Another Look at the “Medical Malpractice Crisis”

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Conventional wisdom tends to hold that physicians are being run out of practice by rising malpractice premiums. Rising premiums have allegedly been precipitated by a plague of frivolous lawsuits filed by greedy patients and lawyers looking to strike it rich. As a result, physicians allegedly can’t do their work and are leaving their practices, and patients allegedly can’t get the care they need.1 If only we had strict caps on damages, then the problem supposedly would be solved.2

Yet however strongly individuals, physicians’ associations and others may believe this, the data do not bear it out. First, as Tom Baker and others have observed, the number of medical malpractice suits, in relation to the number of medical malpractice incidents, is in fact relatively small.3 According to a number of studies done in the last few decades, anywhere between about one and eight percent of all patients who enter the hospital are injured due to medical malpractice during the course of their hospitalization. But only about three percent of those injured due to negligence ever sue.4 Thus, for example, the Harvard Medical Practice Study examined a large, random sample from 2.7 million New York hospital discharges in 1984. Based on their findings, the researchers estimated that

1 See, e.g., American College of Surgeons, The Medical Liability Crisis and the Litigation Explosion, available at http://www.facs.org/ahp/litexplosion.html (last viewed Sept. 27, 2006) (“More and more Americans aren’t getting the care they need when they need it because our legal system has turned into a lawsuit lottery where a few win and the rest of us lose. The “disappearing doctor” phenomenon is getting progressively and rapidly worse. It is an increasingly serious threat to everyone's ability to get the care they need”).

2 See, e.g., AMA Urges House to Pass H.R. 5, July 28, 2005, available at http://www.ama-assn.org/ama/pub/category/15363.html (“Reforms, including a quarter-million-dollar cap on the non-economic damages portion of the award, have been working in California for nearly 30 years. The rest of our nation deserves that same relief”).


there were 27,179 instances of medical negligence that occurred in the state that year. However, patients filed only an estimated 3,570 lawsuits based on those hospitalizations, and out of those suits, only 608 were estimated to have been objectively meritorious. Based on this data, it appears that only a tiny fraction of patients injured by medical malpractice ever sue. Yet physicians’ organizations and others claim that both the number of lawsuits and the verdicts associated with them have skyrocketed in recent years. Could this explain the rise in premium rates? Perhaps it could, but good data in fact show neither any such increase in claims associated with plaintiff payments, nor any substantial increase in settlement and judgment amounts. A few states, such as Texas, keep excellent closed claim data, or data from insurers about all the claims they had that were closed during the year. A study by Bernard Black and his colleagues looked at the Texas closed claims data, and found that, between 1988 and 2002, the number of small, medium and large judgment claims remained relatively constant. Zero-payout claims rose by a little over 1,000 between 1999 and 2001, and accounted for most of the increase in claims during that time.

Might the increase in zero-payout claims contribute to rising premiums? They comprise the vast majority of medical malpractice claims, and do cost money to defend if associated with a case filed in court, even if no money is ultimately paid to the plaintiff. However, not all zero-payout claims have any defense costs associated with them. A Washington closed-claims study found, for example, that 32.6% of all zero-payout

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5 Localio et al., supra note 4.
6 This is not to say that all patients who sue for malpractice have in fact been injured due to malpractice; in fact, evidence suggests there’s only a small overlap between those patients who are injured due to medical malpractice and those who actually sue for medical malpractice. See, e.g., Localio et al., supra note 4.
7 While some proponents of damage caps cite alleged increases in jury verdict amounts from Jury Verdict Research and others, these sources admit they do not include all jury verdicts (let alone settlements), unlike the closed claims data used by Bernard Black and his colleagues, among others. See Jury Verdict Research, About Jury Verdict Research, available at http://www.juryverdictresearch.com/About_JVR/about_jvr.html (last viewed Oct. 5, 2006).
9 Id. at 246.
10 For example, in 2001, at the height of the premium crisis, Texas reported 7,450 zero-payout closed claims, as compared with 1,493 closed claims in which money was paid to the plaintiff through settlement or trial. Black et al., supra note 8, at 246.
11 See, e.g., STATE OF WASH., MEDICAL MALPRACTICE CLOSED CLAIM STUDY: 1994 – 2004 (2005), www.insurance.wa.gov/special/wic/MedMalDataCallOct2005.pdf (finding that 47.4% of all defense costs were spent on zero-payout claims during the study period).
claims had no defense costs.\textsuperscript{12} Bernard Black and his colleagues found in Texas that “defense costs grew smoothly over time and insurers should have good ability to predict them,” and concluded accordingly that “rising defense costs should not cause sharp premium spikes.”\textsuperscript{13}

