each group.

The American Medical Association stated:

"The number of million dollar awards has been increasing since the mid-seventies. The average size of awards is increasing. Some of this is caused by greater awards for economic loss. Economic losses are increasing. However, much of the problem appears to be in the awards for non-economic damages. Jury verdict reporter systems indicate that a large percent of any award is attributable to the non-economic damages."

The American Association of Neurological Surgeons stated:

"Jury awards in particular often have little logic or consistency. Awards for pain and suffering—a nebulous non-quantifiable concept—in particular can be outrageous and lead to million dollar awards."

The Physician Insurers Association of America added:

"Large awards and settlements are inflated by jury enthusiasm to punish the doctor/hospital at fault. As we all become aware of the impact this has on the economy, things may calm down. To this point, multi-million dollar payments, in general, and other sizeable pain and suffering awards are excessive in relation to the health care delivery system's ability to fund them."

The Association of Trial Lawyers of America stated that the 38-percent rise in claim amount for 1981-84 recently reported by the St. Paul Companies, Inc., is a growth rate of only 8.4 percent per year, well under the annual 10.5 percent growth in the Medical Cost Index and the 13.3 percent growth in the national health care expenditures for the same time period. The Association also asserted that researchers have consistently found that jury verdicts in malpractice claims are based primarily on rational decisions about the actual malpractice injuries and generally undercompensate the victims of medical carelessness.

Length of Time to Resolve Claims

Most professional provider organizations viewed the excessive length of time required to resolve claims to be a major current problem that will continue during the next 5 years. The hospital group agreed that this will be a major problem over the next 5 years. The hospital-affiliated and/or consumer interest groups perceived the financial and emotional burdens placed on injured patients by the long time required to resolve claims as major current and future problems (see pp. 94 and 95).

Table 3.6: Major Problems Perceived Concerning the Length of Time to Resolve Medical Malpractice Claims

	Interest groups					
	Professional provider (N=14)		Hospital affiliated (N=5)		Consumer (N=7)	
Major problems	**C**	**F**	**C**	**F**	**C**	**F**
Length of time to resolve claims too long	X	X	X			
The length of time to resolve claims puts a financial burden on the injured patient			X		X	X
The length of time to resolve claims puts an emotional burden on the injured patient			X	X	X	X

Legend
C=Current year (1985).
F=During next 5 years (1986-90).
X=Majority of responding organizations in this group had major problems with specific areas.
N=Number of organizations responding in each group.

The American Association of Retired Persons stated:

"To the extent that it does take a long time to resolve a particular claim, the injured party may very well be financially exposed, depending on collateral sources. Assuming the 'long length of time' to resolve claims, the process is surely an emotional burden on the injured patient, particularly those who have few financial resources."

The National Council of Community Hospitals added that "the physical and emotional status of the patient suffers during a prolonged settlement."

Regarding the future concerns about the length of time required to resolve medical malpractice claims, the American Medical Association stated:

"Information from the various states indicates that the time from the filing to resolution of a claim is increasing. Court dockets are becoming more congested. No lessening in the time to resolve claims can be expected."

The American College of Legal Medicine added that "Patients tend to delay recovery strategies and efforts [in order] to 'maximize damages' often at [the] encouragement of their attorneys."

Equity of Awards/ Settlements

Both the professional provider and hospital-affiliated interest groups believed the unpredictable outcome of medical malpractice claims is a major concern currently and will continue to be one during the next

5 years. Also, most hospital-affiliated organizations pointed out that payments that are for far more or far less than the economic losses sustained by the injured patient are a major current problem (see pp. 96 and 97).

Table 3.7: Major Problems Perceived Concerning the Equity of Awards/ Settlements for Medical Malpractice Claims

	Interest groups			
	Professional provider (N=14)		Hospital affiliated (N=5)	
Major problems	**C**	**F**	**C**	**F**
Outcome of malpractice claims is unpredictable	X	X	X	X
Injured persons with meritorious claims receive payments far more than or far less than economic losses sustained			X	

Legend
C=Current year (1985).
F=During next 5 years (1986-90).
X=Majority of responding organizations in this group had major problems with specific areas.
N=Number of organizations responding in each group.

The American Medical Association said that "Outcomes are unpredictable because the award is made for the courtroom presentation, not necessarily for the actual injury sustained." The National Council of Community Hospitals added that "the present malpractice awards system is a lottery with the injured patient continuing to be at risk for a settlement." The American Hospital Association stated:

"The outcome of malpractice claims vary from case to case, from jurisdiction to jurisdiction, even when variables are similar, reflecting the problems inherent in the tort system."

The St. Paul Companies commented:

"The amount of the award or settlement for similar injuries varies from state to state for many reasons [including]:
1. conservative jurisdiction versus liberal jurisdiction;
2. abilities of the respective attorneys in the case;
3. emotional aspects of the case—sympathy for the particular type of injury;
4. makeup of the jury;
5. insurance coverage (limits available) versus no coverage;
6. ability of medical experts on each side; [and]
7. applicability of pre-judgment interest statute as well as punitive damages."

Legal Expenses/Attorney Fees

Both the professional provider and hospital-affiliated interest groups perceived major problems with the legal expenses and attorney fees for medical malpractice claims (see pp. 96 through 99). More specifically, both interest groups anticipate a major future problem with excessive legal costs associated with defending claims, while the professional provider interest group also perceived this as a major current problem. Moreover, these same two interest groups foresaw major future problems with excessive plaintiff's legal costs associated with pursuing a claim. The hospital-affiliated interest group also perceived that contingency fee arrangements will discourage future small but meritorious claims. Additionally, both the professional provider and hospital-affiliated interest groups believed a major current and future problem was that legal expenses and attorney fees represent an excessive percentage of the awards and/or settlements.

Table 3.8: Major Problems Perceived Concerning the Legal Expenses/ Attorney Fees for Medical Malpractice Claims

	Interest groups			
	Professional provider (N=14)		Hospital affiliated (N=5)	
Major problems	**C**	**F**	**C**	**F**
Legal costs associated with defending claims too high	X	X		X
Plaintiff's legal costs associated with pursuing a claim too high		X		X
Contingency fee arrangements discourage small but meritorious claims				X
Legal expenses, and attorney fees, as a percentage of awards/ settlements too high	X	X	X	X

Legend
C=Current year (1985).
F=During next 5 years (1986-90).
X=*Majority of responding organizations in this group had major problems with specific areas.*
N=Number of organizations responding in each group.

The Council of Medical Specialty Societies commented:

"Lawyers (plaintiff and defense) fees amount to 51 percent of the awards—clearly if the professional liability system is to compensate injured patients, it is not doing so but is rather rewarding attorneys. In addition, there is some indication that juries increase awards to compensate for legal fees."

The University Risk Management and Insurance Association said:

"Legal expenses in the defense have been [escalating] in recent years. Often they equal the amount ultimately paid in settlement. Legal expenses in terms of the plaintiff often reduce their ultimate recovery by as much as 50

percent . . . . Said in another way, should the plaintiff's attorney be entitled to such a fee for his/her services?"

The American Hospital Association added:

"The incentives for legal representatives are not in the small but meritorious cases, but in the larger cases. Lawyers cannot afford to take the smaller cases—even though meritorious. This will become a larger problem as fees are subjected to schedules limiting percentages of award which may be paid for fees."

Physician Group and Hospital Efforts to Reduce or Prevent Malpractice Events

Only the consumer interest group saw major problems currently regarding physician groups and/or hospital actions to prevent or reduce medical malpractice incidents (see pp. 98 through 101). These major current concerns centered on their beliefs that medical societies, hospitals, and peer review groups have failed to take remedial actions against physicians or hospitals with malpractice histories.

Table 3.9: Major Problems Perceived Concerning the Responses by Physician Groups and Hospitals to Reduce or Prevent Medical Malpractice Events

Major problems	Interest group Consumers (N=7) C	F
Medical societies did not take remedial action against members with malpractice histories		X
Hospitals did not take remedial action against physicians with malpractice histories		X
Peer review groups did not take remedial actions against physicians or hospitals with malpractice histories		X

Legend
C=Current year (1985).
F=During next 5 years (1986-90).
X=Majority of responding organizations in this group had major problems with specific areas.
N=Number of organizations responding in each group.

In commenting on these problems, the American Association of Retired Persons stated:

"Physicians have not been up to the task of policing and disciplining themselves. In those instances where physician groups have attempted to discipline their members, they have frequently run into regulatory barriers. In any hospital setting, it is no secret who the 'bad' physicians are. Yet, hospitals have abdicated their responsibility to weed out the 'bad' physicians. Peer review groups are bootstrapped by the very fact that they are 'peers.'"

The People's Medical Society added:

"Unless the doctrine of liability and responsibility is forced upon doctors and hospitals, there will be little change in how physicians practice medicine. The code of 'speak no evil' will permit incompetent providers to continue as before thereby exposing more consumer/patients to the chance of becoming a medical mistake. Hospitals must be given more authority to remove impaired physicians from their staff without fear of a countersuit from the physician who is removed."

The Council of State Governments said:

"There has been little systematic effort or willingness by physician societies, medical licensing boards, and hospitals to call a spade a spade when it comes to incompetent doctors. Hospital administrators seem to be intimidated by physicians and let them make both the quality of care and the business-oriented decisions without exposing the incompetent doctors."

Conversely, the American Association of Neurological Surgeons commented that:

"Malpractice claims against providers in no way indicate marginal or incompetent practice. Fifty percent of the neurosurgeons in New York State had claims filed against them in 1984."

Physician Actions to Reduce or Prevent Malpractice Claims

Both the professional provider and consumer interest groups perceived major current problems caused by strong incentives for physicians to perform medically unnecessary tests or treatments to reduce their risks of being sued. Most of the consumer organizations believed that this practice of defensive medicine would continue to be a major problem during the next 5 years. The consumer interest group also perceived the limited actions physicians have taken to improve physician-patient relationships to be a major problem currently (see pp. 100 and 101).

Table 3.10: Major Problems Perceived Concerning the Individual Physician Actions to Reduce or Prevent Medical Malpractice Claims

	Interest groups	
	Professional provider (N=14)	Consumer (N=7)
Major problems	C F	C F
Physicians have done little to improve physician-patient relationships to reduce or prevent malpractice claims		X
Physicians have strong incentives to perform medically unnecessary tests or treatments to reduce their risk of liability	X	X X

Legend
C=Current year (1985).
F=During next 5 years (1986-90).
X=Majority of responding organizations in this group had major problems with specific areas.
N=Number of organizations responding in each group.

The American Association of Neurological Surgeons commented:

"Defensive medicine [in] surgery is a reality. In terms of insurance and legal jargon this is 'prudent' practice and only a fool would not engage in such practice. The cost of this is not measurable but may run to $30 billion per year."

The American Association of Retired Persons highlighted the following problems with physician-patient relationships:

"Not only have physicians done little to improve patient relationships, but the problem has been exacerbated by increasing numbers of specialists. These specialists or surgeons are often brought in by the primary care physician. Frequently, they never even have a conversation with the patient. When something goes wrong, since there has been so little contact, the patient is left with his/her own perceptions as to what should have occurred."

According to the Association of Trial Lawyers of America, "defensive medicine" is merely careful medicine, and because it improves health care at a cost of only $1.19 per week for the average American, it should not be discouraged.

Hospital Actions to Reduce or Prevent Malpractice Claims

The consumer interest group saw major current and future problems regarding hospitals allowing unnecessary tests to reduce their liability risk. Also, this interest group believed hospitals failing to properly screen the histories of admitting physicians for malpractice claims is a major problem currently (see pp. 100 through 103).

Table 3.11: Major Problems Perceived Concerning the Individual Hospital Actions to Reduce or Prevent Medical Malpractice Claims

Major problems	Interest group Consumer (N=7) C	F
Hospitals have a strong incentive for allowing medically unnecessary tests or treatments to reduce their risk of liability	X	X
Hospitals have not effectively screened or reviewed admitting physicians' histories of malpractice claims	X	

Legend
C=Current year (1985).
F=During next 5 years (1986-90).
X=Majority of responding organizations in this group had major problems with specific areas.
N=Number of organizations responding in each group.

The People's Medical Society stated:

"Reimbursement mechanisms encourage unnecessary and risky procedures because not performing a procedure can cost the hospital money. Fear of restraint-of-trade suits has left hospitals powerless to adequately screen their medical staffs. Since physicians screen physicians and also write letters of recommendation, the hospital administration does little more than affirm the choice of the medical committee."

The American Association of Retired Persons commented:

"Hospitals appear to have done little in the way of screening or reviewing admitting physicians. Physicians barred from practice in one jurisdiction 'hop' to the next jurisdiction to practice."

Impact of Malpractice Suits

Professional provider, hospital-affiliated, and consumer groups agreed that the threat of medical malpractice suits has contributed to

- an increase in cost of medical care,
- an increase in the numbers of physicians deciding to change specialties or retire early,
- an increase in the practice of defensive medicine, and
- a decrease in a patient's access to medical care.

These three groups also agreed, however, that the threat of suits has caused the quality of medical care to increase and has led to more hospital and physician risk management programs to reduce the incidence of malpractice (see pp. 120 through 123).

Alternative Solutions Lack Broad Support and Proof of Effectiveness

Concerns about aspects of the present system for resolving medical malpractice claims have generated various proposals for change. The more frequent criticisms of the system are that

- it involves high legal fees and costs and considerable time to establish provider fault,
- legal fees and costs consume a high portion of malpractice awards and settlements,
- the results are unpredictable, and
- malpractice awards are frequently excessive.

Some believe that these criticisms are unwarranted and disagree that there are flaws in the system. They view the current fault-based system as a deterrent to medical malpractice.

Various approaches for resolving medical malpractice claims have been proposed. Some are in the conceptual stage; others have been used for years. These approaches basically fall into fault-based or no-fault-based systems. Some critics of the present fault-based system for resolving claims have proposed approaches that would pay compensation for specified medically caused injuries without requiring proof that the injuries resulted from the provider's fault. Others have proposed modifications to the present system while maintaining provider fault as the basis for compensating malpractice claims.

We solicited the views of the six interest groups and reviewed the literature on various approaches to determine how they work and what each should accomplish and the experience, where available, with each. Widespread support for any one approach did not exist. Nor was there widespread support for federal involvement. Conversely, there was limited support, primarily by the legal and consumer groups, for various actions to reduce the incidence of medical malpractice claims. The professional provider, consumer, and health care insurer groups supported these actions principally at the state level.

Proposals for Changing the System

The various approaches for resolving claims can be grouped into two broad categories: (1) those in which the basis for compensation is contingent on establishing that the injury was due to provider fault (fault-based) and (2) those that make compensation available without the necessity of establishing provider fault (no-fault).

Within each of these categories, we obtained information on the following:

Fault-Based

- Use of pretrial screening panels.
- The proposed Health Care Protection Act of 1985 (S. 175, 99th Congress).
- The proposed Medical Malpractice Reform Act of 1985 (H.R. 2659, 99th Congress).
- Use of arbitration.

No-Fault-Based

- Elective no-fault medical malpractice insurance.
- Medical adversity insurance.
- The proposed Medical Offer and Recovery Act (H.R. 3084, 99th Congress).
- Social insurance approaches, including a workers' compensation-type approach for medical malpractice and approaches used in New Zealand and Sweden.

The characteristics of these approaches are briefly described in tables 4.1 through 4.6. A more detailed description of each is included in appendix V.

Table 4.1: Fault-Based Approaches—Pretrial Screening Panels and Proposed Health Care Protection Act

	Pretrial Screening Panels	Proposed Health Care Protection Act of 1985
Objective	Screen and promote early disposition of claims before court.[a]	Limit malpractice costs and provide full and expeditious compensation to injured parties.
Claims resolution	Use may be voluntary or mandatory; panels usually consist of 3 to 7 members, including an attorney, a health provider, a lay person. Informal hearing held; panels render nonbinding decision based on existence or provider fault; some may specify damages; panel's decision generally admissible in court.	Claims filed with a pretrial screening panel. Hearing required to be held within 180 days of filing. Panel decision required within 30 days after hearing. If panel finds liability, determines damages. Parties entitled to new trial if desired, but party bringing action liable for court costs and attorney costs of other party if he/she does not prevail.
Compensation	Some panels may recommend damages.	If finding of provider liability, panel would recommend amount of damages.
Cost/ financing	Limited data available; average cost to process claims through Montana panel was $2,469 from 1978 through 1982.[b] Financing may be by disputing parties, state, or both.	Provides federal funds to states that implement the act.
Mechanisms to discourage future malpractice claims	Panels determine provider fault and some communicate this to licensing boards.	Would require panels to report findings of liability to state licensing board and state insurance department and states to establish risk management programs.
Experience	As of July 1985, pretrial screening panels have been established in 25 states; declared unconstitutional in 3 and repealed or expired in 3.[c] Studies show objectives of panels being met in some states and panels not being used in other states.[d,e]	See experience for pretrial screening panels.

[a]Peter E. Carlin, Medical Malpractice Pre-Trial Screening Panels: A Review of the Evidence, Intergovernmental Health Policy Project, George Washington University, Washington, DC, October 1980, p. 15.

[b]Montana Medical Malpractice Panel, Claims Before the Montana Medical Malpractice Panel Through 1982, Helena, MT, January 1983, p. 8.

[c]American Medical Association Special Task Force on Professional Liability and Insurance, Professional Liability in the 80's, Report 2, November 1984, pp. 20-21. Updated as of July 1985.

[d]Carlin, op. cit., pp. 29, 31, 37, 39.

[e]Florida Medical Association. Medical Malpractice Policy Guidebook, 1985, p. 188.

Table 4.2: Fault-Based Approaches—Proposed Medical Malpractice Reform Act and Arbitration

	Proposed Medical Malpractice Reform Act of 1985	Arbitration
Objective	Encourage prompt and fair settlements of malpractice claims and reduce the burden on the court system. Lower administrative and litigation costs.	Substitute for courts in resolving claims. Provides a binding decision regarding provider liability and damages.
Claims resolution	Establishes screening panels consisting of at least three members, including a health care professional, an attorney, and a lay person. Panels hear and decide all malpractice claims according to state law for evidence and procedure using expedited procedures. Panels determine amount of awards. Panel decision subject to court appeal.	Voluntary participation of parties; panels usually consist of three or more members, including a physician, an attorney, and a lay person. Panels conduct hearings which are less formal than court and render binding decisions based on existence of provider fault regarding liability and damages.
Compensation	Determined by panel; recoveries for noneconomic losses limited to $250,000.	Determined on case-by-case basis; amount subject to limits by state law.
Cost/ financing	Provides federal funding to states with qualifying programs.	Generally financed by parties involved.
Mechanisms to discourage future malpractice claims	Requires panel to submit findings of medical malpractice to state insurance commissioner and licensing body. Insurers allowed to adjust rates for liable providers.	Private arbitration process reduces public stigma associated with resolving claims in court.
Experience	See experience for pretrial screening panels.	Used in selected states (California, Colorado, Michigan, Ohio, New York). Few evaluations available indicate may result in faster resolution of claims, reduced loss payments, and reduced defense costs with arbitration.[f,g,h]

[f]Duane H. Heintz, "Medical Malpractice Arbitration: A Viable Alternative," The Arbitration Journal, Vol. 34, No. 4, December 1979, p. 18.

[g]Applied Social Research, Inc., Evaluation: State of Michigan Medical Malpractice Arbitration Program - Summary Report, October 1984, p. 12.

[h]Irving Ladimer, Joel C. Solomon, and Michael Mulvihill, "Experience in Medical Malpractice Arbitration," The Journal of Legal Medicine, Vol. 2, No. 4, 1981, pp. 448-450.

Table 4.3: No-Fault Approaches—Elective No-Fault and Medical Adversity Insurance

	Elective No-Fault	Medical Adversity Insurance
Objective	Reduce the time and costs associated with determining fault; make loss payments more predictable; match loss payments to expenses incurred; eliminate duplicate payments for losses; and compensate more injured patients.	Replace present adversary legal system for resolving medical malpractice claims and eliminate need to establish provider fault for certain medical outcomes. Compensate injured parties promptly but not lavishly.[j] Generate incentives for providers to avoid relatively bad outcomes.
Claims resolution	Providers choose risks to cover under no-fault insurance; other risks handled under tort system. Claims for covered injuries filed directly with insurer. Claims paid promptly.[i]	Avoidable medical outcomes and amount to be paid predetermined. Patient or provider would file claim with insurer who would pay promptly. Under contract version, each provider would voluntarily select which outcomes to cover and purchase no-fault insurance. Outcomes not covered could be pursued under tort system.
Compensation	Pays net economic losses for medical expenses, lost wages, rehabilitative services as losses accrue. No compensation for pain and suffering.	For listed outcomes, pays for medical expenses, lost wages, and possibly pain and suffering. Payments for lost wages and pain and suffering would be limited.
Cost/ financing	Cost of approach unknown. Financed by provider-paid insurance premiums.	Funded by premiums paid by providers.
Mechanisms to discourage future malpractice claims	None.	Premiums paid by providers would be experienced rated.[k]
Experience	None.	None.

[i]Jeffrey O'Connell, "No-Fault Liability by Contract for Doctors, Manufacturers, Retailers, and Others," Insurance Law Journal, September 1975, pp. 532-533.

[j]Clark C. Havighurst and Laurence R. Tancredi, "Medical Adversity Insurance - A No-Fault Approach to Medical Malpractice and Quality Assurance," Insurance Law Journal, February 1974, pp. 1-2.

[k]Clark C. Havighurst, "Medical Adversity Insurance - Has Its Time Come?" Duke Law Journal, Vol. 1975, pp. 1249-1252.

Table 4.4: No-Fault Approaches— Proposed Medical Offer and Recovery Act

	Proposed Medical Offer and Recovery Act
Objective	Promote fair compensation for more victims of medical malpractice, who would receive fair payment for economic losses, quickly, and without the expense, trauma, and delay of litigation.
Claims resolution	Providers make offer to injured parties to pay net economic losses without the necessity of demonstrating provider fault in the litigation system. Offer would foreclose tort action by injured party. If no offer tendered, injured party may pursue in court or request arbitration.
Compensation	Payments would be made for net economic losses, including medical expenses, and rehabilitation and training expenses as they accrue. No payment available for pain and suffering.
Cost/financing	Cost unknown; would be financed by provider-paid insurance.
Mechanisms to discourage future malpractice claims	Health-care institutions must report adverse actions they take against providers to licensing boards. Provides confidentiality and immunity for those who provide information about incompetent or impaired professionals.
Experience	None.

Table 4.5: Social Insurance Approaches—Workers' Compensation-Type Program and New Zealand Program

	Workers' Compensation-type Program	New Zealand Accident Compensation Program
Objective	Compensate all medical care-related injuries without regard to provider fault; provide faster disposition of claims, more predictable awards, and increase injured patient's share of malpractice premium dollars.	Compensate and rehabilitate parties injured in any accident regardless of fault and promote safety throughout community.[l]
Claims resolution	Details would vary by state. Agency would administer claims and resolve disputes regarding award amounts, degree of disability, and length of disability. Injured party files claim with provider or administering agency. If provider's insurer decides not to pay claim, claim may be heard and resolved by administrative law judge.	Injured party files claim with administering agency, which determines whether claim is covered and amount and type of compensation. If covered, agency pays claims. Injured party can appeal agency decision in court.
Compensation	Would pay all medical and rehabilitation expenses; other losses would be paid according to a schedule for specific injuries. Could pay for noneconomic losses.	No limits on compensation for medical and rehabilitation expenses. Lump-sum payment available for noneconomic losses. Limits on compensation for lost income. Death benefits available. Compensation offset by amounts paid under New Zealand's Social Security Act.
Cost/ financing	Unknown costs. Financed by provider-paid insurance premiums.	Financed by (1) levies on employers/ self-employed persons, (2) levies on owners/drivers of motor vehicles, (3) appropriations from Parliament, and (4) investment income.
Mechanisms to discourage future malpractice claims	Provider premiums would be experience rated.	Provides financial assistance for safety program aimed at reducing injuries.
Experience	None for medical injuries.	Became operational on April 1, 1974. Program reported to have been fully accepted by population and physicians.[m]

[l]Accident Compensation Corporation, Accident Compensation Coverage - The Administration of the Accident Compensation Act, Wellington, New Zealand, Seventh Edition, 1983, p. 8.

[m]British Medical Association, Report of the No-Fault Compensation for Medical Working Party, 1983, Appendix I, p. 1.

