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MEDICAL MALPRACTICE INSURANCE

I

There are certain facts that all parties involved in malpractice insurance will agree upon, and these facts constitute what is increasingly referred to as the "malpractice crisis." It is a fact that malpractice insurance premiums for self-employed general practitioners rose by 580 percent from 1960 to 1972 and for self-employed general surgeons by 900 percent! It is also a fact that in 1970, 18,000 claims files were opened which was a 10 percent increase over the previous year. Further, a number of malpractice insurers have gotten out of the business and others have announced their intent to do so. Malpractice suit settlements are getting higher with a 1973 record \$4 million settlement. Out of every \$10 doctor's fee, patients are paying from 20 to 50 cents for malpractice insurance. Finally, the crisis is not national yet but is present in certain regions. As an example, a North Carolina doctor pays just one-third the national average premium figures while a California doctor in the same type of practice pays 2 1/2 times the national average!

It is logical to wonder about the causes for the changes in the field of malpractice claims. A suit for malpractice before World War II was virtually unknown. The Secretary of Health, Education and Welfare's Commission on Medical Malpractice in 1973 speculated on the reasons for change. In years past, sickness and even death at early ages were accepted facts of life. Infant mortality was high and life expectancy far shorter than today. After World War II, a far greater percentage of people became able to afford medical care and thus more people became potential malpractice claimants. Also, the post-war era saw a great rise in expectations in medical care. Great publicity has been given over the past 25 years to the miracles of modern medicine. Television shows portray doctors who always cure patients. Many people look upon health care as a product. You pay your money and you should have good health, otherwise someone is not doing the job right. Finally, it cannot be denied that there are medical accidents and that there are negligent acts committed by health care providers who are, after all, humans prone to human error.

The very nature of modern medicine makes suits more likely. The doctor-patient relationship of past generations is gone. Doctors do not make house calls. Doctors often practice in association so that the same patient will see different doctors on different visits. Doctors who are overworked and harried can be impersonal and short, thereby creating animosity in their patients. All of these things make suits more likely if treatment is not completely satisfactory. Similar statements can be made about large hospitals which can be rather cold and impersonal.

Along with a greater willingness to sue doctors by patients, there has also developed a greater willingness by attorneys to try such suits. There have been some changes in the law and the legal profession that accounts for this. Doctors point to the increased movement to "no fault" automobile insurance as the basis for increased interest by personal injury lawyers in malpractice cases. There is no firm data to confirm or deny this. Lawyers contend that an increased awareness by the general public of their legal rights as manifested in the consumer movement has led to the increase in suits.

There have been a number of legal doctrines that have emerged in the field of malpractice that have had a significant effect on trying malpractice suits. The first of these is res ipsa loquitur which means literally "the thing speaks for itself." In a suit, it can mean that if there is a medical accident it is assumed that it was negligence by the doctor and the burden of proof shifts to the doctor to prove that he was not negligent. This doctrine is not widely used in malpractice suits but in California, it has been extended to rare medical accidents as well as obvious ones such as leaving an instrument in a person after an operation. The doctrine is still not widely used but there is a trend toward its use.

The doctrine of informed consent means that every person has control of his body and no one may do anything to it without permission. This can mean that even if a patient gives his consent to a procedure, if the explanation of what it entailed by the doctor was not adequate, the doctor can be liable. The emphasis is placed on the "informed" in informed consent. The use of informed consent as grounds by a plaintiff is also small but growing with California again leading the way.

All states have time limitations after which a suit cannot be filed. The older an event on which a suit is based, the more difficult it is to see that justice is done. The discovery rule

is different in malpractice cases. There, the statute of limitations does not begin until the patient notices or "discovers" his injury. This can be years after the fact. This leads to what is known as the "long tail" in medical malpractice suits which means that insurers have a much longer wait after any instance of medical care to see if there will be a malpractice claim than in other types of insurance. As an example, the "tail" in auto insurance liability claims averages 1 1/2 years. In malpractice, it averages 6 1/2 years.