Nevertheless, haven’t damage caps worked? Texas is now trumpeted as a poster child for tort reform because of its imposition in 2003 of strict damage caps.\textsuperscript{14} The state’s largest carrier, Texas Medical Liability Trust, reported a 7.5\% reduction for 2007, and others are following in TMLT’s footsteps.\textsuperscript{15} Yet Texas is not alone in experiencing premium reductions. Even “crisis” states such as Pennsylvania, Ohio and West Virginia, also began to see a decline in premium rates, even without the imposition of strict new damage caps.\textsuperscript{16} In these states, as elsewhere, the “crisis” appears to be resolving.

As it turns out, a variety of factors that have had limited relation to any malpractice “crisis” are likely responsible for the rise in premiums. Insurance industries all go through “hard” and “soft” markets. In “hard” markets, premiums rise and insurance becomes expensive and difficult to obtain. In “soft” markets, just the opposite occurs. This “underwriting cycle” can become particularly pronounced in the medical malpractice market, due in part to the long lag between the time an occurrence that gives rise to a claim occurs and the time at which it is ultimately resolved. Often, this may take five to ten years. Thus, medical malpractice insurance actuaries must estimate losses much farther into the future than most other insurers. However exacting they may be in these calculations, they can, and do, sometimes estimate incorrectly. If their estimate is consistently low, then the insurer’s reserves – money set aside to cover anticipated losses – may become low. If so, then the insurer will need to obtain funds from other sources. However, if the insurer’s investments are doing poorly, as they might during an economic downturn, then the insurer may be forced to raise premiums to make up for its losses. When this happens, as it appears to have done from about 1999 through 2001, as well as

\textsuperscript{12} Id. at 32. Not all claims are associated with cases filed in court; some are claims opened when an attorney requests a patient’s records, or when a physician asks risk management to review a matter, for example.

\textsuperscript{13} Black et al., supra note 8, at 245.

\textsuperscript{14} TEX. CIV. PRACT. & REM. CODE §§ 74.301 – 74.303 (West 2006).


previously during the last “crisis” in the 1980s, then the market changes from soft to hard.\footnote{For further information, see generally BAKER, \textit{supra} note 3; Black et al., \textit{supra} note 8.}

Nevertheless, physicians’ and insurers’ associations, among other groups, used this downturn to press for further tort reform, usually in the form of strict caps on non-economic damages, even though it appears unlikely that such caps would have – and have had – a significant effect on premium prices. This should come as no surprise. For insurers, caps on non-economic damages not only may lower their payouts, but also help protect them from some degree of market fluctuation. When one significant variable in their actuarial calculations gets capped, future payout calculations become that much simpler and more reliable. For physicians, damage caps make tort claims that much less desirable for plaintiffs, and that much less likely to be brought by plaintiffs’ attorneys. Suits cost a lot of money to bring, and few plaintiffs’ attorneys will pursue a claim on which they’re likely to make little if any money, even if they get a favorable verdict. The law of diminishing returns dictates it, just as it does the willingness of physicians to take on Medicaid patients when reimbursements are on the decline.\footnote{See, \textit{e.g.}, \textit{PETER J. CUNNINGHAM \& JESSICA H. MAY, MEDICAID PATIENTS INCREASINGLY CONCENTRATED AMONG PHYSICIANS 2, http://www.hschange.org/CONTENT/866/866.pdf.}} And the fewer suits there are, the happier most physicians will be, as no one wants to be sued.

If damage caps won’t likely reduce premiums substantially, then what will? More careful regulation of the insurance industry may help matters, as California found through its enactment of Proposition 103. Yet what if one’s real concern is reducing one’s likelihood of being sued? One could seek damage caps, as in the most recent crisis.

Caps, however, do nothing to address medical errors, which are the source of many successful malpractice claims. Without addressing this issue, the problem will remain. Unless one believes that the tort system can adequately address medical error on both individual and systemic levels, one will need to seek a much broader reform, reform that treats physicians evenhandedly and with relative predictability, compensates patients both fairly and non-excessively, and that ties resolution of claims with both individual and systemic reforms that will help make medical care safer for future patients.

October 2006