Table 4.6: Social Insurance Approaches— Sweden Program

	Sweden Patient Compensation Program
Objective	More adequately compensate persons injured from medical treatment without regard to provider fault.
Claims resolution	Injured party decides whether to receive compensation under program or pursue recovery in tort system. Claims filed with insurer that uses physicians to review claims, determine whether injury is covered and compensation amounts. Injured party can appeal decision to a claims panel and further to arbitration.
Compensation	Compensates only losses not covered by other Swedish insurance programs. Pays for loss of income, medical care, and pain and suffering. Limits amounts for pain and suffering, permanent disfigurement, and disadvantage. Limits total compensation per claimant and per loss event.
Cost/financing	Mostly financed by regional governments (county councils).[n]
Mechanisms to discourage future malpractice claims	Unknown.
Experience	Became operational on January 1, 1975. Claims processing reported to be slow— applications for compensation may take 2 to 3 years to process. Forty percent of all claims are rejected.[n]

[n]British Medical Association, op. cit., Appendix I, p. 3.

Perceived Advantages and Tradeoffs of the Alternatives

As pointed out, the more frequently discussed problems of the present system for resolving malpractice claims focus on the excessive time involved in the settlement process, the high legal and other costs, the inequitable and unpredictable nature of awards, and the excessively high awards. Each of the alternatives discussed in this chapter is designed to address these problems as well as others discussed earlier. Each alternative would approach the problems differently and would address the problems to different degrees. In return for the possible resolution of some problems, however, there would be some likely tradeoffs, or negative effects. Both the positive and negative features of the alternatives may be viewed differently by the various parties involved in settling malpractice claims. For example, while providers may feel that limiting awards may be a positive attribute of an alternative approach, injured patients and their attorneys may not.

A summary of the advantages and tradeoffs of each approach obtained from our review of the literature and discussions with knowledgeable persons is presented in the following sections.

Comparison of Alternatives— Pretrial Screening Panels

Perceived Advantages

1. Reduces number of malpractice cases going to court by:

- Discouraging further litigation of nonmeritorious claims.
- Encouraging early settlement of meritorious claims.

2. Leads to more equitable and objective decisions because panelists better informed than lay jurors.

3. Resolves malpractice claims more quickly than conventional litigation.

Perceived Tradeoffs

1. May involve additional time and expense if case is not resolved as a result of the panel hearing.

2. May violate patient's constitutional rights if use of panels is mandatory before case can go to court.

3. May favor health care providers since most panels have a provider representative.

Comparison of Alternatives— Voluntary Binding Arbitration

Perceived Advantages

1. Resolves malpractice claims more quickly than conventional litigation.

2. Reduces costs associated with resolving malpractice claims.

3. Leads to more equitable and objective decisions because expert arbitrators better informed than lay jurors.

4. Provides greater access for small claims.

5. Results in a final decision not subject to appeal.

6. Reduces burden of courts in hearing malpractice cases.

Perceived Tradeoffs

1. May allow patients to seek compensation through both arbitration and the courts when multiple defendants are involved, some of which have agreed to arbitrate, while others have not.

2. May favor providers if a provider part of the arbitration panel and other panel members defer to that person for technical expertise.

3. May not adequately compensate injured person.

4. May reduce provider's incentive to reduce incidence of malpractice due to private nature of arbitration process versus public stigma associated with court system.

5. Agreements to arbitrate future malpractice claims may not be fully understood by patient to the advantage of the providers.

6. Informality of the arbitration hearings may violate the due process rights of the parties involved.

Comparison of Alternatives— Medical Adversity Insurance

Perceived Advantages	1. Provides compensation to more injured patients than current system. 2. Provides compensation more promptly than current system. 3. Provides similar compensation to injured persons with similar injuries. 4. Provides incentives for providers to improve quality of health care by basing insurance premiums on each provider's experience rating.
Perceived Tradeoffs	1. May cost more than current system since more persons would be compensated. 2. May cause providers to refuse to accept high-risk patients to avoid risk of compensable outcomes. 3. May encourage deterioration of provider-patient relationships since providers would have less incentive to maintain good relations with patients to avoid lawsuits. 4. May be overly complex in resolving claims involving multiple providers and insurers.

Comparison of Alternatives— Proposed Medical Offer and Recovery Act

Perceived Advantages	1. Resolves malpractice claims more quickly than conventional system since no need to determine provider fault. 2. No payments for noneconomic losses, which are often difficult to determine.

3. Eliminates duplicate payments for same incident.

4. Provides payments as losses incurred rather than in lump sum.

5. Provides payments as long as patient's injury continues.

6. Provides means for improving quality of medical care since it provides for reporting any adverse actions to a hospital and/or peer review committees or health care licensing board.

Perceived Tradeoffs

1. Does not compensate injured parties for noneconomic losses (i.e., pain, suffering, mental anguish, or loss of consortium).

2. May not benefit injured parties with small claims since providers would probably not tender any offer.

3. May favor provider since provider decides when or if to tender an offer which precludes the injured party from taking the case to court.

Comparison of Alternatives— Elective No-Fault Insurance

Perceived Advantages

1. Resolves malpractice claims more quickly than conventional system since no need to determine provider fault.

2. Avoids legal fees and costs incurred in determining provider fault.

3. Provides smaller awards since there is no payment for pain and suffering.

4. Reduces payments by amounts received from collateral sources.

5. Provides payments as losses are incurred rather than in lump sum.

6. Provides payments to more injured patients.

7. Provides similar payments for similar injuries/losses.

Perceived Tradeoffs

1. May be confusing to patients because the type and amount of compensation would vary with each provider.

2. May hinder ability of injured patients with small claims to receive compensation if providers elect large deductibles.

3. May do little to improve quality of medical care since it provides no linkages to regulatory or quality assurance activities.

4. May favor providers in selecting covered events since they have greater medical knowledge than patients.

5. May be more costly overall due to increased number of claims filed.

6. Does not compensate injured parties for noneconomic losses (i.e., pain and suffering).

Comparison of Alternatives— Social Insurance

Perceived Advantages

1. Provides greater access to compensation for injured patients as no requirement to determine fault.

2. Provides more predictable awards.

3. Compensates more medical injuries.

Perceived Tradeoffs

1. May be more costly due to more claims paid.

2. Eliminates determination of individual losses in determining amounts paid.

3. Provides no incentive for avoiding medical injuries.

Views of Interest Groups Regarding Alternative Approaches

We obtained the views of the six interest groups about the alternatives previously discussed except for the proposed Medical Malpractice Reform Act of 1985, the proposed Medical Offer and Recovery Act, and elective no-fault insurance. We did not include these two proposed acts in the questionnaire because they had not yet been introduced when the questionnaire was mailed to the organizations. However, we did obtain the views of the interest groups on the proposed Alternative Medical Liability Act (H.R. 5400, S. 2690, 98th Congress), which was the predecessor of the proposed Medical Offer and Recovery Act and encompassed the same procedures for settling claims except that the proposed Medical Offer and Recovery Act includes a provision for arbitrating claims if the provider fails to make an offer. We also solicited the views of respondents about no-fault insurance rather than specifically about elective no-fault insurance and asked the respondents about the concept of social insurance rather than specifically about a workers' compensation-type approach, the New Zealand Accident Compensation Program, and Sweden's Patient Compensation Program.

None of the alternatives was strongly supported by a majority of interest groups (see pp. 124 through 127). The following approaches were favored more than the others:

- Actions to modify the traditional fault-based litigation system for resolving claims with more support for these actions at the state rather than federal level.
- State actions to encourage use of pretrial screening panels.
- State actions to encourage use of arbitration in resolving claims.

Suggested Modifications of Fault-Based Litigation System

Expressing support for state modifications of the traditional fault-based litigation system, the American Medical Association commented:

"The current system is costly, inefficient, and time consuming. The tort system should be reformed to get compensation to those injured by negligence more efficiently and equitably. . . . This reform does not necessarily require that the tort system be replaced."

The St. Paul Companies, Inc., commented:

"We do not believe the federal government should impose itself into modifying the civil justice system. At the state level, some reforms (e.g. caps or limitations on non-economic awards) should prove to be cost beneficial and other reforms will not (e.g. non-binding screening panels)."

The People's Medical Society stated ". . . it would probably be counter-productive to push federal solutions to what should be reformed at the state level."

Expressing support for federal involvement, the American College of Obstetricians and Gynecologists stated:

"The underlying problems related to professional liability will probably only be solved by some significant modification of the traditional fault system. It would be greatly desirable in terms of uniformity for the federal government to act in this area, instead of the states, and perhaps the ultimate likelihood of such a plan passing would be greater if undertaken by the federal government."

The National Council of Community Hospitals commented that "federal law should be enacted to give states incentives to solve the malpractice problem."

The American Association of Retired Persons commented:

"The deterrent effect of the traditional system makes it worth retaining in the absence of other system-wide deterrents to medical malpractice. There is no question, however, that the system must be modified. Whether such action should be implemented by each state or the federal government will depend on the entire package of changes contemplated to deal with medical malpractice."

The American Association of Neurological Surgeons stated that ". . . Punitive damages and joint and several liability concepts must be eliminated. Awards for pain and suffering should be sharply curtailed."

Use of Pretrial Screening Panels

In expressing support for state implementation of pretrial screening panels, the People's Medical Society commented that:

". . . medical experts not involved with the medical system where the alleged injury took place [should] do the screening. A possible model would be federal experts who travel a sort of circuit and review cases, or a national clearinghouse which performs the review."

The Blue Cross and Blue Shield Association commented that "care in establishing such [a] mechanism is required to assure constitutionality."

The Physician Insurers Association of America stated that pretrial screening panels "expedite the discovery process and focus on qualified expert testimony if done properly." The American College of Legal Medicine commented that pretrial screening panels have been effective in many states.

A number of other organizations expressed concerns regarding the effectiveness of pretrial screening panels. For example, the American College of Obstetricians and Gynecologists commented that "pretrial screening panels appear to have done little but increase the amount of time it takes to resolve claims and impose an additional proceeding on the entire process." The American Association of Neurological Surgeons stated that "To date they have not been successful. Perhaps with certain modifications they could work." The American Society of Plastic and Reconstructive Surgeons stated that "Pretrial screening panels haven't worked in recent times because plaintiff lawyers bypass them."

The St. Paul Companies, Inc., commented:

"The track record of screening panels generally has been that the systems merely provide an additional discovery process, adding to defense costs and the time necessary to resolve disputes."

However, the American Medical Association stated:

"Pretrial panels have been effective in some states. Much depends on the number of claims filed and the structure and operation of the panel. The operational factor tends to determine a panel's effectiveness."

Adoption of the Proposed Health Care Protection Act of 1985

Supporting federal enactment, the National Association of Childbearing Centers commented that it "needs some modification but step in right direction." The University Risk Management and Insurance Association commented that "this requires more study, there are some aspects that are quite appealing." The American Academy of Family Physicians commented that "many concepts in [the] Inouye bill are meritorious - some are not . . . action on tort and/or judicial reform should be taken at state not national level."

The American Medical Association commented that "this bill does not address many problems—the non-economic damages, frivolous lawsuits, etc. Panels in some states may be effective, but not in all." The St. Paul Companies, Inc., commented:

"Screening panels add another layer of cost to the system. Under the provisions of S.175—any claimant can appeal for a new trial in circuit court. This would be a costly system for insurers, unless the decision of the screening panel would be binding."

Use of Arbitration

Supporting state implementation of arbitration in resolving malpractice claims, the American College of Obstetricians and Gynecologists stated:

"States that have enacted some form of binding arbitration system appear to have had a fair degree of success with it. Since this is essentially a contractual arrangement, it will be best pursued by the states."

The St. Paul Companies, Inc., commented that "Arbitration can be an effective method of reducing costs, but only if binding on both parties as to both liability and damages." The American Medical Association commented that "Voluntary binding arbitration has proved effective in some states where it has been implemented. It may be especially useful in determining damages if liability is not an issue."

The Physician Insurers Association of America commented that "arbitration on small damage value [cases] would benefit all parties." The Consumer Federation of America stated "arbitration can add predictability and speed to the tort system." The American Association of Retired Persons commented:

"Some form of arbitration for some malpractice cases may be desirable. Here too, the states that have implemented arbitration panels have met with mixed reviews from those using the system. The key is to design a system that meets constitutional challenges, swiftly and fairly resolves claims, and allows access to the traditional tort system for particularly egregious cases."

Use of No-Fault Insurance

Supporting state implementation of no-fault insurance, the People's Medical Society stated:

"This concept may remove some cases from litigation and provide an opportunity for a patient to recover a settlement. It might also lessen the role of

attorneys and thereby reduce the number of malpractice claims that actually reach the courts."

The National Association of Rehabilitation Professionals in the Private Sector stated:

"One method to solve the problem might be to set up a 'no-fault' reimbursement system such as workers' compensation is and charge providers premiums as [workers compensation] premiums are charged. This would limit individual providers expense and insure care of the claimants, eliminating to a degree, lengthy litigation and excess verdicts."

However, some organizations expressed concerns about no-fault insurance. For example, the American Medical Association commented:

"No-fault insurance should not be required to be supported by health care providers. This system requires them to subsidize any and all adverse outcomes. A pure no-fault system would price insurance out of the reach of health care providers. Any deterrent effect of the tort system would be lost."

The Consumer Federation of America stated that "fault is an important element in deterrence/quality of care."

The St. Paul Companies, Inc., commented that "We do not believe a no-fault system can be constructed by statute which will be both constitutional and, more importantly, cost beneficial." The Physician Insurers Association of America stated that "no fault will increase the cost of the system and relieve physicians/hospitals of their obligation to increase loss prevention efforts."

The American Association of Retired Persons commented that ". . . no-fault medical malpractice insurance could come with a high price tag. If payout is based on number of claims, this number could rise substantially without attribution of fault." The Blue Cross and Blue Shield Association commented:

"Defining the compensable event presents many problems. If too narrow, injured parties would not be adequately compensated for their loss and the deterrent effect of our tort system would be undermined. If too broad, cost to the health care system would soar."

Use of Medical Adversity Insurance

Supporting federal and state implementation of medical adversity insurance, the Public Citizen Health Research Group commented that "The attractive feature would be the experience rating of individual providers and setting premiums accordingly."

Although not expressing strong support for medical adversity insurance, the St. Paul Companies, Inc., commented:

"Such a system could prove to be cost beneficial but only if there is still a determination of fault by a tryer of fact (i.e., not everyone with an 'adverse' outcome is automatically reimbursed.)"

The Council of Medical Specialty Societies stated that "this is and has been an interesting idea which needs to be studied."

However, the American Association of Neurological Surgeons commented that it "sounds like the worst of both systems. May work if premiums paid by pts [patients] (not providers.)" The American College of Obstetricians and Gynecologists stated:

"The type of medical adversity insurance described would be almost impossible to implement, would only increase cost and would make the entire system even more of a nightmare than it is now."

Adoption of the Proposed Alternative Medical Liability Act

Supporting federal and state implementation, the American College of Obstetricians and Gynecologists stated:

". . . with some modification, such as restructuring of the timeframe to allow for obstetricians to offer settlements in response to claims in 'bad baby' cases, HR 5400 holds great promise if it is enacted by the federal government and adopted by all of the states to provide an effective alternative dispute resolution system in the medical liability field."

The Council of Medical Specialty Societies commented that "This is an early settlement bill which has faults but might well reduce costs." The University Risk Management and Insurance Association commented that the bill ". . . requires more study, there are some aspects that are quite appealing."

A number of organizations expressed concerns with the bill. For example, the American Society of Anesthesiologists commented that "as written, this legislation is too broad and its impact on the problem is not predictable." The American Academy of Family Physicians saw "many

problems . . . it may be more expensive than current system." The American Medical Association stated:

"The bill will be more costly. No evidence exists [that] it will reduce defensive medicine practices. It forces another system on some states without major problems. It tends to place decisionmaking authority with the insurer, not the physician."

The National Senior Citizens Law Center commented:

"This legislation would not achieve what it was designed to and would penalize old and/or poor people to whom lost earnings measures of damages do not apply. It singled out one small class of tort litigants—people on Medicare or Medicaid or other federal programs who had malpractice claims—for different, unfair, and highly discriminatory treatment."

The St. Paul Companies, Inc., stated that "as drafted, the bill has many flaws. The concept of a modified no-fault approach with a right of appeal, however, holds some promise in principle."

Use of a Social Insurance System

Supporting federal implementation of social insurance, the American College of Obstetricians and Gynecologists commented that "federal social insurance system for medical catastrophes . . . would go a long way toward resolving some of the current problems in the system."

Supporting federal and state implementation, the National Association of Childbearing Centers stated that ". . . [social insurance] would introduce greater equity [but] needs control." The People's Medical Society stated:

"This [social insurance] may prove to be an expensive venture and since it would probably be funded by taxpayers it may not be too popular. The responsibility for medical malpractice should remain with those who caused it."

The American Association of Retired Persons commented:

"Such a system would have no deterrent effect. Before it is generally accepted that medical malpractice 'is a way of life' we should make every effort to support measures that reduce the incidence of medical malpractice and that modify the environment in which medical malpractice claims are made."

The Blue Cross and Blue Shield Association commented:

". . . If it [social insurance] contemplates an 'entitlement' system a la Medicare, costs could soar and problems associated with a no-fault program would arise."

The American Medical Association stated that "to date, proposals for this insurance have been poorly drafted and probably will be expensive. England's system is not one that we suggest the U.S. system should be modeled after." The Physician Insurers Association of America commented that social insurance would be "too costly," and the St. Paul Companies, Inc., stated that ". . . if by it you mean a social security-type system, the cost would be prohibitive."

Views on Possible Actions to Reduce Incidence of Medical Malpractice Claims

We asked the groups surveyed to indicate their support for various actions, not directly related to the tort system, for resolving medical malpractice problems. These approaches focused on possible actions to reduce the incidence of malpractice claims. We did not determine the extent to which these measures have been implemented, however.

As shown in table 4.7, legal and consumer groups strongly supported a variety of actions, including:

- Strengthening the licensing and relicensing of physicians and hospitals.
- Imposing sanctions/disciplinary measures against physicians and hospitals with medical malpractice histories.
- Increasing peer review of physicians' medical practices.
- Increasing information available to consumers about physicians and hospitals with medical malpractice histories.

In addition, the professional providers, hospital-affiliated, and legal groups supported use of risk management programs.

The professional provider, consumer, and health care insurer groups said that most of the actions they supported should be taken at the state level, while the legal and hospital-affiliated groups believed that most actions they supported should be taken at both the state and federal levels (see pp. 124 through 127).

Table 4.7: Actions to Address Medical Malpractice Problems Strongly Supported by Groups Surveyed

Action	Professional provider (n=14)	Hospital affiliated (n=5)	Medical malpractice insurer (n=3)	Legal (n=6)	Consumer (n=7)	Health care insurer (n=2)
Use of risk management programs:						
State level	X	X	•	X	•	•
Federal level	•	X	•	X	•	•
Strengthen licensing and relicensing for physicians:						
State level	•	•	•	X	X	•
Federal level	•	•	•	X	•	•
Strengthen licensing and relicensing for hospitals:						
State level	•	•	•	X	X	•
Federal level	•	•	•	X	•	•
Impose sanctions/disciplinary measures against physicians and hospitals with medical malpractice histories:						
State level	•	•	•	X	X	•
Federal level	•	•	•	•	•	•
Increase peer review of physician's medical practice:						
State level	•	•	•	X	X	X
Federal level	•	•	•	X	•	•
Increase information available to consumers about physicians and hospitals with medical malpractice histories:						
State level	•	•	•	X	X	•
Federal level	•	•	•	X	X	•

Legend:
X=Majority of responding organizations in interest group strongly supported this action.
N=Number of responding organizations in specific interest group.

Following are selected comments provided by respondents regarding these actions.

Risk Management Programs

Commenting on risk management programs, the St. Paul Companies, Inc., said that "Reducing the incidents of malpractice through risk management programs is undoubtedly the single most effective way to reduce costs to the system." The American College of Legal Medicine commented that: "[Risk management programs allow] better patient care, . . . [and] fewer 'problems' because they are anticipated and corrected before they occur."

The National Senior Citizens Law Center said that ". . . the federal government could establish minimum requirements; the state could then

expand [them]." In support of state actions, the People's Medical Society stated:

"This may be the one positive step in searching for a solution to malpractice. The [risk management] program must have teeth to deal with providers and must be free to take strong action. It should be implemented at the state level."

The American Association of Retired Persons stated:

"Risk management, without [something] more, will probably not reduce the incidence of medical malpractice. What it may do is reduce the number of claims. To reduce the incidence of medical malpractice, a risk management program must be coupled with a strong quality assurance program."

However, the American College of Obstetricians and Gynecologists commented:

"Risk management programs are already being implemented on a voluntary basis by physician groups and hospitals, and state or federal action does not appear to be necessary in this area."

The American Medical Association commented:

"Risk management programs are essential in identifying the types of procedures or practices that may lead to claims and injuries. By identifying these issues, problems can be avoided. While the state and federal government should use these programs, they should not also be responsible for their development and implementation."

Physician Licensing and Relicensing

Commenting on strengthening physician licensing and relicensing, the People's Medical Society commented:

"Revoking a license, or restricting a practitioner who has been convicted of malpractice is a positive step. Since all medical practitioners are licensed by states, the state level is the appropriate level to take action. In [addition], each state should be responsible for reporting the names of all providers who had lost a license, or had an action against them to the federal government. A national hot line should be established to track these people."

The American Association of Retired Persons stated:

"In many states the standards for licensing and relicensing of physicians are not designed to ensure that physicians who may be impaired or negligent are not allowed to practice. Licensing laws should be examined to determine their relationship to the incidence of medical malpractice. As with hospitals, the key may not be strengthening; rather, the licensing and relicensing mechanism may have to be modified in order to effectively weed out those providers that contribute significantly to the medical malpractice problem."

The Blue Cross and Blue Shield Association commented:

"We see a need to improve the capacity of state regulatory authorities and operation of private certification mechanisms to identify and 'delicense/decertify' incompetent providers. Prefer to see enforcement of existing rules than creation of new."

The American College of Obstetricians and Gynecologists said:

"Licensing and relicensing of physicians has traditionally been a state responsibility and should remain so. A strengthening of these mechanisms would help to eliminate the portion of the problem which is caused by the negligent physician."

The American College of Legal Medicine said that state and federal actions would "weed out bad actors, incompetents—both behaviorally and professionally."

The American Medical Association commented:

"Licensing, particularly the problem of physicians moving from one state to another, needs to be addressed. However, the current situation will not be eliminated by licensing requirements. A negligent act is not the same thing as incompetence."

Hospital Licensing and Relicensing

Commenting on strengthening licensing for hospitals, the American College of Obstetricians and Gynecologists said:

"Licensing or relicensing of hospitals has traditionally been a state function and should remain so. An increased effort in this area would ensure that hospitals have proper risk management, incident management, and quality assurance programs in place, which should help to improve outcomes."

The People's Medical Society said:

"[State and federal actions] coupled with a strong risk management program may [finally] give hospitals a reason to be more concerned with malpractice. If a hospital fails to take action, they could incur sanctions which may mean a shut-off of federal funds."

The National Senior Citizens Law Center stated:

"Improved enforcement of licensing requirements could, possibly, reduce the incidence of tort claims but is not likely to erase them altogether. Federal government could provide greater financial and technical assistance to state enforcers."

The St. Paul Companies, Inc., stated:

"To the extent the measures are sufficiently meaningful to keep unqualified providers from practicing medicine, such actions should be beneficial."

However, the American Society of Plastic and Reconstructive Surgeons commented that hospital licensing and relicensing seems to be "fairly well done now."

Sanctions or Disciplinary Measures

Commenting on sanctions or disciplinary measures for physicians and hospitals, the American College of Obstetricians and Gynecologists commented:

"Sanctions and disciplinary measures against physicians and hospitals have traditionally been a state matter and should remain so. An increased effort in this area will help reduce, to a certain extent, the part of the problem that is caused by negligent physicians or hospitals."

However, a number of organizations expressed concerns about sanctions. For example, the Council of Medical Specialty Societies said "sanctions are not helpful—education is." The American Society of Plastic and Reconstructive Surgeons said "It is possible for a hospital or doctor to have a series of unwarranted suits. He should not have sanctions for this." The American Association of Neurological Surgeons said "Adverse malpractice histories are not a valid reflection of a provider's ability, competence, or expertise."