An oral guarantee of good results is an oral contract that a certain treatment will lead to certain results. If this can be proven and the results were not forthcoming, then there is a breach of contract and a patient can sue even if there was no negligence involved. This doctrine has on occasion been used when the statute of limitation on negligence has run out since that for breach of contract is always longer.

No criticism of the legal side of malpractice is so loudly proclaimed as is the contingency fee system. In most states, that means two things. First, the lawyer gets nothing if the suit is lost. Second, the higher the award, the higher the percentage that the lawyer may get. This system undoubtedly has two effects. The first is that there is greater incentive to push for higher awards than if an attorney was being paid for his time on a straight rate. The second effect has two sides. On the one hand, without the contingent fee basis, many people, probably the majority, could not afford the cost of a malpractice suit which runs longer than any other type and involves more expensive expert testimony. On the other hand, the person with a legitimate but small malpractice claim will be unable to find an attorney.

Some balance is probably needed on the subject of what lawyers make from malpractice suits. First, despite publicity to the contrary, doctors still win more than they lose of all claims against them. Only 44.8 percent of malpractice claims in 1970 resulted in payment. Only 11.5 percent of claims went to trial. Only 6.5 percent went to verdict. Fewer than one in four verdicts went against the doctor. The odds for an attorney in taking any malpractice case are less than even, and if they go to trial, they are very poor. In short, what a malpractice attorney is losing in time and money on his lost cases has to be made up in his victories if he is to stay in business. Also, the publicity on big awards is overdone. There are probably not over seven, million dollar plus awards per year according to the Secretary's Commission Report. Almost 60 percent of claims paid in 1970 were for less than \$3,000. Only 6 percent were over \$40,000.

Clearly the plaintiff's award is not the whole problem in the cost of malpractice insurance. Insurance companies must bear heavy legal expenses in all trials and in many claims that do not go to trial. These costs are all part of premiums paid by doctors, hospitals and ultimately by all patients.

Criticism and some blame for the current "crisis" is also aimed at doctors and other health care providers by lawyers and others. A frequent criticism is that the medical profession does not adequately regulate itself, the result being a number of incompetent or simply out-of-date doctors being allowed to practice. Not even the harshest critics of the medical profession would claim that any but a very few doctors are not well qualified to practice. There are definitely several problem areas in insuring the competency of health providers, especially doctors.

All doctors are licensed to practice as are nurses and associated health personnel. State boards composed of members of the profession traditionally set the professional standards and police the profession. As a minimum state boards administer initial licensing exams and determine reciprocal licensing. After the license is granted, most states limit the grounds for revocation to criminal behavior. Only 15 states have professional incompetence as grounds for revocation. Nevada is among the 15.

In all states, continuing medical education in the form of refresher courses, seminars and the like are available. Only in Maryland and New Mexico are state boards empowered to require continuing education despite the fact that the profession of medicine has rapidly changed and continues to do so. This same criticism can be leveled at other professions, notably the law.

Self regulation in medicine extends beyond licensing. Hospitals grant staff privileges to doctors. They may also suspend or revoke privileges. In many cases, this is not done. It is, in fact, easier for the other staff physicians to overlook possible incompetence than to make an issue, and revocation of staff privileges often leads to law suits by the doctor against the hospital.

Finally, even where state boards do move to revoke a doctor's license, the doctor can go to court in an ex parte proceeding, meaning only the doctor's side is heard, and get a stay of the revocation pending the adversarial hearing. In many states, months may pass before that hearing and years before a decision is rendered. In the meantime the incompetent doctor continues

to practice. In one California case a doctor was charged with "gross incompetence" in June of 1966, but it was not until September 1972 that the court finally upheld a 90 day suspension of his license!