The American Academy of Family Physicians commented:

"I do believe more aggressive disciplinary actions need to be taken against incompetent physicians. However, the number of malpractice suits filed against a physician is not necessarily indicative of a physician's competence as some of the best physicians doing the most difficult, high risk procedures are more likely to be sued than others."

The American Medical Association stated:

"Professional liability lawsuits, if they indicate a history of repeated negligence, should be the basis for license revocation. Otherwise, the tort system is, and state disciplinary/licensing boards have, adequate authority to discipline physicians."

The St. Paul Companies, Inc., commented:

"To the extent the measures are sufficiently meaningful to keep unqualified providers from practicing medicine, such actions should be beneficial. However, the number of claims filed against a particular health care provider is not necessarily a sound indication of malpractice. Fine physicians performing breakthrough medical procedures often are targets of suits."

Peer Review of Physician Medical Practices

Commenting on peer review, the American College of Obstetricians and Gynecologists said:

"Peer review of physicians medical practices has traditionally been a state matter and should remain so. Once again, an increased state effort in this area will help reduce that part of the problem that has been caused by negligent physicians."

The American Association of Neurological Surgeons stated:

"Peer review should remain a professional obligation and an accountability measure—it should be performed by medical and specialty societies, accreditation agencies, and peer review organizations. [The] State Board of Medical Examiners [should] also play a role."

The Council of Medical Specialty Societies said:

"Adequate peer review would clearly bring to the attention of careless physicians reasonable suggestions for change—less well informed MD's could also be stimulated to get educated since they would be more easily identified by peer review."

The People's Medical Society said:

"Not only increase peer review, but publicize the results of the review. Too many mistakes are still swept under the rug by a hospital review group, and no action is taken."

Increase Information Available

In commenting on providing more information to consumers about physicians and hospitals with medical malpractice histories, the American Association of Retired Persons stated:

"In a world of competition, one of the most effective deterrents for medical malpractice would be increased consumer information. It would be a good role for the federal government."

However, several organizations expressed concerns about this action. For example, the American Society of Plastic and Reconstructive Surgeons commented:

"Consumers are not in a position to understand the difference between real and unwarranted suits. They believe a suit means [that a] doctor or hospital is bad, so this is dangerous to [patient], doctor, and hospital."

The American Medical Association said:

"Court records are available. An incident or a few incidents of malpractice do not necessarily translate into incompetence (i.e., high risk practice). The potential for misuse of this data is great."

The American College of Obstetricians and Gynecologists stated:

"Increasing this sort of information smacks of 'big brother.' It would be preferable for the states to undertake effective peer review licensing and disciplinary measures as an alternative."

The American Academy of Family Physicians commented:

". . . not sure what constitutes a 'medical malpractice history.' It would be a great disservice to hospitals and physicians if government took steps to publicize information about hospitals or physicians based solely on suits filed rather than actual incompetence. Those who repeatedly 'malpractice' probably should lose their license so informing the public would be unnecessary."

The National Association of Childbearing Centers said it was "Concerned about 'witch-hunt'—but could be very effective. More important is education of consumer on how to shop in purchasing services." The St. Paul Companies, Inc., said it is "virtually impossible to provide such information in a non-misleading fair way." The Physician Insurers Association of America commented:

"In certain states some specialties are targets for many suits. Today, payment of an indefensible case is not always indicative of poor medical ability. Such unjustified publicity would further slow the legal process as insureds refused to settle."

Views on Federal Roles in Addressing Malpractice Problems

A majority of the organizations in two interest groups strongly supported different roles for the federal government. The professional provider interest group strongly supported the federal government providing technical assistance to states, while the consumer group strongly supported federal financial incentives and/or penalties to encourage states to act (see pp. 128 through 131).

Technical Assistance

In supporting a federal role of technical assistance, the American College of Obstetricians and Gynecologists commented that "model legislation may help to provide a more unified nationwide system in the medical liability area if it is coupled with the proper incentives." The American Academy of Family Physicians stated that "federal initiatives to encourage and assist states may be appropriate." The American Association of Neurological Surgeons believed that a federal technical assistance role would be prudent and proper. The Public Citizens Health Research Group commented that a federal role of providing technical assistance "would be particularly effective if tied to funding assistance for improvement."

However, the Peoples' Medical Society said "this [technical assistance] should be done on an advisory basis only and should not be legislatively imposed." The Consumer Federation of America added that there is "no need for federal involvement."

Financial Incentives and/or Penalties

The American Medical Association commented that it "is proposing that the federal government provide financial incentives to states to enact specified tort reform. To this extent only, federal intervention is appropriate." The People's Medical Society commented:

"One method of encouraging state action would be a cut-off of federal funds for medical schools and research. However, other sanctions should also be considered which impact upon the medical professional and not the patients."

The American College of Obstetricians and Gynecologists commented:

"Financial incentives and/or penalties as national legislation should only be considered if coupled with model legislation which significantly changes the traditionally fault-based system"

Establishing National Policy Regarding Compensation

The American College of Obstetricians and Gynecologists said:

"a national compensation system for medically-induced injuries which would replace the traditional fault-based system would help to stabilize the situation and remove the adversary atmosphere from these types of cases."

The American Academy of Ophthalmology commented that a national policy "would provide more equity." The Council of Medical Specialty Societies stated that "We need to set nationally agreed amounts for pain and suffering. Since this area is not quantifiable, it needs to be addressed in a policy way nationally." The People's Medical Society cautioned that "if a policy is established on compensation, it should serve as a guideline and not be utilized to set awards."

However, the American Medical Association commented that "defining compensable injuries, the extent of injuries, and the amount of compensation could be unworkable." The Physician Insurers Association of America stated that it would be "too revolutionary, if history with [the] federal workers compensation schedules are an example. Awards are much higher than average state would pay." The Consumer Federation of America commented that establishing such a national policy would be an "appropriate federal role if the Congress decides to federalize broad malpractice issues."

Mandating Uniform System for Resolving Malpractice Claims

Most respondents' comments reflected the lack of support for a federal uniform system for resolving malpractice claims. For example, the College of American Pathologists commented that this role was "not a proper function of [the] federal government." The Council of Medical Specialty Societies commented that "States would resist this encroachment on states' rights." The Blue Cross and Blue Shield Association stated that "the local variances in the malpractice 'problem' argues against a uniform solution."

Other Federal Roles

The American College of Nurse-Midwives strongly supported a federal role of "[providing] reinsurance for health care providers unable to obtain insurance in the open market." The University Risk Management and Insurance Association also strongly supported a federal role of providing federal or state reinsurance for health care providers.

The People's Medical Society strongly supported a federal role of maintaining a national directory of all health care providers who have been found guilty of malpractice and those which have lost their licenses.

The American Association of Retired Persons strongly supported a federal role of establishing a national clearinghouse on information relating to medical malpractice and commented:

"No other issue begs for objective and accurate data to the extent the malpractice issue does. Where good data does exist it has been obscured by the various interests involved. There is also a need for primary data gathering to more fairly understand the scope of the medical malpractice problem."

The Medical Malpractice Insurance and Legal Systems and Responses to Mid-1970's Crisis

A description of the medical malpractice insurance system, the legal system for resolving malpractice claims, and the responses to the mid-1970's crisis follows:

The Malpractice Insurance System

Most health care providers buy medical malpractice insurance to protect themselves from medical malpractice claims. Under the insurance contract, the insurance company agrees to accept financial responsibility for payment of any claims up to a specific level of coverage during a fixed period in return for a fee. The insurer investigates the claim and defends the health care provider.

Structure of the Market

Medical malpractice insurance is sold by several types of insurers—commercial insurance companies, health care provider owned companies, and joint underwriting associations.

In addition, some large hospitals elect to self-insure for medical malpractice losses rather than purchasing insurance, and a few physicians practice without insurance.

Commercial insurance companies involved in the medical malpractice market may also market other lines of property and casualty insurance. The largest commercial insurer in the malpractice market is the St. Paul Fire and Marine Insurance company. St. Paul's national market share on the basis of direct premiums written in 1984 was 17.9 percent.[1]

According to a St. Paul Company official, the firm markets other types of property and casualty insurance, such as auto, fire, and homeowners. Further, a St. Paul Company official said that of total direct premiums written in 1984, 19.9 percent were for medical malpractice coverage and that the firm marketed its policies to physicians in 43 states and to hospitals in 47 states as of November 1985.

A number of insurance companies are owned by health care providers. These companies are usually sponsored by state or county medical societies or hospital associations. The largest medical society created, physician-owned company is the Medical Liability Mutual Insurance Company of New York. On the basis of direct premiums written, this

[1]"General Liability and Medical Malpractice Insurance Marketing -1984," Best's Review, September 1985, pp. 18, 108.

company's national market share was 6.2 percent in 1984.[2] Medical Liability Mutual insures only New York physicians, according to a company official. The largest hospital association owned company is the Pennsylvania Hospital Insurance Company, according to company officials. This provider-owned company is licensed to write malpractice insurance for physicians and hospitals not only in Pennsylvania, but also in 18 other states and the District of Columbia.[3] On the basis of direct premiums written, this company's national market share was 2.6 percent in 1984.[4]

Joint underwriting associations are nonprofit pooling arrangements created by state legislatures to provide medical malpractice insurance to health care providers in the states in which they are established. Although created by a number of states as interim measures to help health care providers find sources of malpractice insurance during the mid-1970's, joint underwriting associations continue to be an important source of coverage in some states. For example, according to officials we contacted, they currently insure most physicians in Massachusetts, Rhode Island, and New Hampshire. Joint underwriting associations are established on the premise that they will be self-supporting through the premiums collected; however, laws establishing the associations generally provide that policyholders can be assessed, up to a specified amount, for deficits experienced by the association. Deficits exceeding those that can be recouped from policyholders can generally be covered through assessments of any company authorized to write casualty insurance or specified lines of insurance in the state.

Size of the Market

The size of the medical malpractice insurance market is difficult to accurately define and quantify because data from a number of insurers involved in selling malpractice insurance are not included in that reported by the A. M. Best Company. Best, the leading insurance rating service in the United States, annually publishes financial data on insurance companies. According to data reported by Best, 160 companies writing medical malpractice insurance in 1983 had direct premiums

[2]Ibid., p. 108.

[3]Testimony Presented to the U.S. Senate Committee on Labor and Human Resources by Donald G. Steffes, President, the Phico Group, July 10, 1984, pp. 2-3.

[4]"General Liability and Medical Malpractice Insurance Marketing -1984," op. cit., p. 108.

written totaling $2 billion.[5] Best reported that direct premiums written for medical malpractice insurance in 1984 totaled $2.3 billion.[6] However, it is believed that a substantial part of the total medical malpractice insurance market is unmeasured. The unmeasured market includes joint underwriting associations, patient compensation funds, a number of provider-owned companies, and self-insurance arrangements by hospitals. The American Medical Association's Special Task Force on Professional Liability and Insurance estimated in 1985 that medical malpractice insurance premiums totaled about $4 billion.[7]

Types of Policies

Malpractice insurance is written as either an occurrence or claims-made policy. Under an occurrence policy, the insurance company is liable for any incidents that occurred during the period the policy was in force, regardless of when the claim may be filed. A claims-made policy provides coverage for malpractice incidents for which claims are made while the policy is in force. Premiums for claims-made policies are generally lower and increase each year during the initial 5 years of the policy because the risk exposure is lower. However, usually after 5 years, the premiums mature or stabilize. About one-half of total premiums now written for medical malpractice insurance are for claims-made policies.[8]

To cover claims filed after a claims-made policy has expired, health care providers can purchase insurance known as "tail" coverage.

Limits of Coverage

Typically, medical malpractice insurance policies have a dollar limit on the amount that the insurance company will pay on each claim (per occurrence) and a dollar limit for all claims (in aggregate) for the policy period, which is usually 1 year. Insurance companies usually have minimum and maximum levels of coverage they will write which may vary depending on the risk or physician's specialty.

[5]"Comparative Experience by State, United States - Medical Malpractice," Best's Executive Data Service, A.M. Best Company, Inc., 1984, p. A5-99-50.

[6]"General Liability and Medical Malpractice Insurance Marketing -1984," op. cit., p. 108.

[7]American Medical Association, Response of the American Medical Association to the Association of Trial Lawyers of America Statements Regarding the Professional Liability Crisis, 1985, p. 5.

[8]Robert Pierce, What Legislators Need to Know About Medical Malpractice, National Conference of State Legislatures, July 1985, p. 5.

Malpractice insurance coverage may be purchased in layers because many insurance companies have maximum limits of coverage they will write for individual risks. If the health care provider desires additional coverage above the company's maximum limits, additional coverage may be purchased from one or more other insurance companies. The first layer of coverage is commonly known as basic coverage; the liability coverage above the basic level is known as excess coverage. Umbrella policies usually cover in a single policy professional, personal, and premises liability up to a specified limit. Generally, umbrella policies provide coverage when the aggregate limits of underlying policies have been exhausted.

Ratemaking

The objective in establishing insurance rates is to develop rates that will be appropriate for the period during which they apply. To be appropriate, the rates must generate funds to cover (1) losses occurring during the period, (2) the administrative costs of running the company, and (3) an amount for unknown contingencies, which may become a profit if not used. The profit may be retained as capital surplus or returned to stockholders as dividends.

Ratemaking attempts to predict future claims and expenses are based on past experience. For two reasons, ratemaking is very complicated. First, circumstances change over time, and many of these changes affect the number (frequency) of claims or the dollar amount (severity) of losses—the two primary factors that affect the cost of insurance. Inflation increases the average severity of claims, and changes in legal theories may increase the frequency and severity of claims. Second, the use of historical statistics to predict future losses is based on the law of large numbers—as the number of insured physicians and hospitals increases, actual losses will approach more closely expected losses.[9] The medical malpractice insurance market is small, thus the statistical base for making estimates of future losses is relatively small. As a result, it is difficult to set accurate premium prices.

The "long tail" of malpractice insurance (the long length of time that may elapse after an injury occurs before a claim is filed and settled) is a further complicating factor because the data base used for estimating future losses may not reflect current actual losses. For example, the St. Paul Fire and Marine Insurance Company's experience indicates that

[9]Bernard L. Webb, et al., Insurance Company Operations - Volume II, American Institute for Property and Liability Underwriters, 1984, p. 4.

". . . 30 percent of its claims are filed in the year of treatment, 30 percent in the year after treatment, 25 percent in the third year, 7 percent in the fourth year, and 8 percent in years five through 10."[10]

Additionally, according to a St. Paul Company official, the firm's experience for physicians and surgeons indicates that 6 percent of its payments for claims are made in the year the claim was reported, 21 percent in the first year after the claim was reported, 21.3 percent in the second year, 15.6 percent in the third year, 11.2 percent in the fourth year, 8 percent in the fifth year, and 16.9 percent after 5 years.

Variation of Rates

Malpractice insurance rates for physicians vary by specialty and geographic location and generally increase proportionate to the amount and complexity of surgery performed. Rates may vary from state to state and within a state. For rating purposes, insurance companies usually group physician specialties into distinct classes. Each class represents a different level of risk for the company.

The number of and composition of rating classes may vary from company to company. For example, the St. Paul Company uses 8 rating classes for physicians, whereas the Medical Liability Mutual Insurance Company of New York uses 14. Rates are typically determined based on the claims experience of the rating class rather than on the experience of the individual physician. Some insurance companies assess a surcharge, in addition to the standard rate, for physicians with an unfavorable malpractice claims experience. Malpractice insurance rates for hospitals are frequently based on the malpractice loss experience (in terms of numbers of claims filed and the amount per paid claim) of the individual hospital. For example, in determining its rates, the St. Paul Company includes a factor to adjust its standard rates for the individual hospital's historical malpractice loss experience.

Regulation of Rates

Statutory requirements generally provide that insurance rates be adequate, not excessive, and not unfairly discriminatory. The degree of regulation of medical malpractice insurance rates varies from state to state. For example, New York has "prior approval" authority in which all rates must be filed with the insurance department before use and must be either approved or disapproved by the superintendent of insurance. Arkansas, Indiana, and North Carolina have "file and use" laws, under

[10]Pierce, op. cit., p. 5.

which the insurers must file their rates with the state's insurance department before the rates become effective; however, the rates may be used without the department's prior approval. The rates may be disapproved if they violate the state's statutory requirements. In California, insurers are not required to file their rates with the state insurance department but may be required to furnish rates and supporting information if requested.

Loss Reserves

Insurance companies are required by state law to establish reserves to cover future losses from claims. Reserves are liabilities based on estimates of future amounts needed to satisfy claims. In addition to amounts covering indemnity payments, the reserves may also include amounts to cover the company's administrative and legal expenses in handling the claims.[11] [12]

Determining proper reserves for medical malpractice claims presents difficulties for insurance companies because such claims may require years to be resolved. Accurate reserves are difficult to establish because the companies must estimate losses incurred but not reported, losses reported but not paid, and losses partially paid but which continue for several years.[13]

Insurance companies derive investment income from those assets encumbered for loss and loss expense reserves, from unearned premium reserves, and from the company's capital and surplus.

Reinsurance

Insurance companies buy reinsurance from other insurers to cover potential losses that may be too large for the individual company to absorb. Reinsurance allows companies to share their risks with other companies and to stabilize insurance losses, which may fluctuate considerably.[14]

[11]U.S. General Accounting Office, Congress Should Consider Changing Federal Income Taxation of the Property/Casualty Insurance Industry, GAO/GGD-85-10, March 25, 1985, p. 11.

[12]Webb, et al., op. cit., p. 281.

[13]Ibid., p. 273.

[14]Bernard L. Webb, et al., Insurance Company Operations, Volume I, American Institute for Property and Liability Underwriters, 1984, pp. 321-324.

The reinsurance market consists of both U.S. and foreign reinsurers and reciprocal reinsurance arrangements among primary insurers. Foreign reinsurers account for a significant share of the reinsurance market. For example, in 1982 about 20 percent of the estimated reinsurance premiums written for U.S. property and liability insurance were paid to foreign reinsurers. Bermuda is a major market for reinsurance, accounting for about 86 percent of all reinsurance purchased in 1982 by U.S. insurers from non-U.S. reinsurers within the Western Hemisphere.[15]

The capacity and willingness of the international reinsurance market to accept part of the risk for potential malpractice losses is important to ensuring the availability of medical malpractice insurance.[16]

The Malpractice Legal System

The medical malpractice legal system encompasses the laws and legal process for seeking compensation for malpractice claims. Only a small percentage of the claims make full use of the legal system (i.e., proceed to jury verdict rather than being dropped or settled). The litigants' decisions on whether to proceed to jury verdict often depend on the cost of and likely outcome from doing so.[17]

Basis for Claim

Medical malpractice claims or lawsuits are generally based on tort law. A tort is a wrongful act or omission, not based on a contract, of an individual which causes harm to another individual. Establishing fault is essential for proving tortious conduct. As it relates to medical malpractice cases, tort law provides a framework for compensating individuals injured by medical malpractice and discouraging substandard medical care because of the threat of lawsuits.[18]

Negligence is the tort upon which most medical malpractice lawsuits are based. To recover damages in court for negligence, the plaintiff's attorney must show that

- the provider failed to meet an acceptable standard of care owed to the patient and

[15]Ibid., pp. 359-360, 363, 365.

[16]American Medical Association, Response to Trial Lawyers, op. cit., pp. 2-3.

[17]Pierce, op. cit., p. 3.

[18]Ibid.

- the provider's failure caused an injury to the patient resulting in damage or loss.

The acceptable standard of care is determined in each case. The injured party must show by expert testimony from health care providers usually from the same specialty and locality that the health care provider departed from the prevailing level of care.

Attorney Involvement

An attorney is almost always needed to sue a health care provider for medical malpractice. Getting an attorney to accept the case may be a problem for the claimant. In deciding whether to accept the case, the attorney considers the:[19]

1. Technical validity of the claim, such as whether the statute of limitations has expired.

2. Apparent degree of the health care provider's liability. Attorneys almost always consult with a physician as to whether there is negligence from which they determine the degree of liability present.

3. Economic factors, namely whether the amount to be recovered merits the attorney's time to pursue the case.

Since most malpractice plaintiff attorneys are paid on a contingency fee basis, the economic factors associated with the case are particularly important. Under the contingency fee arrangement, the attorney is paid a percentage, commonly from 30 to 50 percent, of any award or settlement.[20]

For claims with no award or settlement, the plaintiff attorney does not collect any fee; however, the plaintiff must still pay for other expenses, such as court costs and the attorney's expenses for obtaining evidence. According to Jeffrey O'Connell, Professor of Law, University of Virginia Law School, most plaintiff attorneys will not accept a medical malpractice case with a recoverable amount less than $50,000. A study conducted from January 1970 through September 1972 found that plaintiff

[19]Gerald S. Adler, "Medical Malpractice in Sociological Perspective," Columbia University, 1979, p. 28.

[20]American Medical Association Special Task Force on Professional Liability and Insurance, Professional Liability in the 80's Report 2, American Medical Association, November 1984, p. 22.

attorneys accepted only one out of every eight medical malpractice cases brought to them.[21]

Resolution of Claims

Several states require that malpractice cases be heard by a pretrial screening panel before the case can proceed to court. The function of the panel is to reduce the number of cases going to court by identifying before trial whether the case is meritorious. However, regardless of the panel's decision, the plaintiff can continue the case to court.

The plaintiff and defendant have the option to agree to settle a malpractice claim at any time. In fact, most medical malpractice claims are dropped or settled before they reach jury verdict. For example, a study of 5,832 medical malpractice claims closed by insurance companies during 1974 and 1976 found that only about 7 percent of the claims went to final jury verdict, while about 50 percent were settled and about 43 percent were dropped.[22]

Types of Compensation

In most medical malpractice cases, plaintiffs seek compensation for both economic and noneconomic damages. Economic losses include medical and rehabilitative care expenses and lost wages. Noneconomic damages include amounts for pain, suffering, marital losses, and anguish. Punitive damages available for gross negligence and outrageous conduct of the provider are rarely awarded by juries in medical malpractice cases.

Noneconomic damages may represent a substantial proportion of awards. For example, a 1985 Florida Medical Association study estimated that 51 percent of the plaintiffs who win a verdict receive an award for pain and suffering over $100,000 and, for these cases, the pain and suffering component represents about 80 percent of the total award.[23]

The cost of litigating a medical malpractice case is high. For example, one study estimated that the plaintiff's litigation cost is between 38 and

[21]Stephen K. Dietz, C. Bruce Baird, and Lawrence Berul, "The Medical Malpractice Legal System," Appendix: Report of the Secretary's Commission on Medical Malpractice, Department of Health, Education, and Welfare, DHEW Publication No. (OS) 73-89, January 16, 1973, pp. 89, 97.

[22]Patricia Munch Danzon and Lee A. Lillard, "Settlement Out of Court: The Disposition of Medical Malpractice Claims," Journal of Legal Studies, Vol. XII, June 1983, pp. 347-348.

[23]Florida Medical Association, Medical Malpractice Policy Guidebook, Henry Manne, ed., 1985, pp. 133, 135.

45 percent of the gross recovery from medical malpractice claims.[24] Another study estimates that the plaintiff receives about 40 cents out of every dollar paid for medical malpractice insurance, while the other 60 cents goes for other costs, such as legal costs and insurance overhead expenses.[25]

Responses to Mid-1970's Crisis

Most of the responses to the mid-1970's crisis dealt with changes in the insurance industry to increase the availability of insurance and legal procedures to reduce the cost of malpractice insurance.

Changes in the Insurance Industry to Increase Availability of Insurance

Two major changes occurred in the mid-1970's to increase the availability of medical malpractice insurance. One involved creating new sources of insurance; the other involved changing the type of insurance policy being offered.

New Sources of Insurance

New sources of medical malpractice insurance developed from the establishment of joint underwriting associations, reinsurance exchanges, physician and hospital-owned insurance companies, hospital self-insurance programs, and state-administered excess-limits or patient compensation funds.

Seventeen states enacted enabling legislation creating nonprofit joint underwriting associations to provide medical malpractice insurance where it was not available from private insurers.[26] Although joint underwriting association provisions were seen usually as temporary measures until the market had stabilized, some continue as important sources of insurance in such states as Massachusetts and South Carolina. Similar to a joint underwriting association, the reinsurance exchange provides for pooling risks up to a specified amount but leaves the administration and underwriting activities with an insurance company rather than transferring them to a separate association.

[24]M.W. Reder, "Medical Malpractice: An Economists' View," American Bar Foundation Research Journal, 1976, p. 546.

[25]Patricia Munch, The Costs and Benefits of the Tort System If Viewed as a Compensation System, Rand Corporation, Santa Monica (p. 5921), June 1977, as reported in Florida Medical Association, Medical Malpractice Policy Guidebook, 1985, p. 143.

[26]Franklin W. Nutter," The Second Time Around," Best's Review, August 1985, p. 22.

The mid-1970's crisis was also the impetus for the creation of provider-owned insurance companies to provide medical malpractice insurance coverage and to reduce premiums. By the end of 1977, there were 15 medical society-created, physician-owned insurance companies covering about 76,000 physicians. Several other physician-owned insurance companies not linked to medical societies were also operating. By 1984, there were 30 physician-owned insurance companies writing over 50 percent of malpractice coverage.[27] [28]

Several hospitals dropped their insurance coverage and began to self-insure, either completely or up to a specified amount.

A few states established state-administered insurance programs known as patient compensation funds to limit the potential liability of the individual physicians. Health care providers participating in patient compensation funds can limit their liability for medical malpractice losses by (1) carrying some specified level of basic insurance coverage or proving that sufficient assets are available to cover losses up to the amount and (2) paying a surcharge into the fund. In states that have capped total malpractice awards, the fund will pay for losses between the basic coverage limit and the total maximum award. For funds in states with no maximum award limit, there may be specific legislative provisions to avoid depletion of the fund.

Change in Type of Policy

The second major change in insurance practices involved a switch in type of policy written from an occurrence to a claims-made basis. Before 1975, most medical malpractice insurance policies were occurrence policies. However, the unexpected increases in frequency and amount of claims in the mid-1970's underscored the long tail problem of this line of insurance as insurance companies experienced problems in reliably predicting their future losses and setting accurate premium prices. To alleviate this problem, most insurers switched to a claims-made policy to enable companies to use more recent claims experience for establishing premium prices and reserve requirements.[29]

[27]American Medical Association Special Task Force on Professional Liability and Insurance, Professional Liability in the 80's, Report I, American Medical Association, October 1984, pp. 5-6.

[28]American Medical Association, Response Trial Lawyers, op. cit., 1985, p. 7.

[29]Glen O. Robinson, "The Medical Malpractice Crisis: A Retrospective," forthcoming in Law and Contemporary Problems (1986), March 5, 1985, p. 19.

Changes in Legal Procedures to Reduce the Cost of Insurance

The statutory changes concerning legal rules to reduce the cost of malpractice insurance can generally be grouped into those that affect

- filing claims, such as reforms to shorten the statute of limitations, limit attorney contingency fees, and reimburse defendants' costs in frivolous suits;
- determining amounts recoverable, such as reforms to impose limits on size of malpractice awards, require consideration or offset of amounts obtained from collateral sources, allow or require periodic payments, and delete from claims filed in courts clauses stating the amounts plaintiffs are attempting to recover;
- defining standards of medical care or burden of proof, such as reforms to require local standards of medical care be applied, limit the use of the res ipsa loquitur doctrine (which presumes provider negligence, if not rebutted), and specify qualifications and use of expert witnesses; and
- using the courts in resolving malpractice claims, such as provisions concerning use of pretrial screening panels or arbitration.

The status of these state actions, as of July 1985, is shown in appendix II.

Statute of Limitations

The length of time for medical malpractice claims to be filed was considered a problem for insurance companies in establishing rates and reserve requirements and for defendants in producing pertinent evidence and witnesses. Reforms to shorten or modify a state's statute of limitations were designed to shorten the period of time for filing a malpractice lawsuit after an injury occurs or should have been discovered. As of July 1985, 41 states had provisions in effect that modify their statutes of limitations. Nineteen of these states also had special statutes of limitations in effect for minors. Before the reforms, the statute of limitations for minors to file malpractice claims was suspended until the person reached the age of majority. The reforms usually suspended the statute of limitations for a much shorter time and often specified that the statute would be suspended only until the minor reaches a certain age.[30]

[30]American Medical Association Special Task Force, Report 2, op. cit., pp. 20-21, (updated as of July 1985).

Attorney Fees

As of July 1985, 23 states had legislation in effect to limit attorney contingency fees in medical malpractice cases. This reform was based on the belief that it would lead to more selective screening by plaintiffs' attorneys to ensure that the claims filed had merit. Three approaches for limiting attorneys' fees have been taken:

- A sliding scale that would limit an attorney's fees as the claimant's award or settlement increases.
- Specified percentage of the amount recovered.
- Limiting fees to a "reasonable" amount, as determined by the court.[31]

Awarding Costs, Expenses, and Fees

As of July 1985, 10 states had specific legislation in effect for awarding costs in cases of frivolous actions. This reform was aimed at discouraging frivolous malpractice claims. Generally, when a malpractice plaintiff is found to have acted frivolously in filing claims, the statutes require the malpractice plaintiff to reimburse the health care provider's reasonable attorney's fees, expert witness fees, and court costs in defending the claim.[32]

Limits on Liability

As of July 1985, 12 states had legislation in effect to limit health care providers' liability.[33] The legislation limited the providers' liability in medical malpractice lawsuits by one of the following means:

- Limiting the amount of recovery on certain types of damages (usually noneconomic damages, such as pain and suffering).
- Placing a maximum on the amount of damages recoverable on all damages.
- Placing a cap on provider liability through the use of a patient compensation fund.[34] For example, maximum limits on total damages exist in Nebraska ($1 million) and Indiana ($500,000). Texas has a limit of $500,000, excluding the cost of medical care. California has a $250,000 limit on recovery for noneconomic damages and South Dakota has a limit of $500,000 for "general" damages. The liability of a Wisconsin physician is limited to $200,000 per claim and $600,000 for all claims

[31] Ibid., pp. 17, 18, 20-22.

[32] Ibid., p. 23.

[33] Ibid., pp. 20-21.

[34] Ibid., 18-19.

during a year. This state's patient compensation fund has unlimited liability above the physician's basic coverage. [35, 36] In October 1985, the U.S. Supreme Court refused to hear an appeal of a case testing the constitutionality of limits imposed by California and, in effect, upheld the constitutionality of the limits. [37]

Collateral Sources

This rule of evidence prohibits the introduction of information at a trial concerning benefits the injured patient may have received as compensation for the incident from any other sources (e.g., private health insurance, workers' compensation). During the mid-1970's, a number of state legislatures modified the collateral source rule to reduce duplicate payments for medical malpractice cases. Modifications were of two types. One type required juries to be informed about payments from other sources to the patient during their deliberations in determining the amount of the award. The other type required an offset from the award of either some or all of the amount of payment from other sources. As of July 1985, 17 states had legislation in effect modifying the collateral source rule.[38]

Periodic Payments

As of July 1985, 18 states had periodic payment provisions in effect allowing or requiring courts to convert awards for future losses from a single lump-sum payment to periodic payments over the period of the patient's disability or life. This provision was designed to assure that funds are (will be) available for the purpose intended and to eliminate any windfall to beneficiaries in the event the injured party dies.[39]

Ad Damnum Clause

As of July 1985, 32 states had provisions in effect relating to the ad damnum clause. This clause is the part of plaintiff's initial pleadings that states the amount of monetary damages and other relief requested by the plaintiff in a court action. In medical malpractice claims, the amount the plaintiff initially requests may be inflated and therefore may not accurately reflect the amount of actual damages incurred.

[35] Ibid.

[36] American Medical Association, Limits on Liability, April 1985, pp. 1-2, 6.

[37] Medical Liability Monitor, Vol. 10, No. 10, October 31, 1985, p. 1.

[38] American Medical Association Special Task Force, Report 2, op. cit., pp. 16, 20-21, 23.

[39] Ibid., pp. 19-21.

Large claims may encourage harmful pretrial publicity, damage the reputations of defendants later found not negligent, and influence juries to make awards greater than that indicated by the evidence presented at the trial.[40] Most legislation in this area has provided for the elimination of the clause altogether, thus prohibiting plaintiffs from stating the amount of damages they are attempting to recover in their claims.[41]

Standards of Care/Locality Rule

As of July 1985, 19 states had standard of care provisions in effect.[42] Historically, the standard of care used in medical malpractice cases is the prevailing level of care practiced in the defendant's community. In the early 1970's courts began to interpret "community" to include regional or national standards. This practice was criticized as holding physicians to higher and more costly standards of care and leading to some physicians specializing in testifying for plaintiffs in medical malpractice trials. In response, several states enacted legislation aimed at specifying the appropriate locality (community, state, or national) on which the standard of care should be based.

Res Ipsa Loquitur

The res ipsa loquitur (the thing speaks for itself) doctrine is used in cases where it can be demonstrated that the defendant had exclusive control of the incident. In the early 1970's, a number of states expanded the application of the doctrine and increased its effect from that of a mere inference to a presumption of negligence. This doctrine is commonly used as the basis for a tort claim in cases where a foreign object, such as a surgical instrument or sponge, has been left in a patient's body. Application of the doctrine shifts the burden of proof from the plaintiff to the defendant and requires the defendant to show that the injury did not result from his/her negligence. Since a number of medically caused injuries are not the result of physician negligence, application of the doctrine has been held to place malpractice

[40]Patricia Munch Danzon, "The Frequency and Severity of Medical Malpractice Claims," Rand, R-2870-ICJ/HCFA, Santa Monica, CA, 1982, p. 39.

[41]American Medical Association Special Task Force, Report 2, op. cit., pp. 20-22.

[42]Ibid., pp. 20-21.

defendants at a disadvantage.[43, 44, 45] As of July 1985, 10 states had res ipsa loquitur provisions in effect that either prohibited the use of the doctrine or clarified the circumstances under which it can be used, such as for specific medical injuries.[46]

Expert Witness

Expert witnesses are needed to explain difficult and complex issues in many medical malpractice cases. Because expert witnesses can play an important role in the outcome of cases, some states have enacted legislation pertaining to the qualifications and use of such witnesses. For example, some states, such as Delaware and Idaho, have enacted legislation requiring expert testimony at a trial in order for a plaintiff to prevail on a claim based on negligence. In addition, qualifications for an expert witness may be based on practice in a specific specialty. For example, in order to qualify as an expert witness in a medical malpractice case in Ohio, a physician must devote at least 75 percent of his professional time to the active practice of the medical specialty involved in the action.[47] As of July 1985, 10 states had expert witness legislation in effect to specify the qualifications and use of expert witnesses who testify in medical malpractice cases.[48]

Pretrial Screening Panels

The function of pretrial screening panels is to determine whether a case is meritorious before proceeding to trial and to speed disposition of claims. The pretrial screening panels vary considerably from state to state in their composition and operation. Usually, the state reforms required all malpractice cases to be heard by the pretrial screening panel as a prerequisite to trial. The panel's decision, however, does not prevent the plaintiff from filing a lawsuit. Usually, states allow the panel's decision to be admitted as evidence at a subsequent trial. The constitutionality of mandatory pretrial screening panels has been challenged extensively on the grounds that they interfere with a plaintiff's

[43]Danzon, "The Frequency and Severity of Medical Malpractice Claims," op. cit., pp. 44-45.

[44]Robinson, op. cit., p. 24.

[45]Frank A. Sloan, "State Responses to the Malpractice Insurance 'Crisis' of the 1970's: An Empirical Assessment," Journal of Health Politics, Policy and Law, Vol. 9, No. 4, Winter 1985, p. 634.

[46]American Medical Assoication Special Task Force, Report, 2 op. cit., pp. 20-21.

[47]American Medical Association Department of State Legislation, Standard of Care and Expert Witness Qualification, American Medical Association, April 1985, p. 2.

[48]American Medical Assoication Special Task Force, Report, 2 op. cit., pp. 20-21.

right to a jury trial. As of July 1985, 25 states had pretrial screening panel provisions in effect.[49]

Arbitration

Unlike pretrial screening panels, which are prerequisites to trial by jury, arbitration is a replacement for trial by jury. Supporters of arbitration believe that it offers the benefits of more predictable and equitable results, more prompt claims resolution, and reduced litigation costs compared to trial by jury because it uses an expert panel to resolve claims in a less formal environment. Medical malpractice cases can be resolved under general arbitration statutes in most states; however, in response to the mid-1970's medical malpractice crisis, a number of state legislatures enacted specific provisions pertaining to arbitration of medical malpractice claims. Most of these provisions allow health care providers and patients to voluntarily agree to submit present and future medical malpractice claims to binding arbitration. As of July 1985, 13 states had legislation in effect specifically addressing arbitration of medical liability claims.[50]

[49]Ibid., pp. 15-16, 20-21.

[50]Ibid., pp. 20-22.

Status of State Tort Reforms

Tort reform provisions (as of July 1985)	AL	AK	AZ	AR	CA	CO	CT	DE	FL	GA	HI	ID	IL	IN	IA	KS	KY	LA	ME	MD	MA	MI	MN	MS	MO
Ad Damnum	1	1	1	1	1	1	1		1	1	1		1	2	1	1	1	2	1	1	1			1	1
Arbitration	1	1			1				1	1			1					1	5			2			
Attorney Fees			1		2	1		1	1		1	5	1	2	1	1				1		1			
Awarding Costs				1		1			1				1			1					2				
Collateral Source		1	2		2		1	1	2			5	1		2	1									
Expert Witness								1	1			2	1					1							
Limits on Liability					2							5	3	2			4	1							
Patient Compensation Fund						6			6		5		6	2		1	3	2							
Periodic Payment	1	1		1	2			1	1				1	1		1		1		1		1			
Pretrial Screening Panel		1	2	1			1	1	3		1	1	1	2		1		2	1	1	2				3
Res Ipsa Loquitur		1			1			1	1				1												
Statute of Limitations	2		1	1	1	2		1	1	1	1		2	2	1	2	1	1	1	1	1	1	1	1	1
Special Statute of Limitations for Minors	2		3	1	1	1		1						2		1		1		1	1			1	
Standards of Care	2	2	1	1				1	1	1		2						1				1			

Tort reform provisions (as of July 1985)	MT	NE	NV	NH	NJ	NM	NY	NC	ND	OH	OK	OR	PA	RI	SC	SD	TN	TX	UT	VT	VA	WA	WV	WI	WY
Ad Damnum		1		4		1	1	1		1				1			1	1	1			1		1	3
Arbitration									5	1						1			1	1	1				
Attorney Fees		2	1	3	1		1				1	1	4	5			1		1			1		1	1
Awarding Costs		1		4			1	1					5	5		1									
Collateral Source		2	1	3			5		3	1			3	1		1	1		1			1			
Expert Witness			1	3					4	2	1						1				1				
Limits on Liability		2		3		1			3	1		1			1	1		1			1			1	
Patient Compensation Fund		2				1		1	4			1	1		1									1	6
Periodic Payment				3		1	1		4			1			1							1		2	
Pretrial Screening Panel	2	2	1	1	2	1	1		5	2			3	5			5		1		1			2	
Res Ipsa Loquitur			1	4					3		1			1			1	1							
Statute of Limitations	1	1	1	3		1	1	1	1	1	1	1		1	1	1	2	1	2			1		1	1
Special Statute of Limitations for Minors				3		1	1	1		3				5		1		3	1					1	1
Standards of Care		1	1	4				1	4		1	1					1			1	1	2			

EXPLANATION OF CHART

1 = Provision exists.

2 = Provision found constitutional by highest state court.

3 = Provision found unconstitutional by highest state court.

4 = Provision not severable from an act found unconstitutional by highest state court.

5 = Provision repealed or allowed to expire.

6 = Provision exists in statute, but not implemented.

Source: American Medical Association Division of Legislative Activities, Department of State Legislation.

Organizations Receiving GAO Questionnaire

PROFESSIONAL PROVIDERS

	Completing questionnaire	Not completing questionnaire
01.	American Academy of Pediatrics	American College of Radiology
02.	American Osteopathic Association	American College of Surgeons
03.	American College of Physicians	American Academy of Orthopaedic Surgeons[a]
04.	American Society of Plastic and Reconstructive Surgeons	American Psychiatric Association
05.	American Medical Association	The National Rehabilitation Association
06.	American College of Obstetricians and Gynecologists	
07.	American Academy of Family Physicians	
08.	College of American Pathologists	
09.	American Society of Anesthesiologists	
10.	Council of Medical Specialty Societies	
11.	American Association of Neurological Surgeons	
12.	American Academy of Ophthalmology	
13.	American College of Nurse-Midwives	
14.	National Association of Rehabilitation Professionals in the Private Sector	

HOSPITAL AFFILIATED

	Completing questionnaire	Not completing questionnaire
15.	Council of Teaching Hospitals/Association of American Medical Colleges	None
16.	National Council of Community Hospitals	
17.	University Risk Management and Insurance Association	
18.	American Hospital Association	
19.	National Association of Childbearing Centers	

MEDICAL MALPRACTICE INSURERS

	Completing questionnaire	Not completing questionnaire
20.	The St. Paul Companies, Inc.	Hospital Insurance Forum[a]
21.	Physician Insurers Association of America	American Insurance Association
22.	Alliance of American Insurers	National Association of Independent Insurers

LEGAL

	Completing questionnaire	Not completing questionnaire
23.	Defense Research Institute	Association of American Law Schools
24.	American Society of Law and Medicine	American Bar Association
25.	Association of Trial Lawyers of America	National Health Lawyers Association
26.	National Health Law Program	
27.	National Senior Citizens Law Center	
28.	American College of Legal Medicine	

CONSUMER

	Completing questionnaire	Not completing questionnaire
29.	American Association of Retired Persons	Consumers Union
30.	Chamber of Commerce of the U.S.	National Consumers League
31.	National Insurance Consumer Organization	Business Roundtable
32.	The People's Medical Society	National Association of Insurance Commissioners
33.	Public Citizen Health Research Group	National Conference of State Legislatures
34.	Consumer Federation of America	American Federation of Labor and Congress of Industrial Organizations[b]
35.	Council of State Governments	

HEALTH CARE INSURERS

	Completing questionnaire	Not completing questionnaire
36.	Blue Cross/Blue Shield Association	None
37.	Health Insurance Association of America	

[a]Completed the questionnaire, but stated that responses were not national views.

[b]Classified as not completing the questionnaire since they answered only two questions.

Organizational Questionnaire Results

This appendix contains five tables that provide the organizational questionnaire results regarding (1) medical malpractice problems, (2) the impact of tort reforms and other actions, (3) the impact of medical malpractice suits or the threat of such suits, (4) suggested solutions to medical malpractice problems, and (5) the federal government's role in addressing these problems. Responses include only those scored as major for sections of the questionnaire concerning the malpractice problems and the impact of tort reforms and those scored as strong support for suggested solutions and the role of the federal government. The individual responses of the 37 organizations completing the questionnaire are identified by the numbers 1-37 across the top of the tables. These numbers correspond to those listed for each organization in appendix III.

Table IV.1 shows the medical malpractice problems listed in the questionnaire that were scored by respondents as major problems. This table also shows "Other" major problems volunteered by the respondents. In the table, "C" refers to the problems in the current year (1985) and "F" refers to problems anticipated during the next 5 years (1986-90).

Table IV.2 shows the tort reforms or actions that were scored by respondents as having had a major impact. This table also shows "Other" major impacts volunteered by the respondents for tort reforms or actions listed in the questionnaire. In this table, "*" indicates that the responding organization is aware of the reform or action being implemented in some state, and "X" indicates that the responding organization indicated that the reform has had a major impact overall.

Table IV.3 shows the impact of medical malpractice suits or the threat of such suits. In this table, "D" refers to a decrease, "I" refers to an increase, and "N" refers to no influence.

Table IV.4 shows the suggested solutions listed in the questionnaire for which respondents indicated strong support for federal or state implementation. This table also shows "Other" solutions volunteered by respondents for which they indicated strong support. In this table, "X" indicates strong support for the action. "*F" indicates the action should be taken at the federal level, and "*S" indicates the action should be taken at the state level.

Table IV.5 shows the federal government roles listed in the questionnaire for which respondents indicated strong support. This table also

shows "Other" roles volunteered by respondents for which they indicated strong support. In this table, "X" indicates strong support for the role.

Table IV.1: Medical Malpractice Problems

Major Problems Regarding	Organizations — Professional Provider Group														
	[a]1	2	3	4	5	6	7	8	9	10	11	12	13	14	Sub-total
1. Availability of Medical Malpractice Insurance															
a. Physicians unable to find a source from which the desired levels of **basic** liability coverage can be purchased.			F	F	F	F	F	F				F	F C	F	**9** **1**
b. Physicians unable to find a source from which the desired levels of **excess** liability coverage can be purchased.		F C	F	F	F C	F C	F	F				F	F C	F	**10** **4**
c. Physicians unable to find a source from which the desired coverage for future claims (such as "tail coverage" for claims made policies) can be purchased.		F	F		F		F					F C	F C	F	**7** **2**
d. Hospitals unable to find a source from which the desired levels of **basic** liability coverage can be purchased.		C	F		F		F						F C	F C	**5** **3**
e. Hospitals unable to find a source from which the desired levels of **excess** liability coverage can be purchased.		C	F		F		F						F C	F C	**5** **3**
f. Hospitals unable to find a source from which the desired coverage for future claims (such as "tail coverage" for claims made policies) can be purchased.					F		F							F C	**3** **1**
g. Insurers unable to find a a source from which sufficient levels of **reinsurance** can be purchased.	F C	F C	F		F C	F C	F	F			F	F C	F C	F C	**11** **7**

Hospital Affiliated Group						Medical Malpractice Insurance Group				Legal Group								Consumer Group								Health Insurer Group		
15	16	17	18	19	Sub-total	20	21	22	Sub-total	23	24	25	26	27	28	Sub-total	29	30	31	32	33	34	35	Sub-total	36	37	Sub-total
	F	F		F	3				0						F	1							F	1			0
	C			C	2				0							0								0			0
	F	F		F	3		F		1						F	1							F	1			0
	C			C	2				0						C	1							C	1			0
	F	F		F	3				0	F					F	2	F							1			0
	C			C	2				0							0								0			0
	F	F		F	3				0						F	1							F	1			0
	C	C		C	3				0							0								0			0
	F	F		F	3		F		1						F	1							F	1			0
C	C	C		C	4				0						C	1							C	1			0
	F	F			2				0						F	1								0			0
	C	C		C	3				0						C	1								0			0
	F	F			2		F		1	F					F	2								0			0
	C	C	C	C	4		C		1	C						1								0			0

LEGEND:
C=Current Yr. (1985)
F=During Next 5 Yrs. (1986-1990)
[a]Identification number of responding organization; see appendix III.
[+]Provided by questionnaire respondents.

Major Problems Regarding	Organizations: Professional Provider Group														
	[a]1	2	3	4	5	6	7	8	9	10	11	12	13	14	Sub-total
h. Other+															
(1) MD unable to obtain occurrence coverage to ensure flexibility in practice.											F C				**1** **1**
(2) American College of Nurse- Midwives unable to find carrier to insure members													F C		**1** **1**
(3) Availability of medical malpractice liability insurance for birth centers.															**0** **0**
2. Cost of Medical Malpractice Insurance															
a. Cost of **basic** liability coverage for physicians too expensive.		F C	F	F	F C	F C	F C	F	F C	F C	F C	F C	F C	F C	**13** **10**
b. Cost of excess liability coverage for physicians too expensive.	F	F C	F	F	F C	F C	F C	F	F	F C	F C	F C	F C	F C	**14** **9**
c. Cost of coverage for future claims ("tail coverage") for physicians too expensive.	F	F	F	F	F C	F C	F C		F	F C	F C	F C	F C	F C	**13** **8**
d. Cost of patient compensation fund participation for physicians too expensive.		F C			F C	F	F C		F						**5** **3**
e. Cost of **basic** liability coverage for hospitals too expensive.		F C	F	F C	F C		F C			F C				F C	**7** **6**
f. Cost of **excess** liability coverage for hospitals too expensive.		F C	F	F C	F C		F C			F C				F C	**7** **6**
g. Cost of coverage for future claims ("tail coverage") for hospitals too expensive.		F	F	F	F C		F C			F C				F C	**7** **4**
h. Cost of patient compensation fund participation too expensive for hospitals.		F C			F C		F								**3** **2**

Hospital Affiliated Group						Medical Malpractice Insurance Group				Legal Group							Consumer Group								Health Insurer Group		
15	16	17	18	19	Sub-total	20	21	22	Sub-total	23	24	25	26	27	28	Sub-total	29	30	31	32	33	34	35	Sub-total	36	37	Sub-total
					0				0							0								0			0
					0				0							0								0			0
					0				0							0								0			0
					0				0							0								0			0
				F	1				0							0								0			0
				C	1				0							0								0			0
	F	F		F	3	F	F		2	F					F	2		F					F	2			0
SC				C	2		C		1	C						1		C					C	2			0
	F	F		F	3		F		1	F					F	2		F					F	2			0
C	C			C	3				0	C					C	2		C					C	2			0
	F	F		F	3		F		1	F	F				F	3	F							1			0
	C			C	2		C		1	C					C	2	C							1			0
	F			F	2	F	F		2	F					F	2							F	1			0
	C			C	2		C		1							0							C	1			0
	F	F		F	3				0	F					F	2							F	1			0
		C		C	2				0	C						1							C	1			0
	F	F	F	F	4	F	F		2	F					F	2		F					F	2			0
C	C	C	C	C	5				0	C					C	2		C					C	2			0
	F	F	F	F	4		F		1	F					F	2								0			0
	C	C		C	3		C		1	C					C	2								0			0
	F			F	2		F		1	F					F	2							F	1			0
				C	1		C		1	C						1							C	1			0

LEGEND:
C=Current Yr. (1985)
F=During Next 5 Yrs. (1986-1990)
[a]Identification number of responding organization; see appendix III.
[+]Provided by questionnaire respondents.