There are also problems within the insurance industry that are a part of the malpractice crisis. Already mentioned is the "long tail" in malpractice suits. The effect of this is that insurers do not have data on which to base future premiums that is as firm as in other fields. Also, while millions buy auto insurance or health or life or homeowners insurance, the market base for malpractice insurance is only about 300,000 doctors, dentists and hospitals. The smaller an insurance base, the more prone that group is to fluctuation in claims from year to year. Finally, some insurers have tried to use the "long tail" factor to their advantage. Those new to the field expect that claims will not start showing up for several years. In the meantime, the premium money can be invested and even if claims are high, the investment revenue added to the premiums would more than cover losses. Inflation and higher claims than anticipated ruined this plan and resulted in major losses for several companies leading some to get out of the field. Only 12 insurers provide 90 percent of the malpractice insurance in the country so when even one leaves the field, quite a dislocation occurs.

II

Hopefully, it is clear from the foregoing section that the causes of the malpractice crisis are complex. The fields of law, medicine, insurance and even the media contribute to the problem both individually and in their interactions with one another. It follows that there is no single or simple solution to the "crisis." Solutions will have to be worked out on several fronts. No attempt is made here to determine what the solutions must be. Rather, this paper will conclude by listing the more prominent recommendations from the Secretary's Commission and other sources and explaining the rationale for each. The problems were posed by field; law, medicine and insurance. Recommendations will be listed in the same way.

Law

1. Res ipsa loquitur--Any judicially derived doctrine such as this can be legislatively modified. To ensure that the doctrine is applied no differently in malpractice than in other types of torts would prevent further shifting of the burden of proof to doctors.

2. Informed consent--This doctrine too can be legislatively modified. The extent to which a doctor must explain a proposed procedure to a patient could be limited to a standard prescribed by medical associations or medical boards.
3. Discovery rule--Again, this doctrine can be legislatively modified so that the statute of limitations will be from the time of the negligent act. Such a period could be longer than other personal injury limits but it would be definite, thus giving insurers more certainty on which to base rates.
4. Oral guarantee of good results--This doctrine can be legislatively modified to ensure that there are never implied guarantees in medical practice.
5. Contingency fees--If this system is maintained, and without a "no fault" or a workmens compensation system instead of a tort system there seems no alternative, provide for limits on the percentage that the contingent fee can be. There are two approaches here. New Jersey, by court rule, has adopted a fee system paying 50 percent of the first \$1,000 award and down to 10 percent on any awards over \$100,000. The other approach is that used in Canada where the court determines the attorney's fee based on time and expenses. The second approach would prevent an attorney from making up losses from one suit with the fee from the next one.
6. Ad damnum clauses--A great deal of the publicity about malpractice comes from amounts asked in suits. In fact, the amount asked for is 53 times the amount actually awarded in malpractice suits. Nevertheless, the media headline what the suit asks but seldom follow up with the final award, if any. Pennsylvania court rules provide only that a suit state whether damages desired will be under or over \$10,000.

Medicine

1. Continuing education--Medical boards can be empowered to require certain types of continuing education. Despite good intentions, a great many doctors simply do not participate in continuing education. Some fields of medicine

require more currency than others. State boards could determine what minimum continuing education is necessary.

2. Suspension or revocation of license--Stay orders on suspension or revocations should be strictly limited in duration. In federal court, an adversary proceeding is usually held within 10 days of an ex parte proceeding from which a stay order is issued. If a doctor should not be practicing as determined by a medical board, he must be assured due process but to protect his patients, proceedings must be swift.
3. Probation and rehabilitation--Too often the only disciplinary device a medical board has is revocation of license either permanently or temporarily. In Nevada, if revocation is based on illness or excessive drinking, the doctor may be examined for competency and returned to practice. For revocation for any other grounds, there is no mechanism for requiring special training and reexamination. One reason medical boards may be reluctant to act against doctors is because their only measures are so extreme. If the board had the power to use probation and prescribe refresher training, the incidents of incompetence could very well drop.
4. Reevaluation and recertification--Medical boards could be empowered to require currency testing either through their own tests or through specialty boards. This power would work in conjunction with the power to require certain continuing education.
5. Medical boards--State medical boards used to be concerned primarily with writing and giving tests. Now, test questions are nationally standardized. Therefore, there is no clear reason why lay members cannot serve on medical boards to insure a patient/consumer viewpoint. Nevada has a 5-member, all doctor board.
6. Suspension of staff privileges--Hospitals and staff members should be given limited immunity from suit for their professional actions concerning other doctors and staff privileges. This will make it much easier to discipline doctors whose competence is in doubt.