Major Problems Regarding	Organizations — Professional Provider Group														Sub-total
	[a]1	2	3	4	5	6	7	8	9	10	11	12	13	14	
i. Cost of reinsurance too expensive for insurers.	F C	F C	F	F	F C	F C	F C				F	F C		F C	10 7
j. Other+															
(1) Cost of insurance offered to individual certified nurse- midwives is too expensive in relation to income.													F C		1 1
(2) Cost of medical malpractice liability insurance for birth centers.															0 0
3. Number of Medical Malpractice Claims															
a. A large number of medical events which could result in malpractice claims.	F C				F C	F			F					F C	5 3
b. A large number of meritorious claims.		F C		F C					F					F C	4 3
c. A large number of frivolous claims.	F C	F	F C	F C	C		F C		F	F C	F C	F C		F C	10 9
d. A large number of medical events which could have resulted in malpractice claims, but did not.					F C						F	F		F C	4 2
4. Size of Awards/ Settlements															
a. Awards/settlements excessive in relation to economic costs arising from the injuries.	F C	F C	F C	F C	F C		F C		C	F C	F	F C			9 9
b. Awards/settlements inadequate in relation to economic costs arising from the injuries.															0 0
c. Amounts paid for pain and suffering excessive.	F C	F C	F C	F C	F C		F C		F C	F C	F C	F C			10 10
d. Amounts paid for pain and suffering inadequate.															0 0

Hospital Affiliated Group						Medical Malpractice Insurance Group				Legal Group							Consumer Group								Health Insurer Group		
15	16	17	18	19	Sub-total	20	21	22	Sub-total	23	24	25	26	27	28	Sub-total	29	30	31	32	33	34	35	Sub-total	36	37	Sub-total
	F	F		F	**3**		F		**1**						F	**1**								**0**			**0**
	C	C		C	**3**		C		**1**							**0**								**0**			**0**
					0				**0**							**0**								**0**			**0**
					0				**0**							**0**								**0**			**0**
				F	**1**				**0**							**0**								**0**			**0**
				C	**1**				**0**							**0**								**0**			**0**
					0	F			**1**	F		F	F	F		**4**	F			F	F			**3**			**0**
					0				**0**			C	C	C		**3**	C			C	C			**3**			**0**
	F				**1**	F			**1**			F	F	F	F	**4**				F	F			**2**			**0**
	C				**1**	C			**1**			C	C	C		**3**				C	C			**2**			**0**
					0	F			**1**						F	**1**		F					F	**2**			**0**
					0	C	C		**2**						C	**1**		C						**1**			**0**
		F			**1**				**0**			F		F		**2**	F			F	F			**3**		F	**1**
		C			**1**				**0**			C		C		**2**	C			C	C			**3**		C	**1**
	F	F		F	**3**	F			**1**	F					F	**2**		F						**1**			**0**
C	C				**2**	C			**1**						C	**1**		C		C				**2**			**0**
				F	**1**				**0**							**0**						F		**1**			**0**
					0				**0**							**0**						C		**1**			**0**
	F			F	**2**	F	F		**2**	F					F	**2**		F					F	**2**			**0**
	C				**1**	C	C		**2**						C	**1**		C					C	**2**			**0**
				F	**1**				**0**				F			**1**				F		F		**2**			**0**
					0				**0**					C		**1**				C		C		**2**			**0**

LEGEND:
C=Current Yr. (1985)
F=During Next 5 Yrs. (1986-1990)
[a]Identification number of responding organization; see appendix III.
[+]Provided by questionnaire respondents.

Major Problems Regarding	Organizations — Professional Provider Group														Sub-total
	[a]1	2	3	4	5	6	7	8	9	10	11	12	13	14	
e. Too many awards/settlements over $1 million.	F	F	F		F		F		F	F	F	F			9
	C	C	C		C		C			C	C	C			8
f. Too many duplicate payments from collateral sources for economic losses sustained from medical malpractice injuries.			F		F		F		F	F					5
			C		C		C			C					4
5. Length of Time to Resolve Claims															
a. Length of time to resolve claims too long.		F	F	F	F		F	F	F	F		F		F	10
		C	C	C	C		C	C	C	C		C		C	10
b. The long length of time to resolve claims discourages filing of meritorious claims.															0
															0
c. The long length of time to resolve claims puts a financial burden on the injured party.			F						F			F		F	4
			C						C			C		C	4
d. The long length of time to resolve claims encourages health care providers to settle claims before trial.			F	F											2
			C	C											2
e. The long length of time to resolve claims encourages health care providers not to settle claims before trial.														F	1
														C	1
f. The long length of time to resolve claims puts an emotional burden on the injured patient.			F				F		F	F		F		F	6
			C				C		C	C		C		C	6
g. The long length of time to resolve claims puts an emotional burden on health care providers.			F		F		F			F	F	F			6
			C		C		C			C	C	C			6
h. The long length of time to receive compensation discourages/delays patient rehabilitation treatment.														F	1
														C	1

Hospital Affiliated Group						Medical Malpractice Insurance Group				Legal Group							Consumer Group								Health Insurer Group		
15	16	17	18	19	Sub-total	20	21	22	Sub-total	23	24	25	26	27	28	Sub-total	29	30	31	32	33	34	35	Sub-total	36	37	Sub-total
F	F			F	**3**	F	F		**2**	F					F	**2**		F						**1**			**0**
C	C		C	C	**4**	C	C		**2**						C	**1**								**0**			**0**
		F		F	**2**	F			**1**						F	**1**		F						**1**			**0**
		C	C		**2**	C	C		**2**							**0**								**0**			**0**
	F		F	F	**3**		F		**1**		F				F	**2**		F		F				**2**			**0**
	C		C		**2**		C		**1**						C	**1**				C				**1**			**0**
				F	**1**				**0**							**0**				F				**1**			**0**
					0				**0**							**0**				C				**1**			**0**
	F		F	F	**3**				**0**		F				F	**2**	F		F	F		F		**4**			**0**
	C		C		**2**				**0**		C		C		C	**3**	C		C	C		C		**4**			**0**
					0	F			**1**							**0**								**0**			**0**
					0				**0**							**0**								**0**			**0**
	F				**1**				**0**		F	F				**2**				F		F		**2**			**0**
	C				**1**				**0**		C	C				**2**				C		C		**2**			**0**
	F		F	F	**3**				**0**		F	F				**2**	F		F	F		F		**4**			**0**
	C		C	C	**3**				**0**		C	C	C			**3**	C		C	C		C		**4**			**0**
			F	F	**2**		F		**1**						F	**1**								**0**			**0**
			C	C	**2**		C		**1**							**0**								**0**			**0**
	F			F	**2**				**0**		F				F	**2**				F				**1**			**0**
	C			C	**2**				**0**		C					**1**				C				**1**			**0**

LEGEND:
C=Current Yr. (1985)
F=During Next 5 Yrs. (1986-1990)
[a]Identification number of responding organization; see appendix III.
[+]Provided by questionnaire respondents.

Major Problems Regarding	Organizations: Professional Provider Group														Sub-total
	[a]1	2	3	4	5	6	7	8	9	10	11	12	13	14	
6. Equity of Awards/ Settlements															
a. Awards/settlements for injuries of similiar severity are dissimilar.		F C	F C		F C				F C	F C	F C			F C	**7** **7**
b. Outcome of malpractice claims is unpredictable.		F C	F C	F C	F C		F C		F C	F C				F C	**8** **8**
c. Some injured persons with meritorious claims receive payments far in excess of economic losses sustained while others receive payments far less than economic losses sustained.			F C						F C	F C	F C			F C	**5** **5**
d. Too few injured persons filing meritorious claims receive compensation.															**0** **0**
e. Too many persons with non- meritorious claims receive compensation.	F C	F					F C					F C			**4** **3**
7. Legal Expenses/ Attorney Fees															
a. Legal costs associated with defending claims too expensive.		F	F C	F C	F	F C	F C		F C	F C	F C	F C		F C	**11** **9**
b. Plaintiff's legal costs associated with pursuing a claim too expensive.		F	F C	F C		F C	F C		F C		F C			F C	**8** **7**
c. Contingency fee arrangements discourage small but meritorious claims.					F C						F C				**2** **2**
d. Contingency fee arrangements discourage early settlement of claims.									F C	F C					**2** **2**
e. Legal expenses, and attorney fees, as a percentage of award/s settlement too high.		F	F C	F C	F C	F C	F C		F C	F C	F C	F C			**10** **9**

Hospital Affiliated Group						Medical Malpractice Insurance Group				Legal Group							Consumer Group								Health Insurer Group		
15	16	17	18	19	Sub-total	20	21	22	Sub-total	23	24	25	26	27	28	Sub-total	29	30	31	32	33	34	35	Sub-total	36	37	Sub-total
			F		**1**	F	F		**2**						F	**1**		F		F			F	**3**			**0**
			C		**1**	C	C		**2**					C		**1**		C		C			C	**3**			**0**
F	F		F		**3**	F			**1**							**0**		F		F			F	**3**		F	**1**
C	C		C		**3**	C			**1**					C		**1**		C		C			C	**3**		C	**1**
	F		F		**2**	F	F		**2**						F	**1**		F					F	**2**			**0**
C	C		C	C	**4**	C	C		**2**						C	**1**		C					C	**2**			**0**
					0				**0**							**0**								**0**			**0**
					0				**0**							**0**								**0**			**0**
					0	F	F		**2**						F	**1**		F						**1**			**0**
					0	C	C		**2**						C	**1**		C						**1**			**0**
	F	F		F	**3**	F	F		**2**	F	F					**2**		F					F	**2**		F	**1**
	C	C			**2**		C		**1**							**0**		C						**1**		C	**1**
	F	F		F	**3**	F			**1**							**0**				F				**1**		F	**1**
	C	C			**2**				**0**							**0**				C				**1**		C	**1**
	F		F	F	**3**		F		**1**		F				F	**2**				F			F	**2**			**0**
	C		C		**2**		C		**1**		C				C	**2**				C				**1**			**0**
				F	**1**				**0**		F				F	**2**				F				**1**			**0**
					0				**0**		C				C	**2**				C				**1**			**0**
F	F	F		F	**4**	F	F		**2**	F	F				F	**3**		F					F	**2**			**0**
C	C	C			**3**	C	C		**2**		C				C	**2**		C					C	**2**			**0**

LEGEND:
C=Current Yr. (1985)
F=During Next 5 Yrs. (1986-1990)
[a]Identification number of responding organization; see appendix III.
[+]Provided by questionnaire respondents.

Major Problems Regarding	Organizations — Professional Provider Group														Sub-total
	[a]1	2	3	4	5	6	7	8	9	10	11	12	13	14	
f. High legal costs associated with defending claims encourages insurance carriers and/or health care providers to offer to settle claims with little or no merit before trial.			F C			F C	F C		F C	F C				F C	**6** **6**
g. Contingency fee arrangements encourage claims with little or no merit.			F C		F C		F C		F	F C					**5** **4**
8. Responses by Physician/ Hospital Groups to Reduce or Prevent Medical Malpractice Events															
a. Medical societies did not take remedial action (e.g., sanctions or disciplinary measures) against members with malpractice histories.				F							C	C		F C	**2** **3**
b. Physician specialty boards did not take remedial action against physicians with malpractice histories.			C	F							F C	F C		F C	**4** **4**
c. Hospitals did not take remedial action against physicians with malpractice histories.				F C							C			F C	**2** **3**
d. Hospital accreditation organizations did not take remedial action against hospitals with malpractice histories.											F C			F C	**2** **2**
e. Physicians did not take remedial action against hospitals with malpractice histories.											F C			F C	**2** **2**
f. Peer review groups did not take remedial action against physicians or hospitals with malpractice histories.			F C								F C			F C	**3** **3**

Hospital Affiliated Group						Medical Malpractice Insurance Group				Legal Group							Consumer Group								Health Insurer Group		
15	16	17	18	19	Sub-total	20	21	22	Sub-total	23	24	25	26	27	28	Sub-total	29	30	31	32	33	34	35	Sub-total	36	37	Sub-total
				F	**1**				**0**	F						**1**		F					F	**2**			**0**
				C	**1**				**0**							**0**							C	**1**			**0**
		F		F	**2**	F			**1**						F	**1**		F					F	**2**			**0**
		C			**1**	C	C		**2**							**0**		C		C			C	**3**			**0**
				F	**1**				**0**			F	F		F	**3**			F	F	F			**3**			**0**
				C	**1**				**0**			C	C			**2**	C		C	C	C			**4**			**0**
				F	**1**				**0**			F	F		F	**3**				F	F			**2**		F	**1**
				C	**1**				**0**			C	C			**2**	C			C	C			**3**		C	**1**
		F		F	**2**				**0**			F	F		F	**3**				F	F		F	**3**		F	**1**
				C	**1**				**0**			C	C			**2**	C			C	C		C	**4**		C	**1**
		F		F	**2**				**0**			F	F		F	**3**				F	F			**2**		F	**1**
				C	**1**				**0**			C	C			**2**	C			C	C			**3**		C	**1**
	F			F	**2**				**0**			F	F		F	**3**				F	F			**2**		F	**1**
	C			C	**2**		C		**1**			C	C			**2**	C			C	C			**3**		C	**1**
				F	**1**				**0**			F			F	**2**			F	F	F			**3**		F	**1**
				C	**1**				**0**			C	C			**2**	C		C	C	C			**4**		C	**1**

LEGEND:
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[a]Identification number of responding organization; see appendix III.
[+]Provided by questionnaire respondents.

Major Problems Regarding	Organizations — Professional Provider Group														Sub-total
	[a]1	2	3	4	5	6	7	8	9	10	11	12	13	14	
g. Other+															
(1) State licensing boards have not taken steps to monitor malpractice claims.											F C				**1** **1**
9. Individual Physician Actions to Reduce or Prevent Medical Malpractice Claims															
a. Physicians have done little to improve physician- patient relationships to reduce or prevent malpractice claims.											F C	F C	F C	 C	**3** **4**
b. Physicians have little incentive for improving their relationships with patients because they are paid for events or procedures, not for explaining the manner in which they deliver them.														F C	**1** **1**
c. Physicians have strong incentives to perform medically unnecessary tests or treatments to reduce their risk of liability.			C	C		F C	F C		F		F C	F C	F C	F C	**7** **8**
d. Other+															
(1) Physicians have pressure to perform tests that may not be essential, primarily to protect themselves in the event that a claim later is filed.					F C										**1** **1**
10. Individual Hospital Actions to Reduce or Prevent Medical Malpractice Claims															

Hospital Affiliated Group						Medical Malpractice Insurance Group				Legal Group							Consumer Group								Health Insurer Group		
15	16	17	18	19	Sub-total	20	21	22	Sub-total	23	24	25	26	27	28	Sub-total	29	30	31	32	33	34	35	Sub-total	36	37	Sub-total
					0				0							0								0			0
					0				0							0								0			0
		F			1				0			F				1				F	F	F		3			0
		C		C	2				0			C	C			2	C			C	C	C		4			0
	F	F			2				0			F				1				F		F		2			0
	C			C	2				0			C	C			2	C			C		C		3			0
					0				0							0		F		F		F	F	4		F	1
				C	1				0				C			1		C		C		C	C	4		C	1
					0				0							0								0			0
					0				0							0								0			0

LEGEND:
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[a]Identification number of responding organization; see appendix III.
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Major Problems Regarding	Organizations — Professional Provider Group														
	[a]1	2	3	4	5	6	7	8	9	10	11	12	13	14	Sub-total
a. Hospitals have done little to improve hospital-patient relationships to reduce or prevent malpractice claims.										F					1
										C					1
b. Hospitals have a strong incentive for allowing medically unnecessary tests or treatments to reduce their risk of liability.							F		F					F	3
							C		C					C	3
c. Hospitals have little incentive to establish effective risk management programs.															0
															0
d. Hospitals have not effectively screened or reviewed admitting physicians' histories of malpractice claims.				F											1
				C										C	2
11. Other+															
a. Statutes of limitations are too long.	F														1
	C														1
b. There are no good guidelines for expert witness testimony.	F														1
	C														1
c. There is no system for "no- fault" insurance.	F														1
	C														1
d. Unavailability of occurrence policies preventing MD from forming associations with other MD (who may have different coverage).											F				1
											C				1
e. The American College of OB/GYNs has had insurance for members cancelled or non-renewed.													F		1
													C		1

Hospital Affiliated Group						Medical Malpractice Insurance Group				Legal Group							Consumer Group								Health Insurer Group		
15	16	17	18	19	Sub-total	20	21	22	Sub-total	23	24	25	26	27	28	Sub-total	29	30	31	32	33	34	35	Sub-total	36	37	Sub-total
					0				0				F			1				F		F		2			0
					0				0				C			1	C			C		C		3			0
	F				1				0							0		F		F		F	F	4		F	1
	C				1				0				C			1		C		C		C	C	4		C	1
		F			1				0							0				F	F			2			0
		C			1				0				C			1				C	C			2			0
					0				0				F		F	2				F			F	2			0
				C	1			C	1			C	C			2	C			C	C		C	4			0
					0				0							0								0			0
					0				0							0								0			0
					0				0							0								0			0
					0				0							0								0			0
					0				0							0								0			0
					0				0							0								0			0
					0				0							0								0			0
					0				0							0								0			0
					0				0							0								0			0
					0				0							0								0			0

LEGEND:
C=Current Yr. (1985)
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[a]Identification number of responding organization; see appendix III.
+Provided by questionnaire respondents.

Major Problems Regarding	Organizations — Professional Provider Group														Sub-total
	[a]1	2	3	4	5	6	7	8	9	10	11	12	13	14	
f. The American College of Nurse-Midwives which has sponsored a program of insurance for its members since 1976 has had its insurance non-renewed.													F		1
													C		1
g. Certified nurse midwives are being forced out of business due to inability to obtain insurance.													F		1
													C		1
h. Consumer options in child-birth are being severely limited.													F		1
													C		1
i. Lack of rehabilitation assessment of claimants.														F	1
														C	1
j. Lack of physicians keeping up to date on state of the art procedures.														F	1
														C	1
k. Solvency of insurers of malpractice insurance.															0
															0
l. Maintaining any good market for coverage (price, coverage, stability).															0
															0
m. Ability to pay insurance costs, in times of cost containment.															0
															0
n. Dealing with the catastrophic loss.															0
															0
o. Information/education lag—lack of definitive research—lag between research findings and application in practice or inappropriate application without adequate research.															0
															0
p. Expectations of people— without understanding of affordability of health care expectations.															0
															0

Hospital Affiliated Group						Medical Malpractice Insurance Group				Legal Group							Consumer Group								Health Insurer Group		
15	16	17	18	19	Sub-total	20	21	22	Sub-total	23	24	25	26	27	28	Sub-total	29	30	31	32	33	34	35	Sub-total	36	37	Sub-total
					0				0							0								0			0
					0				0							0								0			0
					0				0							0								0			0
					0				0							0								0			0
					0				0							0								0			0
					0				0							0								0			0
					0				0							0								0			0
					0				0							0								0			0
					0				0							0								0			0
					0				0							0								0			0
		F			1				0							0								0			0
		C			1				0							0								0			0
		F			1				0							0								0			0
		C			1				0							0								0			0
		F			1				0							0								0			0
		C			1				0							0								0			0
		F			1				0							0								0			0
					0				0							0								0			0
				F	1				0							0								0			0
				C	1				0							0								0			0
				F	1				0							0								0			0
				C	1				0							0								0			0

LEGEND:
C=Current Yr. (1985)
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[a]Identification number of responding organization; see appendix III.
+Provided by questionnaire respondents.

Major Problems Regarding	Organizations — Professional Provider Group														Sub-total
	[a]1	2	3	4	5	6	7	8	9	10	11	12	13	14	
q. Health care for profit— layers of industries pulling profit from transactions between providers and recipient of care.															0 0
r. Adversarial approach to solution of problems of medical malpractice—lottery approach fostered by "no limit" to legal fees and awards.															0 0
s. Court rules have affected the situation.															0 0
t. Information problem.															0 0
u. Poor underwriting practices.															0 0
v. Insurance companies didn't have control of data necessary to understand what was happening.															0 0
w. Ratemaking practices were improper, not reflecting investment return.															0 0
x. Insurance system inefficient.															0 0
y. Lack of self-discipline within medical profession.															0 0
z. Inadequate disciplinary measures by state boards.															0 0
aa. Inadequate budgetary support and inadequate legislation to strengthen medical discipline.															0 0
bb. Need for improved and more effectively enforced impaired physician laws.															0 0

Hospital Affiliated Group						Medical Malpractice Insurance Group				Legal Group							Consumer Group								Health Insurer Group		
15	16	17	18	19	Sub-total	20	21	22	Sub-total	23	24	25	26	27	28	Sub-total	29	30	31	32	33	34	35	Sub-total	36	37	Sub-total
				F	1				0							0								0			0
				C	1				0							0								0			0
				F	1				0							0								0			0
				C	1				0							0								0			0
					0		F		1							0								0			0
					0		C		1							0								0			0
					0				0			F				1								0			0
					0				0			C				1								0			0
					0				0			F				1								0			0
					0				0			C				1								0			0
					0				0							0			F					1			0
					0				0							0			C					1			0
					0				0							0			F					1			0
					0				0							0			C					1			0
					0				0							0			F					1			0
					0				0							0			C					1			0
					0				0							0					F			1			0
					0				0							0					C			1			0
					0				0							0					F			1			0
					0				0							0					C			1			0
					0				0							0					F			1			0
					0				0							0					C			1			0
					0				0							0					F			1			0
					0				0							0					C			1			0

LEGEND:
C=Current Yr. (1985)
F=During Next 5 Yrs. (1986-1990)
[a]Identification number of responding organization; see appendix III.
+Provided by questionnaire respondents.

Major Problems Regarding	Organizations — Professional Provider Group														Sub-total
	[a]1	2	3	4	5	6	7	8	9	10	11	12	13	14	
cc.Little mutual compromise between physicians and lawyers is seen on ways to successfully negotiate solutions to rising tide of medical malpractice claims.															0 0
dd. Under Medicare's DRGs, physicians can sometimes be caught in a bind between hospital administrators encouraging the release of patients and physicians not wanting to release because quality of care would suffer and result in malpractice claims.															0 0
ee. Physicians do not adequately inform patients on the differences between complications and signs of negligence.															0 0

Hospital Affiliated Group						Medical Malpractice Insurance Group				Legal Group							Consumer Group								Health Insurer Group		
15	16	17	18	19	Sub-total	20	21	22	Sub-total	23	24	25	26	27	28	Sub-total	29	30	31	32	33	34	35	Sub-total	36	37	Sub-total
					0				0							0						F		1			0
					0				0							0						C		1			0
					0				0							0						F		1			0
					0				0							0						C		1			0
					0				0							0						F		1			0
					0				0							0						C		1			0

LEGEND:
C=Current Yr. (1985)
F=During Next 5 Yrs. (1986-1990)
[a]Identification number of responding organization; see appendix III.
[+]Provided by questionnaire respondents.

Table IV.2: Impact of Tort Reforms and Other Actions

Tort Reform or Action	Organizations — Professional Provider Group														Sub-total
	[a]1	2	3	4	5	6	7	8	9	10	11	12	13	14	
1. Deletion of Ad Damnum clauses		*	*	*	*	*	*	*		*	*			*	**10**
a. Impact on decreasing size of awards/ settlements															**0**
b. Impact on decreasing number of claims															**0**
c. Other Impact+ Reduction of claims cost.															**0**
2. Enactment of a periodic payment of awards provision	*	*	*	*	*	*	*	*		*	*	*	*		**12**
a. Impact on decreasing size of awards/ settlements											X				**1**
b. Impact on decreasing number of claims															**0**
c. Impact on decreasing insurers total cash outlay	X	X			X	X	X			X	X				**7**
3. Limitation on attorney's fees	*	*	*		*	*	*	*		*	*	*	*	*	**12**
a. Impact on decreasing number of claims											X				**1**
b. Impact on increasing portion of awards/ settlement going to injured party	X	X				X				X					**4**
c. Impact on Other Impact+ Has other undesirable side effects—may prevent people who have legitimate claims from finding attorneys to represent them.															**0**

Hospital Affiliated Group						Medical Malpractice Insurance Group				Legal Group							Consumer Group								Health Insurer Group	
15	16	17	18	19	Sub-total	20	21	22	Sub-total	23	24	25	26	27	28	Sub-total	29	30	31	32	33	34	35	Sub-total	36	37	Sub-total
	*	*	*		3	*	*	*	3	*	*	*			*	4	*	*	*	*	*	*		6			0
					0				0							0				X				1			0
					0				0							0				X				1			0
					0			X	1							0								0			0
	*	*	*	*	4	*	*	*	3	*	*	*			*	4	*	*	*	*	*	*		6			0
					0		X		1							0		X						1			0
					0				0							0		X						1			0
					0	X		X	2		X				X	2		X		X				2			0
	*	*	*	*	4	*	*	*	3	*	*	*			*	4	*	*	*	*	*	*		6			0
					0				0							0		X		X				2			0
					0			X	1							0		X						1			0
					0				0							0		X						1			0

LEGEND:
*=Organization is aware of reform or action.
X=Organization indicated major impact.
[a] Identification number of responding organization; see appendix III.
+Provided by questionnaire respondents.

Tort Reform or Action	Organizations: Professional Provider Group														Sub-total
	[a]1	2	3	4	5	6	7	8	9	10	11	12	13	14	
4. Elimination of collateral source rule		*	*	*	*	*	*	*		*	*		*	*	**11**
a. Impact on decreasing portion of award/ settlement going to injured patient					X										**1**
b. Impact on decreasing size of awards/ settlements															**0**
c. Impact on decreasing number of claims															**0**
5. Reduction of time period during which malpractice claims can be filed	*	*	*	*	*	*	*	*		*	*	*	*	*	**13**
a. Impact on decreasing number of claims	X												X		**2**
b. Other Impact+															
(1) Helps eliminate "long tail" problem in obstetrical cases.						X									**1**
(2) Reduction in size of awards.															**0**
(3) Taking away patient's right to bring suit when negligence is not discoverable until after statute of limitations.															**0**
6. Provisions for arbitration of claims	*	*	*	*	*	*	*	*		*	*	*	*	*	**13**
a. Impact on decreasing size of awards/ settlements	X														**1**
b. Impact on decreasing time required to close claims	X										X				**2**
c. Impact on decreasing number of claims to trial	X				X										**2**

Hospital Affiliated Group						Medical Malpractice Insurance Group				Legal Group							Consumer Group								Health Insurer Group		
15	16	17	18	19	Sub-total	20	21	22	Sub-total	23	24	25	26	27	28	Sub-total	29	30	31	32	33	34	35	Sub-total	36	37	Sub-total
	*	*	*		3	*	*	*	3	*	*	*			*	4	*	*	*	*	*	*		6		*	1
					0		X		1							0		X		X				2			0
			X		1		X	X	2							0		X		X				2			0
					0				0							0		X						1			0
	*	*	*		3	*	*	*	3	*	*	*			*	4	*	*	*	*	*	*		6			0
					0				0							0		X		X		X		3			0
					0				0							0								0			0
					0			X	1							0								0			0
					0				0							0						X		1			0
	*	*	*	*	4	*	*	*	3	*	*	*			*	4	*	*	*	*	*	*		6			0
				X	1				0							0				X				1			0
	X			X	2			X	1						X	1				X		X		2			0
	X			X	2			X	1						X	1				X		X		2			0

LEGEND:
*=Organization is aware of reform or action.
X=Organization indicated major impact.
[a] Identification number of responding organization; see appendix III.
+Provided by questionnaire respondents.

Tort Reform or Action	Organizations — Professional Provider Group														
	[a]1	2	3	4	5	6	7	8	9	10	11	12	13	14	Sub-total
7. Use of pretrial screening panels	*	*	*	*	*	*	*	*		*	*	*	*	*	**13**
a. Impact on decreasing size of awards/ settlements	X														**1**
b. Impact on decreasing time required to close claims	X														**1**
c. Impact on decreasing number of claims to trial	X														**1**
d. Other Impact+															
(1) Impact on increasing time required to close claims.						X									**1**
8. Limitation on total size of awards/ settlements	*	*	*		*	*	*	*	*	*	*		*	*	**12**
a. Impact on decreasing size	X	X				X	X		X		X		X	X	**8**
b. Impact on increasing number of awards/ settlement at statutory established limits	X												X	X	**3**
c. Impact on decreasing number of claims															**0**
d. Other Impact+															
(1) Containment of insurance costs.															**0**
(2) May have other undesirable side effects- arbitrary limits on total size of awards discriminate against individuals with legitimate losses.															**0**
9. Informed consent	*	*	*	*	*	*	*	*		*	*	*	*	*	**13**
a. Impact on decreasing size of awards/ settlements															**0**
b. Impact on decreasing number of claims													X		**1**
c. Other Impact+															

Hospital Affiliated Group						Medical Malpractice Insurance Group				Legal Group							Consumer Group								Health Insurer Group	
15	16	17	18	19	Sub-total	20	21	22	Sub-total	23	24	25	26	27	28	Sub-total	29	30	31	32	33	34	35	Sub-total	36	37	Sub-total
	*	*	*	*	4	*	*	*	3	*	*	*			*	4	*	*		*	*	*		5			0
					0				0							0		X		X				2			0
	X				1				0						X	1		X		X		X		3			0
	X				1				0						X	1		X		X		X		3			0
					0				0							0								0			0
	*	*	*	*	4	*	*	*	3	*	*	*			*	4	*	*	*	*	*	*		6			0
	X				1		X	X	2							0		X		X		X		3			0
					0				0						X	1				X				1			0
					0				0							0		X		X				2			0
					0			X	1							0								0			0
					0				0							0		X						1			0
	*	*	*	*	4	*	*	*	3	*	*	*			*	4	*	*	*	*	*	*	*	7			0
					0				0							0								0			0
	X				1				0							0								0			0

LEGEND:
*=Organization is aware of reform or action.
X=Organization indicated major impact.
[a] Identification number of responding organization; see appendix III.
+Provided by questionnaire respondents.

Tort Reform or Action	Organizations: Professional Provider Group														Sub-total
	[a]1	2	3	4	5	6	7	8	9	10	11	12	13	14	
(1) Improve doctor- patient communications and relationship.										X					1
10. Standard of care provisions		*			*						*				3
a. Impact on decreasing size of awards/ settlements															0
b. Impact on decreasing number of claims															0
c. Impact on increasing uniformity in awards															0
11. Burden of proof provisions/res ipsa loquitur doctrine					*						*			*	3
a. Impact on decreasing size of awards/ settlements															0
b. Impact on decreasing number of claims															0
12. Provisions requiring that guarantees of results must be in writing and signed by health care provider to be enforceable in court		*	*		*										3
a. Impact on decreasing size of awards/ settlements															0
b. Impact on decreasing number of claims															0
13. Provisions requiring plaintiff to pay court costs and defendant's legal expenses if found to have acted frivolously in bringing the suit		*	*		*	*	*			*	*		*		8
a. Impact on decreasing number of medical malpractice claims		X				X									2

Hospital Affiliated Group						Medical Malpractice Insurance Group				Legal Group							Consumer Group								Health Insurer Group		
15	16	17	18	19	Sub-total	20	21	22	Sub-total	23	24	25	26	27	28	Sub-total	29	30	31	32	33	34	35	Sub-total	36	37	Sub-total
					0				0							0								0			0
	*		*		2	*	*	*	3		*	*			*	3	*	*		*	*			4			0
					0				0							0				X				1			0
					0				0							0				X				1			0
	X				1				0							0								0			0
	*	*	*		3	*		*	2		*	*			*	3	*	*	*	*	*	*		6			0
	X				1				0							0				X				1			0
	X				1				0							0				X				1			0
	*				1				0		*					1	*	*		*	*			4			0
					0				0							0				X				1			0
					0				0							0				X				1			0
	*	*	*		3	*	*	*	3	*	*	*			*	4	*	*	*	*	*	*	*	7			0
	X				1				0							0		X		X		X		3			0

LEGEND:
*=Organization is aware of reform or action.
X=Organization indicated major impact.
[a] Identification number of responding organization; see appendix III.
+Provided by questionnaire respondents.

Tort Reform or Action	Organizations: Professional Provider Group														Sub-total
	[a]1	2	3	4	5	6	7	8	9	10	11	12	13	14	
14. Provisions requiring individual, prior to filing a medical malpractice action, to notify the health care provider in writing of intention to sue and of date of alleged malpractice					*	*					*		*		**4**
a. Impact on decreasing use of courts to close claims															**0**
b. Impact on decreasing number of claims															**0**
c. Impact on decreasing size of awards/ settlements															**0**
d. Impact on decreasing time required to resolve claims															**0**
e. Other Impact+															
(1) Long-term impact on transfer of information from physician to individual (patient).															**0**
15. Greater use of risk management programs	*	*	*	*	*	*	*	*	*		*	*	*	*	**13**
a. Impact on decreasing number of provider-induced injuries	X								X						**2**
b. Impact on decreasing number of claims														X	**1**

Hospital Affiliated Group						Medical Malpractice Insurance Group				Legal Group						Consumer Group								Health Insurer Group		
15	16	17	18	19	Sub-total	20	21	22	Sub-total	23	24	25	26	27	28	Sub-total	29	30	31	32	33	34	35	Sub-total	36	37	Sub-total
	*	*			2	*	*	*	3		*	*			*	3	*	*		*	*	*		5			0
					0				0							0				X				1			0
					0				0							0				X				1			0
					0				0							0				X				1			0
					0		X		1							0				X				1			0
					0				0							0						X		1			0
	*	*	*	*	4	*	*		2		*	*			*	3	*	*	*	*	*	*		6			0
				X	1				0			X				1		X		X				2			0
				X	1				0			X				1		X						1			0

LEGEND:
*=Organization is aware of reform or action.
X=Organization indicated major impact.
[a] Identification number of responding organization; see appendix III.
+Provided by questionnaire respondents.

Table IV.3: Impact of Medical Malpractice Suits or the Threat of Such Suits

Impact On	Organizations — Professional Provider Group														
	[a]1	2	3	4	5	6	7	8	9	10	11	12	13	14	Sub-total
1. The quality of medical care provided.	N	I	N	I	I	I	I	I	I	N	I	I	I	I	I/N/D 11/3/0
2. The quality of the physician/patient relationship.	I	D	D	D	D	D	D		D	D	D	N	D	I	2/1/10
3. The cost of medical care.	I	I	I	I	I	I	I	N	I	I	I	I	I	I	13/1/0
4. Patient's access to medical care.	D	D	D	N	D	D	D	N	D	N	D	N	D	N	0/5/9
5. The number of physicians deciding to select certain specialties when first entering practice.	I	N	I		D	N			N	N	N	I	I	D	4/5/2
6. The number of physicians deciding to change specialties once established in practice.	I	I	I	I	I	I	I		N		I		I	D	9/1/1
7. The number of physicians deciding to practice in certain geographic locations.	I	N	I	I	D	I			N		N	N	I	D	5/4/2
8. The number of physicians deciding to retire early.	I	I	I	I	I	I	I		N	I	I	I	I	I	12/1/0
9. Unnecessary tests and procedures ordered by physicians (practice of defensive medicine).	I	I	I	I	I	I	I	N	I	I	I	I	I	I	13/1/0
10. Unnecessary tests and procedures required by hospitals (practice of defensive medicine).		I	I	I			I		I	N	I	I	I	I	9/1/0
11. The number of difficult cases or risky procedures undertaken by physicians.	D	N	D	N	D	D	D	D	N	N	D	D	D	N	0/5/9

Hospital Affiliated Group						Medical Malpractice Insurance Group				Legal Group							Consumer Group								Health Insurer Group		
15	16	17	18	19	Sub-total	20	21	22	Sub-total	23	24	25	26	27	28	Sub-total	29	30	31	32	33	34	35	Sub-total	36	37	Sub-total
					I/N/D																						
I	I	I	I	I	5/0/0	N	D		0/1/1	I	D	I			I	3/0/1	I	D	I	N	I	I	D	4/1/2		N	0/1/0
I	I	I	I	I	5/0/0	I	D		1/0/1	D	D	N			I	1/1/2	N	D	D	D	D	I	D	1/1/5		I	1/0/0
I	I	I	I	I	5/0/0	I	I		2/0/0	I	I	N			I	3/1/0	I	I	I	I	I	I	I	7/0/0		I	1/0/0
	D	N	D	D	0/1/3	N	D		0/1/1	N	D	N			D	0/2/2	N	D	D	N	D	D	N	0/3/4		N	0/1/0
N	I	D	I		2/1/1	I	I		2/0/0		I	N			I	2/1/0	I	I	D	I	N	N	I	4/2/1		N	0/1/0
D	I	I	I	I	4/0/1	I	I		2/0/0		I	N			I	2/1/0	I	I	I	I	N	N	N	4/3/0			0/0/0
N	I	I	I	I	4/1/0	I	N		1/1/0			N			I	1/1/0	N	I	N	I	N	N		2/4/0			0/0/0
I	I	I	I	I	5/0/0	I	I		2/0/0		I	N			I	2/1/0	I	I	I	I	N	N	I	5/2/0		I	1/0/0
I	I	I	I	I	5/0/0	I	I		2/0/0	I	I	N			I	3/1/0	I	I	I	I	N	I	I	6/1/0		I	1/0/0
	N	I		I	2/1/0	I	N		1/1/0	I	I	N			I	3/1/0	I	I	I	I	N	I	I	6/1/0		I	1/0/0
D	D	D	D	D	0/0/5	D	D		0/0/2	N	D	N			I	1/2/1		N	N	D	N	N	D	0/4/2		N	0/1/0

LEGEND:
D=decrease N=No influence
I=Increase
[a] Identification number of responding organization; see appendix III.

Impact On	Organizations — Professional Provider Group														
	[a]1	2	3	4	5	6	7	8	9	10	11	12	13	14	Sub-total
12. The number of difficult cases or risky procedures permitted by hospitals.		N	D	N	D		D	D	D	N	N		D	N	**0/5/6**
13. The development of hospital risk management programs.		I	I	I	I	I	I	I	I	I	I	I	I	I	**13/0/0**
14. The development of physician risk management programs.	I	I	I	I	I	I	I	I	I	I	I	I	I	I	**14/0/0**
15. Staff-to-patient ratios in hospitals.		N	N	I	N				N	N	N			N	**1/7/0**

Hospital Affiliated Group						Medical Malpractice Insurance Group				Legal Group							Consumer Group								Health Insurer Group		
15	16	17	18	19	Sub-total	20	21	22	Sub-total	23	24	25	26	27	28	Sub-total	29	30	31	32	33	34	35	Sub-total	36	37	Sub-total
D	N	D	D		0/1/3	D	D		0/0/2		D	N			I	1/1/1		N	N	D	N	N	D	0/4/2		N	0/1/0
I	I	I	I	I	5/0/0	I	I		2/0/0	I	D	I			I	3/0/1	I	I	I	I	I	I		6/0/0		N	0/1/0
I	I	I	I	I	5/0/0	I	I		2/0/0	I	D	I			I	3/0/1	I	I	I	I	I	I	I	7/0/0		N	0/1/0
N	N	N		N	0/4/0	N	N		0/2/0			N			N	0/2/0	N	N	I	N	N	N	I	2/5/0			0/0/0

LEGEND:
D=decrease N=No influence
I=Increase
[a] Identification number of responding organization; see appendix III.

Table IV.4: Suggested Solutions

Strong Support For		Organizations: Professional Provider Group														
		[a]1	2	3	4	5	6	7	8	9	10	11	12	13	14	Sub-total
1. Modifying the traditional fault-based litigation system for resolving claims.	*F	X	X		X		X						X		X	6
	*S	X		X		X		X		X			X		X	7
2. Using no-fault medical malpractice insurance.	*F	X	X		X		X								X	5
	*S	X		X											X	3
3. Using pretrial screening panels.	*F	X	X								X		X			4
	*S	X	X	X				X			X		X			6
4. Using arbitration in resolving claims.	*F	X	X			X							X			4
	*S	X		X		X	X						X			5
5. Using medical adversity insurance in which insurance pays a claimant according to a predetermined schedule of adverse outcomes. It is funded with premiums paid by providers based on their individual claims experience. Claims for outcomes not listed would be resolved through the traditional court system.	*F		X													1
	*S	X		X												2
6. Using social insurance system covering medical malpractice claims.	*F				X		X									2
	*S	X														1
7. Using risk management programs.	*F	X			X	X					X	X			X	6
	*S	X	X	X	X	X		X		X	X	X			X	10
8. Strengthening licensing and relicensing for physicians.	*F	X														1
	*S	X	X	X	X			X		X		X				7
9. Strengthening licensing and relicensing for hospitals.	*F															0
	*S		X	X			X	X		X		X				6
10.Imposing sanctions or disciplinary measures against physicians and hospitals with medical malpractice histories.	*F													X		1
	*S													X		1

Hospital Affiliated Group						Medical Malpractice Insurance Group				Legal Group							Consumer Group								Health Insurer Group		
15	16	17	18	19	Sub-total	20	21	22	Sub-total	23	24	25	26	27	28	Sub-total	29	30	31	32	33	34	35	Sub-total	36	37	Sub-total
	X			X	2				0						X	1								0			0
	X			X	2	X			1						X	1				X				1			0
				X	1				0							0								0			0
				X	1				0							0				X			X	2			0
				X	1		X		1						X	1								0			0
				X	1				0						X	1		X		X			X	3	X		1
				X	1				0			X				1								0			0
				X	1	X			1			X				1				X				1	X		1
				X	1		X		1							0					X			1			0
				X	1				0							0				X	X			2			0
	X			X	2				0							0				X		X		2			0
	X			X	2				0							0				X				1			0
	X	X		X	3		X		1		X	X		X	X	4			X					1			0
	X	X		X	3	X	X		2		X	X		X	X	4			X	X		X		3	X		1
	X			X	2				0		X	X	X	X	X	5			X		X			2			0
	X			X	2				0		X	X	X	X	X	5			X	X	X	X		4	X		1
	X			X	2				0		X	X	X		X	4			X		X			2			0
	X			X	2				0		X	X	X	X	X	5			X	X	X	X		4	X		1
	X			X	2				0			X	X		X	3			X		X		X	3			0
	X			X	2				0		X	X	X	X	X	5		X	X	X	X	X	X	6			0

Legend:
*F=Federal action. *S=State action. X=Strong support for action.
[a] Identification number of responding organization; see appendix III.
+Provided by questionnaire respondents.

Strong Support For		Organizations: Professional Provider Group													
		[a]1	2	3	4	5	6	7	8	9	10	11	12	13	14 Sub-total
11. Increasing peer review of physician's medical practices.	*F				X								X	X	3
	*S			X	X						X		X	X	5
12. Increasing amount of information available to consumers about physicians and hospitals with medical malpractice histories.	*F													X	1
	*S													X	1
13. Adopting the Alternative Medical Liability Bill (H.R. 5400, S. 2690, 98th Congress 2nd session.)	*F	X	X				X								3
	*S	X					X					X			3
14. Adopting the Health Care Protection Bill (S. 175) as introduced in the 99th Congress 1st session.	*F		X												1
	*S														0
15. Other+															
a. Provide for insurance system whereby patients (consumers) and not MD (providers) pay for insurance premiums.	*F											X			1
	*S											X			1
b. Investigation of Insurance companies	*F														0
	*S														0
c. States should consider collateral source rules. Also, the elimination of joint and several liability would be cost effective.	*F														0
	*S														0
d. State Insurance Disclosure Acts (as was enacted in 1985 in Washington) increased regulation of insurers improved tax structure (factoring investment income).	*F														0
	*S														0

Hospital Affiliated Group						Medical Malpractice Insurance Group				Legal Group							Consumer Group								Health Insurer Group		
15	16	17	18	19	Sub-total	20	21	22	Sub-total	23	24	25	26	27	28	Sub-total	29	30	31	32	33	34	35	Sub-total	36	37	Sub-total
	X			X	2				0		X	X	X		X	4			X		X			2	X		1
	X			X	2				0		X	X	X		X	4		X	X	X	X	X		5	X	X	2
	X			X	2				0		X	X	X	X	X	5	X		X		X		X	4			0
	X			X	2				0		X	X	X	X	X	5		X	X	X	X	X	X	6		X	1
	X			X	2				0							0								0			0
	X			X	2		X		1							0								0			0
	X			X	2				0							0								0			0
	X				1				0							0				X				1			0
					0				0							0								0			0
					0				0							0								0			0
				X	1				0							0								0			0
				X	1				0							0								0			0
					0				0							0								0			0
					0	X			1							0								0			0
					0				0							0								0			0
					0				0			X				1								0			0

Legend:
*F=Federal action. *S=State action. X=Strong support for action.
[a] Identification number of responding organization; see appendix III.
+Provided by questionnaire respondents.

Table IV.5: Federal Government Role in Addressing Medical Malpractice Problems

Strong Support For The Federal Government To	Organizations: Professional Provider Group														
	[a]1	2	3	4	5	6	7	8	9	10	11	12	13	14	Sub-total
1. Establish a mechanism to provide technical assistance such as model legislation and guidance to states and/or organizations.	X	X	X		X				X	X	X			X	8
2. Establish a national policy regarding compensation for medically-induced injuries.	X	X		X		X				X		X		X	7
3. Establish a mechanism to provide financial incentives and/or penalties to encourage states to take certain actions.	X	X			X									X	4
4. Mandate a uniform system for resolving medical malpractice claims.		X		X		X									3
5. Other+															
a. Provide reinsurance for health care providers unable to obtain insurance in open market.													X		1
b. Provide access to federal and/or state reinsurance as may be needed in order to maintain the ability of the hospital/health care provider to continue to deliver services and protect the public in the event of a negligent act.															0
c. Provide incentives to medical schools and hospitals so that training fits actual medical need, i.e., more family practitioners, less specialists.															0

Hospital Affiliated Group						Medical Malpractice Insurance Group				Legal Group							Consumer Group								Health Insurer Group		
15	16	17	18	19	Sub-total	20	21	22	Sub-total	23	24	25	26	27	28	Sub-total	29	30	31	32	33	34	35	Sub-total	36	37	Sub-total
	X	X			2		X		1							0					X		X	2		X	1
	X				1				0		X					1			X			X		2			0
	X	X			2		X		1		X					1		X	X	X	X			4		X	1
	X				1				0		X					1								0			0
					0				0							0								0			0
		X			1				0							0								0			0
					0				0				X			1								0			0

LEGEND:
X=Strong support for action.
[a] Identification number of responding organization, see appendix III.
+Provided by questionaire respondents.

Strong Support For Federal Government To	Organizations: Professional Provider Group														
	[a]1	2	3	4	5	6	7	8	9	10	11	12	13	14	Sub-total
d. Establish a national clearing house on Sinformation relating to medical malpractice.															0
e. Maintain a national directory listing all medical providers/institutions who have been found guilty of malpractice. Also, list all providers who lose licenses.															0

Hospital Affiliated Group						Medical Malpractice Insurance Group				Legal Group								Consumer Group								Health Insurer Group			
15	16	17	18	19	Sub-total	20	21	22	Sub-total	23	24	25	26	27	28	Sub-total	29	30	31	32	33	34	35	Sub-total	36	37	Sub-total
					0				0							0	X							1			0
					0				0							0				X				1			0

LEGEND:
X=Strong support for action.
[a] Identification number of responding organization, see appendix III.
+Provided by questionaire respondents.

Description of Alternative Approaches for Resolving Claims

The alternative approaches for resolving malpractice claims that we examined are described below. These approaches are grouped as fault-based or no-fault.