Insurance

1. Grievance mechanisms--Malpractice suits are sometimes filed because a patient has a complaint that cannot be aired in any other way. Hospitals and local medical associations can develop grievance mechanisms on their own. In addition, a state office of consumer health affairs could be established. In Nevada, the existing division of consumer affairs could be empowered to investigate health care complaints.
2. Alternatives to litigation--
 - a) Screening panels--These already exist in Nevada on a voluntary basis. They consist of doctors and attorneys. Obviously, any resolution of a claim without going to trial lowers overall costs. Legislation could make going to the screening panels a requirement before a suit could be filed. Screening panels only try to determine if a claim is valid. They do not set amounts.
 - b) Arbitration--There are two basic approaches to arbitration. The parties may agree to go to arbitration or there may be law requiring arbitration. In the latter approach, there is usually a top limit to the arbitration award beyond which a suit is necessary. New Hampshire has enacted such a law covering a number of professions including medicine. Two counties in Pennsylvania as a means of cutting down court loads have by rule required that all tort cases under \$10,000 go to arbitration.

In either screening or arbitration, resort to trial can be discouraged by a requirement that the party who brings suit after rejecting the recommendation of the screening panel or the arbitration panel will be assessed a part of court costs if he loses.
3. Reinsurance--All but the very largest malpractice insurers need to be able to reinsure. This is a process by which an insurer insures his clients. It is taking out insurance on insurance. Reinsurance is becoming more difficult to find, thereby increasing risks to the primary insurer. A bill has been introduced in Congress to have the federal government become a reinsurer in malpractice insurance.
4. "No fault"--Senators Kennedy and Inouye have introduced a federal no fault malpractice insurance bill. There are

definitely problems with the tort system. The problem is that personal injury auto insurance is not analogous to malpractice insurance. We all know what an automobile accident is. Not even doctors can agree on what a medical accident is. In short, how would a no fault system determine what a compensable incident was? There is no answer at present to this. Until there is, there cannot be a workable no fault system in malpractice.

5. Workmens Compensation model--The workmen's compensation system has some no fault aspects but there is a panel of experts, presumably doctors, lawyers and knowledgeable lay people, who would determine awards. This is a cross between imposed arbitration and pure no fault. The insurer in such a system could be government or private insurance. In either case there could be an upper limit beyond which the individual could still go into court. Doctors would be covered on, say, the first \$100,000 but would have to take out coverage for extraordinary claims. In 1970, only 3 percent of all claims paid were in excess of \$100,000. Proponents claim that such a system is much less costly in terms of litigation and has the additional advantage of making it possible to settle small claims that are now left out. A bill to this effect has been introduced in the California Senate.

III

Despite the fact that the president's message on health in 1971 stated that "The consequences of the malpractice problem are profound" and that "It must be confronted soon and it must be confronted effectively . . ." virtually nothing other than the creation of a study commission has been accomplished. In the meantime, the situation has gotten worse to the point of crisis and now legislative remedies are demanded. Bills thus far introduced in Congress would set up a reinsurance program (S 188), national no fault (S 215), national imposed arbitration (S 482) and further study (H 1305 and H 1378). California has the proposed workmen's compensation model for malpractice introduced by Senator George Carpenter on February 12.

There is a demand that the legislature do something. What that is is not clear. Trying to anticipate what Congress will do does not provide any clarity. This paper has only attempted to highlight the issues. It has made no attempt to assess the situation in Nevada concerning malpractice, but rather has tried to make

the subject in general comprehensible. Finally, it has made no attempt to recommend action. Various proposals are presented with the arguments their proponents use and do not reflect any positions of the Office of Research.

SUGGESTED READING
(Available in the Research Library)

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