Approaches That Maintain the Fault-Based System

Modifying medical malpractice tort law and establishing alternatives to the use of the courts for resolving malpractice claims are two approaches that maintain the concept of provider fault as the basis for compensating injured patients.

The present system for resolving malpractice claims through the legal system is based on establishing that the injury was due to the health care provider's fault, usually negligence. Even though most medical malpractice claims are resolved before jury verdict, the characteristics of the legal system influence which claims are resolved and how they are resolved before jury verdict. Several advantages are attributed to the traditional litigation system, including the protection of individuals' substantive and due process rights, the screening out of unreliable evidence through the use of formal rules of evidence, and an impartial process for resolving claims.[1]

The process for establishing whether the patient's injury was due to the provider's fault is also considered by some individuals to serve as a deterrent to medical malpractice. On the other hand, some believe the litigation system has certain undesirable features, including the need for the injured party to obtain an attorney to gain access to the system, its failure to compensate all medical injuries, the unpredictable nature of compensation, and lack of uniformity in compensating losses.

Alternatives to Use of Courts

The use of pretrial screening panels and arbitration for medical malpractice claims are two approaches designed to discourage use of the courts in resolving medical malpractice claims. As described previously, several states enacted tort reforms to establish pretrial screening panels and to allow the use of arbitration for malpractice claims. A main distinction between the two is that pretrial screening panels serve as a prerequisite to the court, whereas arbitration replaces the court. We examined pretrial screening panels and arbitration separately from the

[1]Institute of Medicine, Beyond Malpractice: Compensation for Medical Injuries, National Academy of Sciences, Washington, D.C., March 1978, p. 33.

other tort reforms since they both are designed to discourage use of the courts.

Pretrial Screening Panels

Pretrial screening panels review medical malpractice cases before they go to court. The panels' objective is to reduce the number of malpractice cases going to court by (1) discouraging further litigation of non-meritorious claims and (2) encouraging early settlement of meritorious claims. Pretrial screening panels are prerequisites to court, and the plaintiff maintains the option of pursuing the claim in court. If effective in reducing the number of claims reaching the court, pretrial screening panels could offer the benefits of

- a less formal, less time-consuming,[2] and possibly less expensive claim resolution mechanism[3] and
- possibly more accurate decisions because the panelists may be better informed than lay jurors.[4, 5]

However, if pretrial screening panels are not effective in reducing the number of claims going to court, they may add an additional step to the claims resolution process that would involve additional time and expense.[6, 7] Other concerns about pretrial screening panels are that they (1) may violate the patient's constitutional rights to due process, if use of panels is mandatory;[8] (2) may favor the health care provider since

[2]Ibid., p. 35.

[3]Robert Pierce, What Legislators Need to Know About Medical Malpractice, National Conference of State Legislatures, July 1985, p. 16.

[4]Peter E. Carlin, Medical Malpractice Pre-trial Screening Panels: A Review of the Evidence, Intergovernmental Health Policy Project, George Washington University, Washington, D.C., October 1980, p. 15.

[5]American Bar Association, Legal Topics Relating to Medical Malpractice, Department of Health, Education, and Welfare, Washington, D.C., January 1977, p. 52.

[6]Pierce, op. cit., pp. 16-17.

[7]Florida Medical Association, Medical Malpractice Policy Guidebook, 1985, p. 188.

[8]Ibid., p. 187.

most panels have a provider representative;[9, 10] and (3) may not be used extensively unless their use is mandatory.[11, 12]

Since 1975, 31 states have enacted provisions for pretrial screening panels; however, the provisions were declared unconstitutional in 3 states and expired or were repealed in 3 others.[13] The characteristics of pretrial screening panels vary significantly from state to state. In most states, all medical malpractice cases must be heard by the panel before they can go to the court. In other states, use of panels is voluntary. Generally, the panels range in size from three to seven members and usually consist of a judge or lay person, one or more attorneys, and one or more health care providers from the same specialty as the defendant or from the same type of institution. The panel typically conducts an informal hearing in which it hears testimony and reviews evidence about the case.

Rules pertaining to evidence heard by the panel are not as strict as those in court. The nature of the panel's decision varies from state to state. For example, in some states panels decide the liability of the defendant; in other states they determine whether the evidence supports the plaintiff or defendant. Some panels may also specify damages suffered by the plaintiff where provider liability is found. The parties may accept or reject the panel's decision. If they accept the decision, the claim may be dropped if the decision was in favor of the defendant or may be settled if it was in favor of the plaintiff. If they reject the decision, they retain their rights to take the claim to court. However, if the claim goes to court, the pretrial screening panel's decision is admissible in most states. Some states also provide an expert medical witness at subsequent trials. In October 1980, eight states also required their pretrial screening panels to report claims involving provider liability to the state's licensing board.[14]

[9]Institute of Medicine, op. cit., p. 35.

[10]Pierce, op. cit., p. 17.

[11]American Medical Association Special Task Force on Professional Liability and Insurance, Professional Liability in the 80's Report 2, American Medical Association, November 1984, p. 16.

[12]Florida Medical Association, op. cit, p. 187.

[13]American Medical Association Special Task Force, Report 2, op. cit., pp. 20-21, (updated as of July 1985).

[14]Carlin, op. cit., p. 26.

A 1980 study of pretrial screening panels found that several state panels seemed to be effectively disposing of claims before the claims went to court. Data obtained in the study indicated that most parties adhere to the panel's decision and losing parties seem more willing to settle or abandon their claims. For example, the study reported large percentages of claims dropped or settled in selected states after a panel hearing:[15]

- Hawaii: 72 percent of claims settled after panel finding of liability; 60 percent settled or dropped after panel finding of no liability.
- New York: 66 percent of claims settled before trial between 1976 and 1978 after panel hearing.
- Tennessee: 281 of 376 claims (75 percent) settled, withdrawn, or dismissed after panel hearing.
- Virginia: 75 of 197 claims (38 percent) disposed of after panel hearing.
- New Jersey: 88 percent of claims disposed of after panel decision.
- Missouri: 45 percent of claims filed with panel resolved with no lawsuit being filed.
- Florida: About 70 percent of claims terminated, dismissed, or settled after claims filed with mediation panel.

(Panels are no longer in effect in Tennessee, Missouri, and Florida because they have been ruled unconstitutional by state courts, repealed by state legislatures, or allowed to expire.)

The study also reported that the possibility or threat of a pretrial screening panel hearing seems to promote early disposition of claims in some states. Furthermore, the study found that screening panels resolve the malpractice claims quicker than conventional litigation. However, the study also pointed out that many panel systems are inactive or underutilized, especially in states where their use is voluntary. Other state panel systems, such as those in Kansas, Pennsylvania, and Rhode Island, have experienced lack of cooperation problems among parties and panelists that have considerably hampered their effectiveness.[16]

A 1985 Florida Medical Association study reported that although some state panels are reportedly processing malpractice cases efficiently and disposing of them at the panel hearing stage, other states report a

[15]Ibid., pp. 29, 31.

[16]Ibid., pp. 32, 37, 39.

serious backlog of cases and administrative problems. This study concluded that it is unclear whether panels are more effective in expediting dispute resolution than other court efforts, such as a special malpractice court with emphasis on the pretrial stage and limits on the discovery period.[17]

The constitutionality of pretrial screening panels has been challenged extensively on several grounds, including

- violation of equal protection clauses,
- violation of due process clauses,
- denial of the right to trial by jury, and
- delegation of judicial power.

Pretrial screening panels have been found constitutional by the highest state court in nine states (Arizona, Indiana, Louisiana, Maine, Montana, Nebraska, New Jersey, Ohio, and Wisconsin). Panels have been declared unconstitutional by the highest state court in three states (Florida, Missouri, and Pennsylvania).[18]

Two bills have been introduced in the 99th Congress that would give states financial incentives to establish pretrial screening panels. These are the (1) proposed Health Care Protection Act of 1985 (S. 175) and (2) proposed Medical Malpractice Reform Act of 1985 (H.R. 2659).

Proposed Health Care Protection Act of 1985

The proposed Health Care Protection Act of 1985 (S. 175) was introduced in the 99th Congress on January 3, 1985. The bill would provide monetary incentives for states to establish medical malpractice screening panels and includes provisions regarding risk management programs, periodic payment of awards, attorney's fees, and reporting requirements of the panels.

Under the act, the malpractice screening panels would be required to have at least three members, including

- one health care professional, chosen from a published list of licensed or certified health care professionals;
- one person admitted to practice law in the state's courts; and

[17]Florida Medical Association, op. cit., pp. i, 188.

[18]American Medical Association Special Task Force, Report 2, op. cit., pp. 20-21.

- one layperson.

Claims would be filed with a panel in the state where the alleged malpractice occurred, and the defendant to the claim would be required to provide a timely response. A hearing, based on rules and procedures established by the panel, would be held within 180 days of claim filing, subject to one continuance of 90 days for extenuating circumstances. The panel would be required to provide a written decision within 30 days after the hearing. In cases where the panel finds liability, it would award damages and provide for periodic payments for awards over $100,000. The parties would be entitled to a trial de novo (new trial) in state court if the parties file a motion within 60 days of the panel's decision. However, the panel's decision would be admissible as evidence, and the party bringing the action would be liable for all court costs and reasonable attorney's fees of the opposing parties if he or she does not substantially prevail in the action. In claims where the defendant is found liable for damages, the panel would be required to report the nature of the claim and decision to the state insurance commission and licensing board within 30 days after the decision.

The bill also contains provisions regarding attorney's fees and risk management programs. The amount of payments to the claimant's attorney would be subject to a sliding scale, whereby attorney's fees are reduced proportionately as the award increases.

The bill encourages states to establish health care facility risk management programs to identify and report all known or suspected incidents of malpractice and their causes. It would require each risk management office to establish case files on each incident and to review the cases to identify actions to be taken to reduce further incidents.

Proposed Medical Malpractice Reform Act of 1985

The proposed Medical Malpractice Reform Act of 1985 (H.R. 2659) was introduced in the 99th Congress on June 4, 1985. The bill is intended to establish a program in the Department of Justice to fund state medical malpractice programs that comply with federal standards. Major provisions in the bill include

- creating medical malpractice screening panels to resolve claims,
- establishing criteria for panel composition and panel operating procedures,
- establishing a limit of $250,000 for noneconomic losses that panels may award claimants,

- requiring panel decisions and settlements to be reported to the state insurance commissioner and to the appropriate state licensing or certification body, and
- establishing a sliding scale for claimant attorney's fees which would involve setting limits on such fees based on the award amounts.

The screening panels created under the act would hear claims and determine damages. Parties to a claim could appeal the panel decision to the appropriate state court for review. That court could send the parties back to the state panel if there were procedural errors, allow a trial if the panel decision were clearly erroneous, or uphold the panel decision. If a trial were allowed, neither the written record of the panel proceedings nor the written panel decision would be admissible in the trial.

Panels would be composed of at least three members:

- One or more health care professionals licensed or certified by the state, and when practical, of the same medical specialty as the defendant.
- One or more people admitted to practice law in the state.
- One or more lay people not affiliated with the health care professions and who represent consumers.

Panel members and panel employees would be immune from suit for defamation, libel, or slander arising from their official duties with a panel. The only exception to immunity would be if there were malice or knowledge that a defamatory statement is false.

Procedures for claims processing would require the claimant to file a claim with the panel. A copy would also be served on each defendant. Defendants would be required to answer claims in a timely fashion. Panels could hold hearings, take testimony, and receive evidence. Panels could administer oaths to witnesses and issue court-enforceable subpoenas to witnesses and for evidence. Panels would follow applicable state law for evidence and procedure, subject to any special rules that may be established by a state's attorney general. Panels would be required to decide a claim within 1 year of the claim filing, plus one 90-day continuance for extraordinary circumstances. Information about collateral sources of payment would be allowed only for determining the amount of an award. Panels would dismiss frivolous claims and impose administrative costs on claimants who pursue such claims. Those costs could not exceed $10,000.

A panel would be required to transmit its written decision to the claimant and each defendant within 30 days after the conclusion of the hearings. The decision would contain a statement of the findings of fact, conclusions of law, and the amount of damages awarded, if any. Awards would be enforceable by the appropriate state court. Awards for noneconomic losses would be limited to $250,000.

Panel findings and settlement agreements filed with the panels would be reported to the state insurance commission and to the appropriate state licensing or certification body. The insurance commissioner would make the reports available to the public. The insurance commissioner would also allow malpractice insurers to adjust rates for providers who are found liable by a panel, or who entered into three or more settlements within the 3-year period before their application for malpractice insurance, if they agreed to pay the claimants in those settlements.

Plaintiff attorney contingency fees would be limited by a sliding scale in which the fees would decline as the awards increase.

Arbitration

Arbitration is a fault-based alternative to the use of the courts in resolving medical malpractice claims. It involves submitting a dispute between parties to persons, selected by law or agreement, for resolution. The use of arbitration may be voluntary or compulsory among the parties, and the arbitration decisions may be nonbinding or binding on them.[19] Voluntary and binding arbitration is the form of arbitration proposed for resolving medical malpractice claims. As such, it is considered to be a substitute for the court in resolving malpractice claims. Arbitration panels operate with less formality than courts, but tort law principles govern the decisions in that liability is established only upon finding that the injury was due to the health care provider's negligence or fault.[20]

Several advantages have been attributed to the use of binding arbitration over court litigation for medical malpractice claims:

- More prompt resolution of claims.[21]

[19]Institute of Medicine, op. cit., p. 36.

[20]American Arbitration Association, Arbitration - Alternative to Malpractice Suits, November 1975, p. 5.

- Informal, less complex, and private hearings.[21]
- Less costly.[21]
- More objective and equitable results from expert arbitrators compared to lay juries.[22]
- Greater access available to small claims.
- Final decisions not subject to appeal.
- Reduced burden of the courts in hearing medical malpractice cases.[23]

However, several concerns have been noted:

- Malpractice cases involving multiple health care providers, some of which have agreed to arbitrate while others have not, could allow the patients to seek compensation through both arbitration and the courts.[24]
- Arbitration panels may be biased in favor of providers if a provider is a member of the panel and other members defer to this person for technical expertise.[24]
- Since arbitration awards are smaller than court awards, they may inadequately compensate the injured person.
- The informality of the arbitration hearings may violate the due process rights of the parties involved.[24]
- Patients agreeing to arbitrate future malpractice claims may not fully understand arbitration agreements.
- The private nature of arbitration process may reduce the public stigma of provider liability, which may reduce providers' incentive to reduce the incidence of malpractice.

Medical malpractice claims can be arbitrated in most states under general arbitration statutes. In July 1985, 13 states had specific arbitration statutes for resolving medical malpractice claims.[25] Most such statutes allow arbitration agreements to cover both present and future claims; however, all require that the patients' participation in the arbitration agreement must be voluntary. So far, no state has enacted legislation

[21]Institute of Medicine, op. cit., pp. 36-38.

[22]Irving Ladimer, Joel C. Solomon, and Michael Mulvihill, "Experience in Medical Malpractice Arbitration," The Journal of Legal Medicine, Vol. 2, No. 4, 1981, pp. 443-444, 451, 454.

[23]Institute of Medicine, op. cit., p. 38.

[24]Institute of Medicine, op. cit., pp. 37-38.

[25]American Medical Association Special Task Force, Report 2, op. cit., pp. 20-21.

requiring compulsory arbitration for medical malpractice claims.[26] According to Dr. Irving Ladimer (see page 17), arbitration has been used in resolving medical malpractice claims in California; Colorado; Michigan; Suffolk County, New York; and Cleveland and Cincinnati, Ohio. Two health maintenance organizations in California—Ross-Loos Medical Group and Kaiser—also use medical malpractice arbitration.[27]

Generally, the arbitration process for malpractice claims is similar to the operation of a pretrial screening panel, except that the members of the arbitration panel are specifically trained in dispute resolution and have the authority to make a final ruling on provider liability and damages.[28] Although specific characteristics may vary regarding the process of medical malpractice arbitration, generally it would involve initially an agreement among the patient and health care provider(s) to arbitrate any malpractice claims. This agreement may cover existing or future claims. Upon experiencing an injury and deciding to file a claim, the patient would file the claim with an administering organization, which would then help select members of an arbitration panel.

Panels generally consist of three or more members, including a physician, an attorney, and others, such as a layperson or a retired judge. Before the hearing, the panel and the parties meet to discuss types of evidence that will be allowed. Discovery mechanisms available for court are also available to the parties before the hearing. At the hearing, both parties present their evidence to the panel. The hearings are less formal than court proceedings, and the rules of evidence are often relaxed. After the hearing, the panel decides whether the health care provider is liable, using the principles of tort law. If liability is found, the panel may assess damages. The panel's decisions are final and enforceable by the courts. An appeal can be made only if the arbitration contract was illegal or if improper arbitration procedures were used.

We identified the following four studies on the use of arbitration:

Southern California Arbitration Project

Begun in July 1969, the Southern California Arbitration Project, the first hospital-based arbitration experiment in the country, involved

[26]Frank A. Sloan, "State Responses to the Malpractice Insurance 'Crisis' of the 1970's: An Empirical Assessment," Journal of Health Politics, Policy, and Law, Vol. 9, No. 4, Winter 1985.

[27]Ladimer, Solomon, and Mulvihill, op. cit., p. 433.

[28]Institute of Medicine, op. cit., p. 36.

eight hospitals in the Los Angeles area. About 90 percent of medical staff physicians at these hospitals agreed to have any medical malpractice claims arising from incidents during hospitalization resolved through voluntary binding arbitration. Patients were asked to agree at the time of admission to arbitrate any future medical malpractice claims arising from their hospitalization.

A study examining differences between the arbitration hospitals and a control group of similar hospitals for periods before the experiment (1966-69) and after the experiment began (1970-75) found that[29]

- arbitration hospitals had 63 percent fewer claims filed over the two time segments;
- arbitration hospitals closed claims 22 percent faster; and
- arbitration hospitals realized net differential savings on closed claims of 62 percent—41 percent for loss payments and 21 percent for investigation and defense costs.

Michigan Medical Malpractice Arbitration Program

As a condition of insurability, hospitals and other health care institutions in Michigan are required by a 1975 statute to offer arbitration for resolving any medical malpractice claims to patients at the time of treatment. The statute requires that the arbitration agreement contain a clause advising the patient that agreeing to arbitration is not a prerequisite to health care and that the agreement may be rescinded by the patient within 60 days of discharge.

A 1983 study by Applied Social Research, Inc., of 2,611 medical malpractice hospital-based claims closed between June 1, 1978, and June 30, 1982, in Michigan found that[30]

- the average elapsed time between injury and claim closing was shorter for claims filed in court than filed with arbitration (39.1 versus 41.1 months);
- expenses associated with defending claims were less for claims filed with arbitration than claims filed in court ($3,652.50 versus $3,914.60);
- the median indemnity payment for claims filed with arbitration was less than claims filed in court ($1,000 versus $1,875); and

[29]Duane H. Heintz, "Medical Malpractice Arbitration: A Viable Alternative," The Arbitration Journal, Vol. 34, No. 4, December 1979, p. 18.

[30]Applied Social Research, Inc., Evaluation: State of Michigan Medical Malpractice Arbitration Program - Summary Report, October 1984, pp. 5, 6, 12.

- time between filing of claim and resolution was less for claims filed with arbitration than for claims filed in court (20.2 versus 22.8 months).

The study also concluded that indemnity payments made for comparable injuries were more consistent in arbitration than in the court system.

American Arbitration Association Study

The American Arbitration Association examined the association of the forum (arbitration or court) for resolving medical malpractice claims with certain outcomes (time and cost). The study included samples of claims closed for the periods 1971-80 for arbitration and 1975-78 for court. Since all of the claims examined were from one California region and the arbitration sample was small, the study cautioned that generalizations should not be made. Nevertheless, the study found that[31]

- cases that entered arbitration were likely to involve fewer defendants and were based on injuries somewhat less severe than cases that enter the courts;
- there appeared to be no association in either court or arbitration between the number of defendants involved in an incident and the probability of obtaining indemnity;
- the total amounts of indemnity paid per incident in arbitration and in court were not statistically different;
- the amount of the indemnity increased with a larger number of defendants and more severe injury in both forums; and
- time from injury to claim closure was shorter for claims that entered arbitration than for claims that entered court at all levels of injury severity.

Study of Ross-Loos Medical Group Use of Binding Arbitration

Since 1929, the Ross-Loos Medical Group in California has used binding arbitration for resolving medical malpractice claims. This experience was evaluated by Dr. David S. Rubsamen in a report prepared for the 1973 Department of Health, Education, and Welfare Secretary's Commission on Medical Malpractice.[32] The study examined 177 active and

[31]Ladimer, Solomon, and Mulvihill, op. cit., pp. 448-450.

[32]David S. Rubsamen, "The Experience of Binding Arbitration in the Ross-Loos Medical Group," Appendix: Report of the Secretary's Commission on Medical Malpractice, Washington, DC, DHEW Publication No. (OS) 73-89, January 1973, pp. 424-425.

closed cases, of which 35 were closed cases dating back to 1964. However, only three cases were resolved by completed arbitration. The study drew the following conclusions:[33]

- Arbitration was an unqualified success for Ross-Loos physicians since they felt reassured that claims could be resolved in privacy and with minimal delays.
- Defense costs were economical for arbitration proceedings.
- Attorneys interviewed agreed that, properly selected, a neutral arbitrator would be objective.
- The existence of arbitration at Ross-Loos did not promote a plethora of suits.

No-Fault Approaches for Resolving Malpractice Claims

A number of no-fault approaches for compensating medical injuries have been proposed. These approaches usually are designed to avoid many of the difficulties in the current litigation system, such as those associated with establishing that medical injuries resulted from health care provider negligence or fault. A common characteristic of no-fault approaches is that compensation for covered events becomes available upon establishing only that the event or injury occurred without the necessity of identifying its causation. The no-fault approaches generally specify what types of losses are compensated and usually limit the amount of compensation available; however, amounts of compensation available to the injured person are generally more predictable than in the current fault-based system. Because access to compensation is easier for the injured person under no-fault approaches, concerns are expressed that more claims may be filed, which may increase total costs.

The approaches vary in the types of injuries compensated, the procedures for filing claims, and financing. Except for the approaches used in Sweden and New Zealand, the no-fault approaches are theoretical. We obtained information on the following no-fault approaches for compensating medical injuries:

- Medical adversity insurance.
- Elective no-fault insurance.
- Social insurance approaches, including a worker's compensation-type approach for medical malpractice, and approaches used in New Zealand and Sweden.

[33]Ibid., p. 443.

In addition, we obtained data on a quasi no-fault plan—the proposed Medical Offer and Recovery Act (H.R. 3084, 99th Congress).

Medical Adversity Insurance

Medical adversity insurance was initially proposed by Professor Clark Havighurst and Dr. Lawrence Tancredi as a no-fault insurance plan to eventually replace the present adversarial legal system for resolving medical malpractice claims.[34] Under the plan, a patient experiencing a predetermined medical outcome specified in the policy would be automatically compensated for certain expenses and losses and would be denied any other recovery for the medical outcome.[35]Access to the traditional fault-based system, i.e., litigation or arbitration, would be available for injuries or outcomes not included in the policy.[36]

Medical adversity insurance would reportedly offer compensation to more injured patients and provide compensation more promptly for covered events than the current system. It would use a uniform method of compensating injured persons with similar injuries. By experience-rating insurance premiums paid by health care providers, it purportedly would generate incentives for providers to improve the quality of medical care in order to avoid the medical outcomes covered under the plan.[37] Individual provider experience data developed under the plan were also offered as a means of possibly strengthening provider peer review. Other advantages would include a simple administrative procedure for obtaining compensation for covered events and highly predictable amounts of compensation for covered events.[38]

On the other hand, Professor Havighurst (see p. 17), stated that medical adversity insurance may (1) have higher costs than the current system since more persons would be compensated, (2) cause providers to select less appropriate treatments or refuse to accept high-risk patients in order to avoid the risk of compensable outcomes, (3) encourage a deterioration of provider-patient relationships since providers would have less incentive to maintain good relations to avoid lawsuits, and (4) result

[34]Clark C. Havighurst and Laurence R. Tancredi, "Medical Adversity Insurance - A No-Fault Approach to Medical Malpractice and Quality Assurance," Insurance Law Journal, February 1974, p. 69.

[35]Ibid., p. 71.

[36]Ibid., p. 74.

[37]Institute of Medicine, op. cit., p. 40.

[38]Ibid., p. 40.

in problems in resolving claims when multiple providers and insurers are involved if several different insurers are involved with various outcomes covered for each provider (if the approach is implemented contractually).

Under medical adversity insurance, a list of relatively avoidable medical outcomes or events would be developed by panels composed of physicians, lawyers, and consumer representatives. The outcomes included on the list would be clearly defined to reduce the potential for claims disputes between patients and insurers. Over time, more avoidable outcomes would be added to the list of covered outcomes.[39] The panels would also establish the amounts of compensation to be paid for losses related to the injury. Compensation would be paid for medical expenses, lost wages, and possibly pain and suffering. However, there would be minimum and maximum limits on compensation for lost wages, and compensation for pain and suffering could vary based on the temporary or permanent nature of the injury. Panels would periodically review covered outcomes and compensation amounts to add or delete compensable outcomes based on changes in medical practice and to adjust compensation amounts.[40]

As initially proposed, medical adversity insurance would have been implemented by legislation. As such, health care providers would be required to participate in the plan, and statutory provisions would address amounts of compensation available. Providers would be required to inform the patient of the occurrence of a covered outcome. Failure to inform the patient would make the provider, rather than the insurer, personally liable for any compensation and also for any punitive damages assessed by a claims court.

Upon occurrence of the covered outcome, the patient or provider would file the claim with the insurer, who would determine whether the injury was a covered outcome and if so, make the compensation payment promptly. Disputes that might arise between the injured parties and insurers regarding whether injuries are covered events would be resolved through the courts or arbitration.

[39]Clark C. Havighurst, "Medical Adversity Insurance - Has Its Time Come?" Duke Law Journal, Vol. 1975, p. 1254.

[40]Havighurst and Tancredi, op. cit., pp. 71-72.

The medical adversity insurance plan would be funded by premiums paid by health care providers. Premiums would be based on the individual provider's experience in terms of number of claims and amounts of compensation paid. The individually rated premiums are designed to provide financial incentives for providers to avoid outcomes covered by the plan.

Professor Havighurst now believes that medical adversity insurance should be implemented through the use of private contracts rather than by legislation. Under the contractual approach, health care providers would voluntarily contract with insurers to cover certain designated outcomes, which would be paid on a no-fault basis. Patients would also contract with providers to accept, without further recourse for compensation, those compensation amounts for events covered in the provider's medical adversity insurance policy. Variations in the covered events and compensation amounts would exist among health care providers. Under this approach, the patient would be responsible for identifying whether a covered event has occurred and for filing the claim with the provider's insurer. Patients who experienced injuries not covered in the provider's medical adversity insurance policy could seek damages in the courts or through arbitration.

Medical adversity insurance is theoretical since it has not been used. The estimated cost of the approach, if implemented, is unknown, although its costs are expected to appear higher than under the current system.[41] Professor Havighurst believes that costs may decline over time if the approach is successful in improving the quality of medical care.

Proposed Medical Offer and Recovery Act

The proposed Medical Offer and Recovery Act (H.R. 3084) was introduced in the 99th Congress on July 25, 1985. The bill's objective is to provide fair compensation for more victims of medical malpractice, who would receive fair payment for economic losses quickly, without the expense, trauma, and delay of litigation. Professor Jeffrey O'Connell (see p. 17), a principal proponent of this approach, said the bill would solve the following problems in the present tort system for resolving malpractice claims:

- The need to determine provider fault, which is difficult and costly.
- Payment for noneconomic losses, which are difficult to determine and costly.

[41]Havighurst and Tancredi, op. cit., pp. 89-91.

- Duplicate payment of losses already paid by other sources to the injured party.
- Lump-sum payments, which may overcompensate the injured party for losses sustained.

The proposal is considered a quasi-no-fault plan because, under the plan, health care providers can selectively decide to foreclose a patient's right to sue the provider for damages from medical malpractice. Under the proposal, health care providers within a designated period of time (180 days from an occurrence) can offer to pay a patient's net economic losses arising from medical injuries and, by tendering the offer, foreclose the patient's right to sue the provider for medical malpractice except for cases in which the provider intentionally caused the injury or a wrongful death occurred. Under the proposal, the health care provider and his or her insurer could choose which cases would be in the provider's interest to tender an offer.

Only the patient's economic losses, above amounts paid by other sources such as private health insurance, from the injury would be paid under the proposal. Economic losses include medical expenses, rehabilitation and training expenses, work losses, and replacement services losses. Reasonable attorney's fees to collect benefits would also be allowed. No compensation would be available for any noneconomic losses from the injury, such as pain, suffering, mental anguish, or loss of consortium.

According to Professor O'Connell, the vast majority of payments would be made to patients as the losses are incurred rather than in lump sum. Patients would submit reasonable proof of net economic losses incurred to the health care provider's insurer, which would be required to make payments within 30 days. Payments would be available as long as the patient's injury continues. However, future payments for the injury would not be available if no payments have been made within the last 5 years. Provisions also allow the health care provider or his insurer to require the injured party to submit to a mental or physical examination if the injured party's mental or physical condition is material and relevant to compensation benefits.

The proposal requires that any lump-sum settlement over $5,000 be reviewed by the court to ensure that it is fair to the injured party.

In cases where the health care provider does not make an offer, the patient can request within 90 days that the claim be resolved by binding

arbitration. Recovery from arbitration would be limited to the patient's net economic losses and reasonable attorney fees.

To participate in the program, health care providers would be required to carry sufficient malpractice insurance or post sufficient bond. This provision is designed to protect patients from providers unable to pay compensation.

The proposal includes provisions designed to enhance the quality of medical care. To participate in the program, health care institutional providers are required to report any actions adversely affecting the clinical privileges of a health care professional (other than suspension of privileges for 30 or fewer days or discontinuance of a contract) to the appropriate state health care licensing board. It also provides confidentiality and immunity from suit to those furnishing information regarding the incompetence of a health care professional to a hospital or peer review committee or health care licensing board.

The proposed legislation is designed to serve as model legislation for states to consider in enacting state legislation to encourage prompt payment of patients' economic losses. Unless a state enacts similar legislation by January 1, 1988, the program would apply to beneficiaries of federal health programs, including Medicare, Medicaid, the Federal Employee Health Benefit Program, the Veterans Administration, and the Civilian Health and Medical Program of the Uniformed Services.

The cost of this approach is unknown since it has never been used. Professor O'Connell believes that the cost would probably not exceed the cost of the current system and may be lower because (1) providers would not tender offers for small claims for which they believe the plaintiff would have difficulty obtaining an attorney and (2) offers would be tendered for large claims that may go to court and the offer would limit payments to the patient's net economic losses.

Elective No-Fault Insurance

Elective no-fault insurance was proposed as an alternative to the fault-based system for resolving accident claims, including those arising from medical care.[42] Under elective no-fault insurance, health care providers could elect individually to choose certain risks or adverse outcomes for which they could purchase no-fault insurance. Compensation would be paid to injured persons upon occurrence of the covered outcome without

[42]Institute of Medicine, op. cit., p. 41.

having to find the health care provider at fault for the injury. Payment of compensation on a no-fault basis would foreclose the patient's right to file claims in the current fault-based system, unless the provider's insurance was inadequate to pay losses or the injury was intentional. Access to the traditional fault-based system, i.e., court or arbitration, would be available for injuries or outcomes not covered in the provider's elective no-fault insurance policy. Elective no-fault insurance was designed to offer the following purported benefits for covered outcomes over the fault-based system for resolving claims:[43]

- Legal fees and costs to determine whether injuries were due to provider fault and the stigma of liability would be avoided.
- No payments for pain and suffering would be available.
- Payments would be reduced by amounts from collateral sources, such as sick leave or health insurance.
- Payments would be made as losses accrue to the injured person rather than in a lump sum.

Even though more persons would be expected to be paid under elective no-fault insurance, the amount of payment to each was expected to be much less. The Institute of Medicine attributed the following advantages to the approach:[44]

- Access to compensation for covered events would be simple.
- Providers would be able to elect the injuries and type of losses to be covered, set limits on no-fault benefits, and specify appropriate deductible levels.
- There would be certainty of compensation for the injured patient within a specified range of elected events.
- Delays and costs inherent in traditional litigation would be eliminated for covered events.

However, the Institute of Medicine found the following disadvantages with the approach:[45]

- Elective no-fault would be confusing to patients because the type and amount of compensation would vary from provider to provider.

[43]Jeffrey O'Connell, "No-Fault Insurance for Injuries Arising from Medical Treatment: A Proposal for Elective Coverage," Emory Law Journal, Vol. 24, 1975, pp. 35-36.

[44]Institute of Medicine, op. cit., p. 43.

[45]Institute of Medicine, op. cit., p. 43.

- The ability of providers to elect substantial deductibles for the purpose of discouraging nuisance claims would do little to assure compensation to those with small but meritorious claims.
- There would be no linkages to regulatory or quality assurance activities and no provision for merit-rated premiums.
- The greater knowledge of providers could bias the election of covered events in favor of providers.

Another concern is that implementation of the approach could be more costly than the current system because a much larger number of smaller claims may be filed under elective no-fault insurance.

Under elective no-fault insurance, health care providers could individually choose to cover certain predetermined risks or outcomes under no-fault insurance and choose to have other risks or outcomes handled under the fault-based system. For outcomes covered, providers could purchase no-fault insurance or self-insure for specified limits of coverage.

Elective no-fault insurance would provide compensation to cover the injured person's out-of-pocket net economic losses for medical expenses, lost wages, replacement services[46] (such as the cost of a maid or gardener), and rehabilitative services. Compensation would also be available for survivors' economic losses and replacement services due to the covered outcome. Compensation amounts would be reduced by any payments received from collateral sources.

Up to the limits of the provider's no-fault insurance policy, compensation would cover 100 percent of expenses for medical expense, lost wages, reasonable replacement services, and reasonable rehabilitation services. However, the proposal limited compensation to $200 per week for lost wages, survivors' economic loss, replacement services loss, and survivors' replacement services.[47] Compensation would not be available under elective no-fault insurance for pain and suffering. Compensation under the proposal would be paid as the losses are incurred by the injured party or survivor rather than in a lump sum. The proposal would also permit health care providers to specify deductibles for the no-fault insurance policies in which claims below the deductible level could be handled under the fault-based system.

[46]Jeffrey O'Connell, "An Elective No-Fault Liability Statute," Insurance Law Journal, May 1975, pp. 264-268, 269, 279.

[47]Ibid., pp. 261, 268, 269, 279.

Claims for injuries covered under the no-fault insurance would be filed directly with the provider's insurer. The insurer would determine whether the claim is covered under the provider's no-fault insurance policy. For covered injuries, not later than 30 days after the claim is filed, the insurer would review documentation for expenses claimed and pay the claimant.

The costs of operating an elective no-fault insurance system are unknown. However, it could cost more than the current system if more claims are generated. If this becomes a problem, Mr. O'Connell believes that the frequency of claims could be reduced by raising the policy's deductible.

Elective no-fault insurance is a theoretical approach and has never been used for resolving medical malpractice claims.

Social Insurance for Compensating Medical Injuries

The concept of social insurance[48] for compensating medical injuries, including those caused by medical malpractice, was cited as a possible approach in 1978 by the National Academy of Sciences' Institute of Medicine. The state workers' compensation program has been offered as a model for a social insurance system that would compensate medical injuries.[49] Sweden and New Zealand have social insurance-type programs for compensating medical injuries.

Common characteristics of social insurance systems identified by the Institute of Medicine included the following:[50]

[48]Social insurance is defined in the Dictionary of Insurance by Lewis E. Davids as: "A device for the pooling of risks by their transfer to an organization, usually governmental, that is required by law to provide pecuniary or service benefits to or on behalf of covered persons upon occurrence of certain pre-designated losses under all of the following conditions: (1) coverage is compulsory by law in virtually all instances; (2) except during a transition period following its introduction, eligibility for benefits is derived, in fact or in effect, from contributions having been made to the program by or in respect of the claimant or the person as to whom the claimant is a dependent; there is no requirement that the individual demonstrate inadequate financial resources, although a dependency status may need to be established; (3) the method for determining the benefits is prescribed by law; (4) the benefits for any individual are not usually directly related to contributions made by or in respect of him but instead usually redistribute income so as to favor certain groups such as those with low former wages or a large number of dependents; (5) there is a definite plan for financing the benefits that is designed to be adequate in terms of long-range considerations; (6) the cost is borne primarily by contributions which are usually made by covered persons, their employers, or both; (7) the plan is administered or at least supervised by the government; and (8) the plan is not established by the government solely for its present or former employees."

[49]Institute of Medicine, op. cit., p. 43.

[50]Institute of Medicine, op. cit., pp. 43-45.

- Programs are established on the premise that society is better able to bear the cost of adverse outcomes than the injured party.
- Compensation is usually predetermined and limited in amount and duration.
- Benefits are scheduled, that is, a standard formula is applied to the same types of injuries.
- An administering agency processes and validates claims and makes payment of the benefits.
- Determination of fault is usually irrelevant.
- Compensation is essentially automatic for covered losses.
- General tax revenues would fund a "pure" social insurance system.

The Institute of Medicine identified the following advantages of social insurance:[51]

- Access for injured patients to compensation would be enhanced.
- More medical injuries would be compensated, but probably at a lower average amount per claim than in existing approaches.
- Awards would be predictable.

However, the Institute also identified the following disadvantages:[52]

- The budgetary cost would be high.
- In exchange for predictability of awards, individualized valuation of loss would be eliminated.
- Certain social insurance plans would not retain provider accountability or offer incentives for providers to avoid medical injuries, although this is not a necessary characteristic of social insurance.

Three types of social insurance systems for compensating medical injuries are described below. The workers' compensation-type approach is conceptual, while the New Zealand Accident Compensation Program and Sweden's Patient Compensation Program have been in use for a decade.

[51]Institute of Medicine, op. cit., p. 46.

[52]Institute of Medicine, op. cit., p. 46.

Workers' Compensation-Type Approach

As described earlier, state workers' compensation programs have been referred to as a model for compensating medically related injuries. However, modification of a state workers' compensation program to be applicable to medical injuries is only in the conceptual stage, and specific procedures have not been defined.

Workers' compensation programs used in the United States vary from state to state. These programs provide compensation for work-related injuries or diseases.[53] State administering agencies handle claims arising from work-related injuries. These agencies (1) supervise compliance with statutory requirements and (2) resolve disputes between the injured party and the employer.[54]

Compensation types and amounts are specified in each state's workers' compensation statute. Such statutes usually provide for[55]

- full compensation of medical and rehabilitation expenses and
- limited compensation for lost income (usually 50 to 67 percent).

Noneconomic losses are not compensated.

Under the program, employers are responsible for paying benefits to workers. Most employers purchase insurance to cover them against workers' compensation claims. Sources of insurance available to employers vary among the states—some require employers to insure with an exclusive state fund; some allow them to insure with either the state fund or to self-insure; and others allow them to either self-insure, purchase insurance from a state fund, or purchase insurance from a private insurer. Premiums vary by type of industry, size of company, and sometimes the company's accident experience. However, state rate-setting commissions usually determine the premiums.[56]

Mr. Eric Oxfeld (see p. 17) provided information on how workers' compensation programs may be modified for compensating medical injuries. Although a workers' compensation approach applied to medical injuries is only conceptual, he said that certain basic elements would remain,

[53]U.S. Chamber of Commerce, Analysis of Worker's Compensation Laws 1985, p. vii.

[54]Ronald Conley and John Noble, "Workers' Compensation Reform: Challenge for the 80's," Research Report of the Interdepartmental Workers' Compensation Task Force, Vol. 1, June 1979, p. 42.

[55]U.S. Chamber of Commerce, op. cit., pp. 17-27.

[56]Conley and Noble, op. cit., pp. 42-43.

including (1) compensation for all injuries, regardless of provider fault; (2) limited recovery by injured parties; and (3) mandatory provider participation. Compensation would be available for medical and rehabilitation expenses and some limited amounts for noneconomic losses.

Claims would be filed with the provider or the administering agency. The agency would determine whether the claim is covered by the program, the degree of the patient's disability, and the appropriate compensation amount. For some claims, the agency may not need to be involved; rather the provider would accept the claim. The system could be financed by health care providers through three types of insurance mechanisms: (1) private insurers, (2) self-insurance, and (3) state-run programs.

Mr. Oxfeld believes a workers' compensation-type approach for resolving malpractice claims would offer the following advantages:

- Faster disposition of claims, especially for more common and obvious injuries.
- More predictable awards.
- Lower cost of health care if malpractice insurance costs are reduced and practice of defensive medicine declines.
- Larger percentages of the insurance premium dollar would go to the injured patient.

However, he believes that such a system may have the following disadvantages:

- A larger number of claims.
- More disputes over the degree or length of disability.
- Social resistance to foreclosing the patient's right to sue for damages.
- Difficulty in updating benefit schedules and limits on compensation.
- Resistance to having limits on recoveries for medical injuries and no limits on recoveries for similar injuries caused by other circumstances.

New Zealand Accident Compensation Act

New Zealand's Accident Compensation Act, which became effective in April 1974, removed all claims for damages for accidental injuries from its tort system.[57] Under the act, compensation is available on a no-fault basis for personal injury or death arising from all accidents, including

[57] Accident Compensation Corporation, Accident Compensation Coverage - The Administration of the Accident Compensation Act, Wellington, New Zealand, Seventh Edition, 1983, pp. 9-10.

medically related ones. All New Zealand residents are covered by the system at all times.[58]

Under the program, various types of compensation are available when a person suffers personal injury by accident, including

- payment for loss of earnings (80 percent of average weekly earnings at time of accident but limited to a maximum of about $340 in U.S. dollars a week);[59]
- reasonable cost of medical and/or dental treatment;
- reasonable cost of transport to doctor or hospital for initial treatment;
- reasonable cost of transport, accommodation, and meals in certain cases for further medical or rehabilitative treatment;
- payment in certain cases for damage to, or loss of, natural teeth;
- payment for damage to any artificial limb or aid and to any clothing and spectacles worn or used at the time of the accident;
- payment for reasonable cost of necessary constant personal attention of injured party following the accident;
- actual and reasonable expenses and losses necessarily and directly suffered as a result of the injury;
- rehabilitation and retraining assistance;
- lump sum for permanent physical disability (limited to maximum of about $9,600 in U.S. dollars);[60]
- lump sum for pain and suffering, disfigurement, and loss of enjoyment of life (limited to maximum of about $5,650);[61]
- lump sums to dependent spouse (limited to maximum of $2,260) and dependent children (limited to maximum of $1,130) in the event of death as a result of accident;[62]
- possible compensation to a member of injured party's family for loss of services through injury or death by accident;
- earnings related compensation to dependent spouse and other dependents as a result of death by accident.
- payment to dependents for loss of support, such as reduction in pension as result of death by accident;

[58]Ibid., pp. 9, 12-14, 17.

[59]Accident Compensation Corporation, Benefits and How to Claim Them, Wellington, New Zealand, April 1, 1983, p. 3.

[60]Ibid., p. 3.

[61]Ibid., p. 3.

[62]Ibid., p. 3.

- actual and reasonable expenses incurred by persons helping injured party after accident; and
- reasonable funeral expenses.

The Accident Compensation Corporation administers the program. To receive compensation, a person must file a claim with the Corporation. The Corporation determines whether the claim is covered under the program and, if so, determines and pays compensation. If the accident victim is dissatisfied with the Corporation's determination of the injury's applicability under the law or compensation amounts, he can appeal the decision to the Accident Compensation Appeal Authority, to New Zealand's High Court, and then to the Court of Appeal on questions of law. According to a British Medical Association study,[63] awards under the program are processed promptly although delays are experienced when nonaward decisions are appealed. The Accident Compensation Corporation does not grant about 40 percent of the claims for medical injury.

The program is financed by three sources: (1) levies on employers and self-employed persons, (2) levies on owners and drivers of motor vehicles, and (3) money appropriated by Parliament. Investment income is also used to fund the program. Total expenditures under the program for the year ended March 31, 1984—including compensation payments, financial grants, safety programs, and other expenses—were about $161 million in U.S. dollars.[64]

According to the British Medical Association study, the program appears to have been fully accepted by the New Zealand population and physicians.

Sweden's Patient Compensation Program

Sweden established its patient compensation program on January 1, 1975,[65] to more adequately compensate persons injured from medical treatment. Injured patients have a choice of pursuing compensation in tort or receiving compensation under the patient compensation program without having to prove health care provider fault.

[63]British Medical Association, Report of the No-Fault Compensation for Medical Injury Working Party, 1983, Appendix I, p. 1.

[64]Accident Compensation Corporation, op. cit., p. 55.

[65]British Medical Association, op. cit., Appendix I, p. 2.

The program is the result of a private agreement between the Federation of County Councils (the regional government) and a consortium of Swedish insurers. The program is not an activity of the Swedish federal government. The county councils are the principal owners and operators of Sweden's hospitals and clinics and are the principal employers of most physicians. The insurance consortium administers the program. The insurance arrangement provides coverage for the county councils and its employees, even if the injured party sues in tort.

The program runs in parallel with other Swedish social, health, and sickness plans and covers about 90 percent of Sweden's population.[66] Compensation is provided for injuries if a direct connection exists between the injury and health care treatment and the losses are not compensated under other social programs. Specifically, five types of injuries are covered:[67]

1. Treatment.

2. Diagnostic.

3. Accidental.

4. Infection.

5. Injuries caused by diagnostic treatment.

Claims for compensation are handled by the consortium, which employs full-time physicians to assess the validity of claims, i.e., whether the injuries are covered, and to determine the amounts of compensation. If the claimant is not satisfied with the consortium's decision, he or she can appeal to a claims panel for a review of the claim. The decision of the review panel may be appealed further to arbitration in accordance with Swedish arbitration law. Under the program, before compensation can be paid, the injured party must have (1) been on a sick list over 14 days with at least 50-percent incapacity for work, (2) been incapacitated for work for over 14 days, (3) substantial permanent disability, or (4) died.[68] Claimants are required to submit their claims within 3 years of

[66]British Medical Association, op. cit., Appendix I, p. 2.

[67]British Medical Association, op. cit., Appendix I, p. 2.

[68]British Medical Association, op. cit., Appendix II, pp. 2-3.

the date the injury was discovered and not later than 10 years after receiving the treatment causing the injury.

The program fully compensates loss of income and medical treatment and care during the period of acute illness. Compensation generally corresponds with the amount that would have been paid in tort, if liability had existed. Indemnities for pain and suffering during the periods of acute illness are generally determined according to the payment schedule in table V.1:[69]

Table V.1:Sweden Program—Indemnities for Pain and Suffering (In Swedish Kronar Per Month)[a]

	First 3 months after injury	Next 3 months if necessary	Next 6 months if necessary
Hospitalization:			
Severe injury	1,200	900	600
Other injury	900	900	600
Other care	550	550	250

[a]As of November 15, 1985, a Swedish Kronar was equivalent to about 12-1/2 cents.[70]

Indemnities for permanent disfigurement and disadvantage are paid in lump sum as shown in table V.2.[71]

Table V.2:Sweden Program—Indemnities for Permanent Disfigurement and Disadvantage (For Injured Parties Under 25; Reduced Proportionately As Age Increases Over 25)

Degree of disability(%)[a]	Indemnity (in Swedish Kronar)
100	102,000
80	78,700
60	58,000
40	37,900
20	20,400
10	13,100

[a]Only selected degrees of disability are shown.

As of July 1, 1982,[72] total liability of the consortium for sick care from injuries was limited to 75 million Swedish Kronar per year. Also, each

[69]British Medical Association, op. cit., Annex 1., p. 1.

[70]Wall Street Journal, Vol. 206, No. 99, November 18, 1985, p. 60.

[71]British Medical Association, op. cit., Appendix I, p. 1, Annex 2.

[72]British Medical Association, op. cit., Appendix II, pp. 1, 6.

loss event is limited to 20 million Kronar, and each injured party is limited to 2 million Kronar.

Most of the cost of the program is financed by the premiums paid by the county councils, which amounted to 58.8 million Swedish Kronar in 1983. The individual citizen's cost for the program was about 5 Kronar.

According to the British Medical Association's No-fault Compensation for Medical Injury Working Party in 1983, claims processing in the program was slow. An application for compensation may take as long as 2 or 3 years before it is accepted or rejected. In addition, about 40 percent of all claims do not receive compensation.[73]

[73]British Medical Association, op. cit., Appendix I, p. 3.

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